

**Feasibility of the Back2School Intervention in the Finnish Context:
A Transdiagnostic Cognitive-Behavioral Intervention for School Attendance Problems**

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Abstract: <p>School attendance problems (SAPs) is a heterogeneous clinical phenomenon with a wide variety of associated etiologies, symptoms, and perpetuating factors. Most existing intervention manuals based on cognitive behavioral therapy are specific to a certain type of SAP. Due to this heterogeneity, transdiagnostic interventions have been recommended, to target the entire spectrum of SAP with the same manual. This study aimed to evaluate the feasibility of Back2School (B2S), a transdiagnostic and modular cognitive behavioral therapy intervention for school attendance problems in a Finnish context. The sample consisted of 16 families distributed over 5 clinicians who received training in the B2S manual. We evaluated four different parameters: sample characteristics, data collection procedures and outcome measures, treatment satisfaction and acceptability, and treatment effects. The results showed that the treatment effects were not replicated to the same extent as the original study due to differences in sample characteristics, with the sample in this study being relatively high functioning on many important clinical variables. However, self-report measures and qualitative data indicated high treatment satisfaction among all respondent groups. The study found a higher degree of missing data, compared to the original study, due to more complex data collection procedures, highlighting the need for future studies to digitize data collection to reduce workload and increase the proportion of collected data. We also recommend changing the recruitment process and inclusion criteria to ensure a more representative sample to evaluate with stronger scientific rigor the effect of Back2School on school attendance problems.</p>	
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Abstrakt: <p>Skolfrånvaroproblem (SAP) är ett heterogent kliniskt fenomen med en bred variation associerade etiologier, symtom och vidmakthållande faktorer. De flesta interventionsmanualer baserade på kognitiv beteendeterapi är specifika för en viss typ av skolfrånvaroproblematik. På grund av denna heterogenitet har transdiagnostiska interventioner rekommenderats för att behandla hela SAP-spektrumet med en och samma manual. Denna studie syftade till att i en finsk kontext utvärdera genomförbarheten av Back2School (B2S), en transdiagnostisk och modulär kognitiv beteendeterapeutisk intervention för skolfrånvaroproblem. Samplet bestod av 16 familjer fördelade på 5 kliniker som fick utbildning i B2S-manualen. Vi utvärderade fyra olika parametrar: samplets egenskaper, datainsamlingsprocedurer, behandlingstillfredsställelse, acceptans och studieprocedurer samt behandlingseffekt. Resultaten visade att behandlingseffekten inte replikerades i samma utsträckning jämfört med den ursprungliga studien, framför allt på grund av skillnader i samplets egenskaper. Vårt sampel var jämförelsevis högfunktionerande på många centrala kliniska variabler. Självrapporteringsmått och kvalitativa data indikerade dock hög behandlingstillfredsställelse bland alla respondentgrupper. Studien fann en högre grad av uteblivna data på grund av komplexa datainsamlingsprocedurer vilket belyser behovet av framtida studier som skulle digitalisera datainsamlingen för att minska arbetsbelastningen och öka andelen insamlade data. Vi rekommenderar också att kommande randomiserade studier ändrar rekryteringsprocessen och inklusionskriterierna för att säkerställa ett mer representativt sampel för att med starkare vetenskaplig noggrannhet utvärdera effekten av Back2School för skolfrånvaroproblem.</p>	
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Feasibility of the Back2School Intervention in the Finnish Context:

A Transdiagnostic Cognitive-Behavioral Intervention for School Attendance Problems

The prevalence, associated difficulties, and possible increase of school attendance problems (SAP) have been a subject of concern in Finnish schools. In a government report on the current situation, Määttä et al., (2020) estimated the Finnish prevalence of SAP to be around 2-3% in Finnish secondary schools, the mean duration of the problem lasting over 2 years of the 3 years spent in secondary school education, indicating a somewhat chronic course among most students experiencing SAP-problems (Määttä et al., 2020). The literature indicates a wide range of short and long-term complications that are associated with school non-attendance, such as socioemotional difficulties (Gottfried, 2014; Malcolm et al., 2003), poor academic performance (Gershenson et al., 2017; Gottfried, 2014), early school dropout (Carroll, 2010; Christle et al., 2007; Schoeneberger, 2012), future unemployment (Attwood, & Croll, 2006), and various forms of psychopathology (Bools et al., 1990; Egger et al., 2003; Flakierska et al., 1988). A wide range of psychosocial risk factors has been identified concerning SAP. The authors of the field have traditionally differentiated between individual factors (such as temperamental individual differences and physical illness), family factors (such as rapid changes in the familial structure, parental psychopathology, and dysfunctional parental styles), school factors (such as the transition to a new school, social exclusion, bullying and dislike of a specific school subject) and community factors (such as performance pressure and lack of support) (Heyne, 2006; Maynard et al., 2018; Thambirajah et al., 2008).

Theoretically, the different risk factors can be understood from the perspective of Bronfenbrenner's theory of bioecological systems. According to Bronfenbrenner, psychosocial development emerges from different interactions between the child and different levels of their distal and proximal environment. The theory divides the developmental interactions into five levels with interacting influences ranging from the immediate environment (e.g. family, peers, and school) to more distal sources of developmental influence (e.g. community services, societal values, cultural beliefs and policies, and the broader historical context) (for in-depth theoretical description, see Bronfenbrenner, 1977; Bronfenbrenner & Morris, 2007; Melvin et al., 2019a).

In the SAP intervention literature, a lack of best practice guidelines can be observed regarding psychosocial interventions, arguably particularly in the Nordic countries, with very few intervention trials conducted (Määttä et al., 2020). Given the rising concern regarding school attendance problems and the lack of scientifically validated psychosocial interventions in Finnish students and specialized health care, there is an evident need for evidence-based interventions for

school attendance problems. The present study aims to bridge this gap between science and practice by evaluating the feasibility of the Back2School program, a transdiagnostic cognitive-behavioral intervention for school attendance problems in the Finnish context, and to provide helpful guidelines for future efficacy trials of the intervention.

Due to the broad spectrum of relevant etiological factors, and the long history of the SAP literature, due to its high relevance to children's psychosocial functioning, the definition, terminology, and taxonomy of the different types of SAP have been a subject for debate and discussion (Heyne et al., 2019). Beyond the shared factor of school non-attendance, SAP is a considerably heterogeneous clinical phenomenon, with a wide range of associated symptomatology with different precipitating and perpetuating factors underlying the appearance and maintenance of non-attendance (Heyne et al., 2019; Kearney 2008; Lomholt et al., 2020). Therefore, an agreement on the 1) threshold for problematic school absenteeism, and 2) the categorization of different types of problematic school absenteeism, is crucial for a phenomenological understanding of the concept, and eventually for the planning of correctly targeted interventions.

Definition and categorization of school attendance problems

Different attempts to reach a common agreement regarding the definition and categorization of school attendance problems have been made in the modern SAP literature. Many attempts have been made to formulate the appropriate threshold level between normal and problematic absenteeism (e.g. Gentle-Genitty et al., 2015; Kearney, 2003; Kearney, 2008) and to differentiate between the specific types of school attendance problems (e.g. Atkinson et al., 1985; Broadwin, 1932; Heyne, 2019).

Kearney's model is arguably the one that is closest to approaching consensus between researchers for identifying the threshold for a problematic level of SAP in today's field (Kearney, 2008). The model consists of three separate indicators: 1) the child has missed a minimum of 25% of total school time for at least 2 weeks; 2) significant difficulty attending school for a minimum of 2 weeks and a considerable negative impact on the daily functioning of the child or the family; and 3) a minimum of 10 days absence from school during 15 weeks, excluding holidays. These criteria also serve the function of differentiating problematic school absenteeism from normal or expected absenteeism, with the latter being described by Kearney as "agreed on by parents and school officials as legitimate in nature and not involving detriment to the child" (Kearney, 2003).

The struggle to accurately conceptualize the heterogeneity of school attendance problems in separate descriptive subcategories can historically be attributed to inconvenient semantic factors regarding the terminology (for a comprehensive summary, see Heyne, 2019), and quantitatively, possibly, to overlapping categories within the SAP spectrum (Kearney, 2005; Lyon & Cotler, 2007). With regard to the terminology, various terms have been used throughout the literature with

different meanings, confusing both practitioners and researchers. Terms such as “school refusal”, “truancy”, “school refusal behavior” and “problematic absenteeism” have been used inconsistently in a context-independent way (Heyne et al., 2018). Different authors use different terms to describe different levels of analysis of school attendance problems. For example, “truancy” is used by some authors synonymously with terms such as “school attendance problems” or “school refusal” to describe the general construct of unexcused absence from school. By others, truancy is used to describe the act of deliberately skipping school without the parents being aware, often to search out tangible rewards outside of school, and often with accompanying externalizing psychopathology (Bools et al., 1990; Vaughn et al., 2013).

This kind of interchangeable terminology, mixing different levels of analysis, has been a characteristic problem of the SAP literature (Birioukov, 2016; Heyne et al., 2019; Keppens & Spruyt, 2017). Many attempts were made during the 20th century to create an accurate and clinically useful taxonomy for different school attendance problems (Broadwin, 1932; Hiatt, 1915; Kahn & Nursten, 1962; Reid, 1985), historically differentiating between the “neurotic” and the “characterological” types of school attendance problems (Coolidge et al., 1957; Kearney, 2001). The taxonomy that is commonly used in the modern literature differentiates between three types of school attendance problems: school refusal (SR), truancy (TR), and school withdrawal (SW) (Heyne et al., 2019). The fourth category of school exclusion (SE) has also been discussed, however without the same degree of scientific consensus as the three primary constructs. SR portrays school absenteeism that is associated with emotional distress and internalizing psychopathology, mainly anxiety and depression (Berg et al., 1968; Berg, 1992; Heyne et al., 2019). Historically, this description is in line with the “neurotic” absenteeism motivated by emotional distress. The absence is not hidden from the child’s parents and the child is not displaying significant externalizing symptoms. TR refers to absenteeism without the parents’ permission and the attempt to hide it from them. It is often associated with externalizing psychopathology and the pursuit of tangible reinforcements outside of school (Berg, 1997; Gentle-Genitty et al., 2015; Keppens & Spruyt, 2017). Historically, TR would be the equivalence of the characterological absenteeism mediated by antisocial behavior and tendencies (Sheldon, 2015). SW describes school non-attendance that is initiated and maintained by parental efforts, without the motivation to make the child return to school (Berg et al., 1978; Berg, 1992). The additional category of SE relates to absenteeism that can be attributed to reasons caused by the school, such as inappropriate disciplinary measures or a failure to offer the necessary support to attain the child’s needs (Heyne et al., 2019).

The functional differences between the different types of school attendance problems reflect the need for tailored interventions and the problem of conceptualizing SAP as a homogenous clinical variable in treatment planning (Kearney, 2006; Lomholt, 2020). In the clinical literature, the

focus has been on the two most prevalent (Määttä et al., 2020) and arguably, functionally most different (Heyne et. al, 2019), types of SAP: school refusal and truancy. The clinical utility of this distinction is comparable to the different treatment approaches that evidence-based practice guidelines suggest regarding the treatment of internalizing versus externalizing psychopathology (Chronis et al., 2006; David-Ferdon & Kaslow, 2008; Eyberg et al., 2008; Silverman et al., 2008). Indeed, Kearney has formulated a possible more clinically applicable alternative to the tripartite model, with a division of SAP into four subtypes, divided into two categories according to the type of behavioral reinforcement that underlies the maintenance of absenteeism (Kearney & Silverman, 1990; Kearney & Silverman, 1993; Kearney & Silverman, 1999; Kearney, 2006). Kearney's theory adopts a functional perspective, describing four theoretical underlying reasons for the maintenance of school absenteeism: 1) avoidance of school-related stimuli that provoke general negative affectivity (negative reinforcement); 2) escape from anxiety-provoking social and/or evaluative situations (negative reinforcement); 3) pursuit of attention from significant others (positive reinforcement); and 4) pursuit of tangible reinforcement outside of the school setting (positive reinforcement) (Kearney, 2002).

Existing interventions for SAP and the “problem” of heterogeneity

A distinction between school attendance problems with school refusing features versus truant features should be considered when reviewing the literature on interventions for SAP, not only because of the different negative outcomes and developmental pathways associated with this rough categorization of school non-attendance but also because of the different clinical methods typically applied for these types of SAP (Keppens & Spruyt, 2020; Maynard et al., 2018).

Traditionally, the literature on SAP interventions has been specific to a particular type of school attendance problem, with school refusal behavior with its functional relationship to internalizing symptoms being the most studied type of attendance problem and cognitive behavioral therapy (CBT) the most studied type of intervention (Heyne et al., 2019; Maynard et al., 2018). CBT is a psychotherapeutic approach that focuses on the interaction between thoughts, emotions, and behaviors as perpetuating factors behind psychological distress. The theoretical foundation behind CBT lies in the integration between the so-called cognitive model and behavioral learning theory. From a cognitive point of view, CBT considers negatively distorted thinking and selective attention as key mechanisms behind the maintenance of psychological symptoms. CBT tries to enhance a more adaptive form of thinking by challenging and replacing these cognitive models and schemas with more realistic ones. The behavioral aspect of CBT focuses on how learned behaviors through the principles of classical and operant conditioning can maintain distress and maladaptive functioning. By identifying and modifying maladaptive behaviors, using for example the behavioral principles of reinforcement and extinction, CBT tries to achieve interaction effects with the

cognitive interventions to relieve symptoms and increase the clients' everyday functioning (Beck, 1979; Beck, 2020).

The psychosocial approach to treating school refusal has a history stemming from the early 20th century with a variety of treatments being tested, including psychodynamic, familial, Rogerian, and psychopharmacological approaches (e.g. Blagg, 2018; Melvin & Gordon, 2019b; Sahel, 1989; Wu et al., 2013). During the last four decades, behavioral, cognitive, and cognitive-behavioral approaches have developed to be the most prominent forms of interventions found in the literature (e.g. Bernstein et al., 2000; Blagg & Yule, 1984; Hannan et al., 2019; King et al., 1998; Last et al., 1998). Early behavioral interventions laid a heavy emphasis on conditioning principles, using for example exposure-based techniques, relaxation training, social skills training, and contingency management. Contemporary forms of interventions with a behavioral foundation have increasingly started to integrate cognitive components with behavioral ones, such as cognitive restructuring, a focus on distorted beliefs, and psychoeducational efforts (Maynard et al., 2018). Furthermore, the course of treatment has evolved from standardized manuals to modular and individually tailored interventions relying on individual case formulations and an emphasis on the functional behaviors and cognitions maintaining non-attendance and associated psychiatric symptoms (Heyne & Rollings, 2002; Heyne et al., 2008; Tolin et al., 2009). Active involvement of the child's family and school staff is also considered essential to today's CBT-based interventions (Heyne et al., 2008; Lomholt et al., 2008; Reissner et al., 2019).

At least six different CBT manuals for school refusal can be found in the literature. The manuals vary in e.g. degree of modularity, target school refusal severity, number of sessions, intervention course, emphasis on individual case formulations and functional analysis, and included outcome measures (Heyne & Rollings, 2002; Heyne et al., 2008; Kearney & Albano, 2000; Last, 1993; Strömbeck et al., 2021; Tolin et al., 2009). However, each manual contains an individual treatment period, involvement of parents and school staff, and key cognitive-behavioral concepts (e.g. cognitive restructuring, exposure-based techniques, psychoeducation, family-based work, and behavioral activation).

In the most comprehensive review to date of cognitive-behavioral therapy for school refusal, the meta-analysis done by Maynard et al. 2018, including 7 randomized controlled or quasi-experimental trials of CBT, provided preliminary evidence for CBT with regard to increasing school attendance in school-refusing youths (Maynard et al., 2018). However, due to the lack of replication studies and variability regarding for example number of sessions, treatment course, and level of family involvement, the authors concluded that more evidence is needed before CBT can be established as an empirically based intervention for school refusal. The intervention studies have also shown age-related differences in treatment response for adolescents compared to children.

Treatment response appears to be lower for school refusal in adolescence, for whom CBT fails to reach satisfactory treatment results for one-third to two-thirds of the cases referred to treatment (Heyne, 2022a; Heyne, 2022b). Furthermore, questions regarding the mechanisms of change in school attendance and problems of causality between school non-attendance and related constructs were raised due to the lack of evidence regarding the effect of CBT on reducing school refusal-related anxiety. This could either reflect 1) an inverse functional relationship in which school attendance evokes anxiety, instead of anxiety evoking school non-attendance, possibly implying the need for a heavier emphasis on school-based interventions in cognitive behavioral interventions for school refusal, or 2) the phenomenon of temporarily heightened anxiety levels at the post-intervention assessment point, before the beginning of the process of habituation and desensitization seen in exposure-based interventions (Maynard et al., 2018).

Although there is a lack of studies using the golden standard design of intervention trials, the randomized controlled trial (RCT), the evidence suggests a general positive effect of CBT on school attendance among school-refusing children. The effect is general in the sense that no specific CBT intervention has consistently been empirically supported as superior to any other CBT intervention. The somewhat counterintuitive finding regarding sustained anxiety levels parallel to increased school-attendance points to other key mechanisms of change than immediate symptom relief in CBT for school refusal. Although the mechanisms of change in CBT for school refusal are somewhat unclear, studies on the factors that mediate intervention outcomes have shown child self-efficacy to be a key mediating cognitive construct for positive treatment outcomes, both in the realm of increasing school attendance and decreasing related psychiatric symptoms (Heyne et al., 2015; Maric et al., 2013).

In an article by Keppens and Spruyt (2020), the existing interventions for truant children and adolescents were examined in the most comprehensive review to date. The review included 16 studies using a randomized controlled, quasi-experimental, or single-group design. A tangible degree of variety could be observed compared to the school refusal literature, with truancy interventions being conducted at many different administrative levels (individual, school, and community levels). Even though heterogeneous effect sizes were found among the included studies, some general conclusions could be made. Firstly, interventions aiming to reduce truancy are generally somewhat effective. Secondly, the solely conditional use of reward and punishment is insufficient at best and counterproductive at worst. The authors concluded that operant behavioral principles only work when a certain degree of bonding between the young person and the school is maintained, suggesting an emphasis on multilevel interventions targeting the individual child, the school, and the community. Indeed, the literature does indicate better results with intervention efforts that are targeted at different levels, and when different stakeholders share the same goals.

Finally, Keppens and Spruyt advocate for the need for a coordinator between different tiers of support and stakeholders within the same intervention. Thus, interventions for truancy suggest that operant behavioral principles could be effective for decreasing truant behavior, if it's applied in a context with a high degree of school bonding, with intervention efforts being conducted at different levels. and with active involvement by stakeholders that work towards the same agreed-upon goal. Finally, the review demonstrates the importance of having the different phases of an intervention coordinated.

As described above, psychosocial interventions for SAP have traditionally been type-specific, roughly categorized into interventions for school refusal and interventions for truancy. Given the heterogeneity of SAP and the finding that a considerable overlap has been demonstrated among youth with SAP (Berg et al., 1978; Kearney & Silverman, 1999; Lyon & Cotler, 2007) transdiagnostic treatment approaches have been suggested (Lomholt et al., 2020; Reissner et al., 2019). The advantage of a transdiagnostic intervention, rather than a type-specific one, is the possibility of a broader application of the same treatment manual (Lomholt et al., 2020). Evidence-based psychological treatments have had a tradition of being disorder-specific, with an emphasis on unidimensional psychopathological processes, such as anxiety, depression, or behavioral problems (Chorpita et al., 2013). A similar phenomenon can be observed in the SAP intervention literature, with most interventions being specific to a certain type of school attendance problem (Keppens & Spruyt, 2020; Lomholt et al., 2020; Maynard et al., 2018). Not only is this process time and resource-consuming from an academic perspective, with a variety of different treatment protocols that need to be validated and scientifically tested, but the disorder-specific approach also neglects the frequently occurring phenomenon of comorbidity in the clinic (e.g. Merikangas et al., 2010).

With a phenomenon such as SAP, with its characteristic heterogeneity, this question becomes even more relevant, emphasizing the need for a “one size fits all” intervention. The evidence, therefore, suggests a need for interventions that can adapt to a variety of factors underlying problematic school attendance (Heyne et al., 2019; Kearney, 2006). Modular treatments that incorporate different treatment pathways according to the individual case conceptualization based on the clinical assessment have indeed demonstrated superior treatment outcomes in studies of adolescent psychopathology (Weisz et al., 2012).

In the field of interventions for school attendance problems, the Modular Manual for the Treatment of Problematic School Absenteeism (MT) is the first attempt at a modular and transdiagnostic approach (Reissner et al., 2019). MT is a German manualized multidisciplinary intervention program that targets children with school refusal, truant behavior, or a mixture of both. The intervention uses a multilevel approach with a case conceptualization that targets the behavioral level (1) internalizing (school refusal), 2) externalizing (truancy), and 3) mixed, the functional level

(according to Kearney's model of positive versus negative reinforcement) and the syndromic-diagnostic level (diagnosis of child psychopathology). MT consists of four different modules including 1) individual and group CBT, 2) family counselling, 3) school counselling; and 4) psychoeducational physical exercise. At the time of writing, one randomized controlled study has been published that evaluates the effect of the MT intervention (Reissner et al., 2015). The study showed an increase of 60% in school attendance during 6 months among school-avoiding children and adolescents with comorbid psychiatric disorders (60% internalizing disorders, 25% mixed disorders & 15% externalizing disorders). This increase was slightly, but statistically non-significantly, higher compared to the treatment-as-usual group. Improvement was also seen in additional outcome measures, with a more notable reduction of depressive symptoms seen in the MT group compared to treatment-as-usual.

The second modular intervention found in the literature, which is the subject of this pilot study, is the transdiagnostic, modular cognitive-behavioral Back2School intervention (B2S; Thastum, & Kjerholt, 2020a). Back2School and MT are similar in their multi-level structure of the intervention, with individual CBT being combined with parent and school work. They are both transdiagnostic in the context of a common assessment phase that creates a case conceptualization connected to different treatment pathways with different disorder-specific techniques depending on the dominating underlying symptomatology and functional reinforcement schedules.

The Back2School intervention: foundations and initial outcomes for a manualized transdiagnostic approach

B2S was originally developed by Aarhus university as an intervention aiming to increase school attendance and decrease associated psychological problems, such as anxiety, depression, and behavioral problems (Thastum, & Kjerholt, 2020a). The intervention is an attempt to target the described problem of heterogeneity regarding SAP, and the lack of broader transdiagnostic interventions in the literature. The intervention adopts a functional approach, in line with Kearney's model previously described. The intervention begins with a standardized assessment period common for all and a treatment period that utilizes different therapeutic mechanisms and strategies depending on the content of the individually tailored case conceptualization and descriptive functional analysis. B2S is a modular intervention, with 11 individual sessions with the child, parent, or both together, and regular school meetings to develop a comprehensive plan for the child's return to school. During the assessment period, a descriptive functional analysis is created based on the School Refusal Assessment Scale (SRAS; Kearney, & Silverman, 1993), which is a measure of the four functions (divided into negative and positive reinforcements) described by Kearney. Beyond the overarching goal of increasing school attendance and decreasing psychological distress, different treatment goals are formulated depending on the individual client's

clinical profile, and different cognitive-behavioral strategies are adapted to the treatment plan depending on the type of core symptomatology and reinforcement schedules underlying the absence from school. One of three treatment pathways is chosen according to the primary difficulty underlying the child's absence from school: anxiety, depression, or behavioral problems. Each of these programs consists of various cognitive-behavioral techniques that are in line with the evidence-based CBT treatment procedure of the targeted problem: an exposure-based program for anxiety, a behavioral activation program for depression, and a contingency and parent management program for behavioral problems. The different treatment pathways manifest the intervention's transdiagnostic nature in providing flexibility within the intervention course that follows the evidence on the heterogeneity and comorbidity of SAP-related psychopathology (Egger et al., 2003).

To this date, the B2S program has been tested in one Danish feasibility study (Lomholt et al., 2020), and is currently being tested in a yet-to-be-published randomized controlled study (study protocol: Thastum et al., 2019). The feasibility study demonstrated positive initial treatment outcomes and showed adequate feasibility in the Danish school context. The level of school absenteeism was reduced from a baseline average of 67% to 26% at post-intervention, and the effects were maintained and furtherly increased at the 12-month follow-up (20%). Furthermore, the study showed significant reductions in anxiety, depression, and behavioral problems, with effect sizes in the medium-to-strong range. Measures of youth and parental self-efficacy were also included, based on the literature regarding the mediating properties of self-efficacy on behavioral change, making it a construct with high clinical relevance. The results showed a significant increase in the self-efficacy of the youths and their parents, maintaining strong effect sizes at the 12-month follow-up. In addition to preliminary outcome measures, four measures of feasibility were examined: 1) recruitment and sample characteristics; 2) data gathering procedures; 3) resources, and ability to implement the study and intervention, and 4) the acceptability of the study procedures and intervention. The results showed a low drop-out rate compared to other interventions for school attendance problems, positive qualitative feedback regarding the emphasis on the involvement of the school in the intervention process, and high treatment satisfaction reported by the parents and the youth, with the teachers reporting slightly lower levels of satisfaction (Lomholt et al., 2020). However, because of the nature of a feasibility study, with a larger emphasis on the examination of the suitability and acceptability of an intervention in a given context, and a lesser emphasis on the statistical power of the evaluation of treatment effects, the interpretation of the initial treatment outcomes should be made with caution. The most significant limitations were related to the small sample size (N=26) and the lack of a control group. The aim of Lomholt's study was primarily to lay the foundations for a future randomized controlled study, and to implement changes in the

intervention and study processes that were indicated by the feasibility study (such as the increase in school consultation in the manual). See Table 1 for an overview of the components of the B2S intervention.

Table 1

Session-by-session summary of the Back2School program

Session	Participants	Session topic
Assessment	C, Y, P	Semi-structured background interview and psychopathological interview. The family fills out questionnaires before the assessment session. The clinician provides psychoeducation about the B2S program and SAP.
Session 1	C, Y, P	Case formulation, SMART goals, and behavioral reinforcement. Psychoeducation about SAP.
Session 2	C, P	Establishing good routines and introducing the concepts of positive feedback and reinforcement. Discussions about motivational aspects. Identification of perpetuating factors for the case formulation.
Session 3	C, P	Clear demands and deliberate disregard of negative behavior. Repetition of positive feedback and reinforcement. Principles for the extinction of unwanted behavior.
Session 4	C, Y, P	Return to school. The meaning and consequences of avoidance behavior. Psychoeducation about exposure therapy. Creation of an exposure hierarchy.
SM 1	C, Y, P, T	Planning school participation to increase the child's attendance at school. Psychoeducation about B2S to the school staff.
Session 5	C, Y, P	Psychoeducation, the cognitive model, and cognitive restructuring.
Session 6	C, Y, P	Return to school: follow-up and problem-solving. Continued exposure work.
Session 7	ANX & DEP: C, Y, P BEH: C, P	ANX: Focus on security behaviors and the exposure hierarchy. DEP: The vicious cycle of depression and behavioral activation. BEH: Rule-governed behaviors and the use of token economy.
SM 2	C, Y, P, T	Following up on the youth's return to school. Planning possible school efforts in helping the youth with academic struggles, anxiety, depression, and behavioral problems.
Session 8	C, P	ANX: Follow-up on the exposure hierarchy. Discussing the parents' role in the reinforcement and extinction of anxiety symptoms. DEP: Continued behavioral activation BEH: Problem-solving with the family. Token economy and the use of negative feedback.
Session 9	ANX & DEP: C, Y, P BEH: C, P	ANX: Exposure therapy DEP: Behavioural activation BEH: Problem-solving with the family. Token economy and the use of negative feedback.
Session 10	Optional	Summaries of homework. Optional techniques are suggested by the clinician.
Session 11	C, Y, P	Preparation for termination. Relapse prevention.
SM 3	C, Y, P, T	The role of the school in preventing relapse.

Booster session	C, Y, P	Follow-up. Maintenance of the treatment response.
SM 4	C, Y, P, T	How the school plans to secure the youth's school attendance and comfort and how the recurrence of school attendance problems can be prevented.

Note. C= Clinician; Y= Youth; P= Parent; T= Teacher; SM= School meeting; ANX= Anxiety; DEP= Depression; BEH= Behavioural problems

The present study

In the Finnish school context and health care, there is a lack of best practice guidelines and available evidence-based manualized interventions for the treatment of school attendance problems. This study aims to begin the effort to bridge this gap, with the conduction of a feasibility study in the Finnish school context. Replicating the methodology of Lomholt et al. (2020), this trial is conducted with a single-group non-randomized design, gathering both quantitative and qualitative data for the evaluation of feasibility and treatment outcomes. According to a distinction made by The British National Institute for Health Research (NIHR), a feasibility study aims to “examine whether the study can be done” (National Institute for Health Research [NIHR], 2012). In contrast, a pilot study is defined as “smaller versions of the main study used to test whether the components of the main study can all work together” (Osmond & Cohn, 2015). Other sources emphasize the aim of the pilot study to also evaluate treatment outcomes, whereas the feasibility study focuses on the assessment of research and methodological processes. Thus, this study occupies features of both a feasibility and a pilot study.

This study is formulated upon one research questions:

- 1) Is the Back2School feasible in a Finnish school context concerning its intervention and study procedures? Feasibility is measured with five parameters: 1) sample characteristics; 2) data collection procedures and outcome measures; 3) treatment satisfaction; 4) acceptability, and study procedures; and 5) treatment effects.

The aim of this study is to produce helpful guidelines and create a foundation for future intervention studies with more rigorous designs (e.g. RCT) to test the treatment effects of the B2S intervention in a Finnish context.

Methods

Participants

Replicating the design of Lomholt et al.'s (2020) feasibility study, our original aim was to include 25 families that were to be equally distributed among the 12 clinicians that took part in B2S training. After the recruitment process and the B2S training program, conducted by the KouluKunnossa project in the municipality of Lohja in southern Finland, our final data set of the intent-to-treat sample consisted of 16 families and five clinicians that agreed to participate in this study. Each clinician treated between two and six families. During the intervention process, three families dropped out, resulting in a final post-intervention sample that consisted of 13 client families. The sample of 13 youths that completed the intervention was 10 to 16 years old ($M = 14$ years). This final sample included four of the clinicians that participated in the B2S training seminar, with the fifth clinician answering questionnaires about the intervention but without providing client data. This study includes four groups of informants: the youths, the parents, the clinicians, and the teachers.

Inclusion criteria

Our inclusion criteria were derived from the Danish feasibility study regarding suitability for the B2S program (Lomholt et al., 2020) and from Kearney's criteria of problematic absenteeism (Kearney, 2008). Requirements for the participating youth were 1) enrolment in one of seven public schools in south western Finland; 2) ages 10-16 years in 4-9th grade, excluding the second semester of ninth grade; 3) parent-reported $> 10\%$ school absenteeism during the last 3 months of School; 4) fluent language skills in either Finnish or Swedish; 5) a commitment from the youth and one of the parents to participate in the assessment and intervention procedures, and 6) written informed consent from the holder of parental legal rights and responsibilities

Ethical considerations

The study was approved by the research ethics committee of Abo Akademi University.

Procedure

The study was conducted as a collaboration between Abo Akademi University and the KouluKunnossa project. The data collection took place during the 2021-2022 academic year.

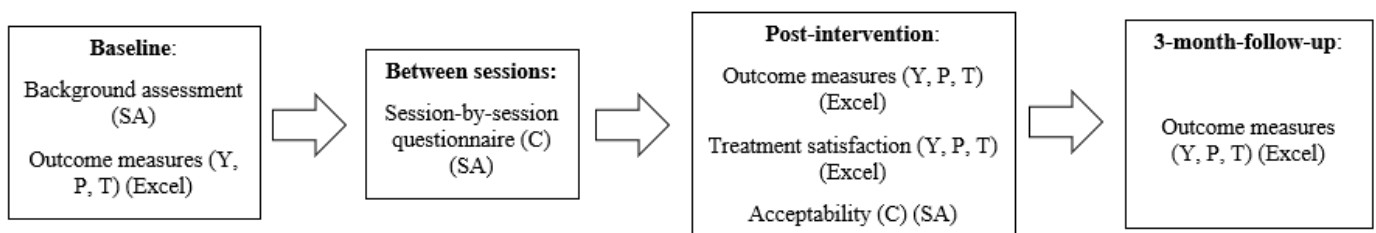
In the recruitment of clinicians, the following inclusion criteria were applied: commitment to working according to the B2S program, experience in clinical work with families, and basic knowledge of CBT principles and techniques. Eleven clinicians participated in a four-day seminar where they were educated on the manual, the different processes of the intervention, and the different steps of this study with its data collection procedures. Five of these eleven clinicians

agreed to participate in the study and were included. The participating families were recruited by the KouluKunnossa project from schools and family services in the municipality according to the described inclusion criteria. All families received information before the beginning of the intervention and provided written informed consent regarding their participation in the intervention and this feasibility study. Informed consent was also gathered from the participating school staff.

Ethical and legal procedures, such as the collection of informed consent and providence of information regarding the legal aspects of this study, were also conducted by the KouluKunnossa project. Data were collected on three different measurement points: pre-intervention, post-intervention, and a 3-month follow-up data collection point. The background questionnaires were administered at the pre-intervention stage and the questionnaires regarding treatment satisfaction and treatment acceptability were completed at the post-treatment data collection point. Outcome measures were completed by the child, the parents, and the teacher at each data-gathering point. The results of these were reported back to the researchers by the clinicians via ready-made Microsoft Excel sheets (one child/teacher and one parent sheet for each measurement point) distributed to the clinicians. An encrypted file sender application and secure e-mail addresses were used when transferring the files. The results from the clinical assessment done before treatment were reported via a questionnaire in Survey Analytics by Question Pro. The same applied to a session-to-session questionnaire, child school absenteeism, clinician-reported session feedback, and clinician feedback on the acceptability of the intervention. See Figure 1 for an overview of the data collection procedure.

Figure 1

Data collection procedure



Note. SA= Survey Analytics by Question Pro; Y= Youth; P= Parent; T= Teacher; C= Clinician

Intervention

The Back2School intervention is a manualized cognitive-behaviorally oriented program developed by Aarhus University for the treatment of various forms of school attendance problems. The original Danish manual was translated into Finnish and Swedish prior to this study (Thastum et al., 2020b). A wide range of inspiration for the B2S program can be found in the literature, with interventions for school refusal such as the @school intervention (Heyne et al., 2008), the When

Children Refuse School (Kearney & Albano, 2018) intervention, and the Cool Kids intervention for child and adolescent anxiety (Lyneham et al., 2003). B2S is also based on the Danish transdiagnostic and modular MindMyMind-program for the treatment of anxiety, depression, behavioral problems, and trauma (Jeppesen, 2017), the Adolescent Behavioral Activation Program for depressive problems (McCauley et al., 2016), and the Parent Management Training - Oregon model (Forgatch, 2016) for the treatment of children with behavioral problems. Similarly to the MindMyMind intervention, Back2School adopts a transdiagnostic and modular approach, meaning that the intervention process and the use of evidence-based CBT techniques are tailored according to the dominating underlying problem which is formulated based on the clinical assessment.

The intervention starts with an initial assessment period, consisting of various questionnaires, a semi-structured background interview with the child and his or her parents, and a semi-structured psychopathological interview to assess the presence of various diagnostic clusters of psychiatric symptoms. A treatment plan is then formulated based on a jointly agreed upon case conceptualization created by the clinician and the client together with his or her parents and the previously described SRAS-R measure, which is a descriptive functional analysis that is used to assess the dominating type of reinforcement that underlies the child's school attendance problem.

The intervention program itself consists of 11 sessions with the child and/or the parents and one follow-up session which is held three months after the last session. Homework assignments are given after each session. To ensure that the school professionals are adequately included in the intervention process, a minimum of three meetings are held with the school staff and one follow-up meeting three months after the last session with the child and his or her family. The role of the school professionals is to work together with the clinician and the family according to the treatment plan and to support a quick and smooth return to school. Depending on the child's situation, the school staff can also implement some of the therapeutic strategies that are chosen for the treatment plan, such as contingency management and positive reinforcement.

The procedure of the initial assessment and the content of the first six sessions are identical for all clients, regardless of the key underlying reinforcement schedule motivating the absence from school. The second half of the program is then tailored according to the case conceptualization and its targeted mechanisms for change and treatment goals, hence the transdiagnostic nature of the intervention. The overarching goal of the intervention, regardless of the underlying problem, is to help the child to return to normal school attendance as fast as possible and to be able to enjoy the time spent in school.

Assessment

Semi-structured background interview

The semi-structured background interview was conducted in two parts: one part with only the parents and a second part with the parents and the child together. The interview is a comprehensive assessment of, for example, family functioning, the child's psychological, cognitive, and somatic developmental history, academic history, school and home environment, psychological and physiological health, parent and child self-efficacy, motivational factors, and readiness to change. Various worksheets are included in the manual to help the clinician and the family to conceptualize the current situations and the functional properties of certain key problem behaviors to school absenteeism. Finally, treatment goals are formulated following the SMART principle (Specific, Measurable, Achievable, Relevant, and Time-bound (O'Neill, 2000), which is a goal conceptualization technique that is commonly applied in clinical situations.

Semi-structured psychopathological interview

The semi-structured psychopathological interview was conducted together with the child and the parents. The interview aimed to determine the presence of clinically significant psychopathology. The interview schedule goes through a broad variety of existing child and adolescent psychiatric conditions in a checklist manner, with different excluding items dictating the course of the interview. The criteria for evaluating a diagnostic category as clinically meaningful psychopathology require not only the presence of key symptoms but also a significant negative impact on the child's level of functioning. The included diagnostic categories are panic disorder, separation anxiety, social anxiety, specific phobias, agoraphobia, obsessive-compulsive disorder, traumatic stress reactions, general anxiety, depression, self-harming behaviors, hypomania/mania, substance use, tics, hyperactivity and/or impulsivity, conduct problems, psychotic experiences, eating pathology and developmental pathologies.

Measures of treatment outcome

Primary outcome measures

Absenteeism. Data for our primary outcome variable of absenteeism was gathered at each data collection point by parent reports provided to the clinician. Following the period of two weeks recommended in Kearney's criteria, the teacher and parents were asked to report the number of hours the child should have been in school, and the number of hours the child de facto was at school, operationalizing absenteeism into a percentage of expected school attendance during the last two weeks at baseline, post-intervention and 3-month follow up.

Secondary outcome measures

Anxiety. For measuring anxiety symptomatology, the Revised Child Anxiety and Depression scale (RCADS; Chorpita et al., 2000) was used. The RCADS is a 47-item self-report questionnaire of a broad range of youth internalizing symptoms. The measure consists of 6 subscales: separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder,

obsessive-compulsive disorder, and major depressive disorder. Items are answered on a 4-point scale with the answer options "never", "sometimes", "often" and "always". A Total Anxiety scale is computed from the five anxiety subscales (scores ranging from 0–111) and a Total Internalizing scale (scores ranging from 0–141) is computed based on the total sum of the 6 questions (5 anxiety scales and one depression scale). Both the child self-report version and the parent-reported version were used in this study. The RCADS has demonstrated acceptable-to-good internal consistency in both clinical ($\alpha = .78-.88$) (Chorpita et al., 2005) and non-clinical ($\alpha = .60-.96$) (Donnelly et al., 2019) samples, and adequate one-week test-retest reliability (.65-.80) (Chorpita et al., 2000).

Emotional, behavioral, and social difficulties. To measure the degree of emotional, behavioral, and social difficulties, The Strengths, and Difficulties Questionnaire (SDQ; Goodman, 1997) was used. SDQ is a questionnaire with 25 statements that aim to measure emotional, behavioral, and social problems in children and young people. The questions were answered by the student, parents, and the student's class teacher on a three-point Likert scale with the statements "not true", "partially true" and "completely true". Factor analytical studies have identified five different scales that reflect individual differences in the degree of psychopathology and prosocial behavior among children and adolescents: emotional problems, conduct problems, hyperactivity, peer problems, and prosocial behavior. Based on the subscales, three additional scales are calculated: externalizing symptoms (scores ranging from 0 to 10), internalizing symptoms (scores ranging from 0 to 10), and the total scale score (scores ranging from 0 to 20). The Finnish version of the SDQ has shown acceptable internal consistency and adequate inter-rater reliability (Koskelainen et al., 2000).

Depression. For measuring the degree of core depressive symptomatology, the short version of the Mood and Feelings Questionnaire was used (SMFQ; Angold et al., 1995). The SMFQ consists of 13 items, in this study, the measure was conducted on both the child and the parent. The items are answered on a 3-point Likert scale and a sum is computed as a total score of depressive symptoms with scores ranging from 0 to 26. The questions target core affective and cognitive depressive symptoms during the last 2 weeks, creating a temporal consistency with the diagnostic criteria of major depressive disorder (APA, 2013). The SMFQ has demonstrated good internal consistency ($\alpha = .85$) and with a cut-off score of 8 or more, 60% sensitivity, and 85% specificity with a psychiatric diagnosis of major depressive disorder (Angold et al., 1995).

Presence and function of SAP-related symptoms. The Inventory of School Attendance Problems (ISAP; Knollmann et al., 2019) was included as an outcome measure of both symptom presence and strength and as a measure of these symptoms' functional relationship to the maintenance of school absenteeism. The ISAP is a 48-item self-report measure with 13 factor analytically derived subscales of externalizing and internalizing symptomatology: depression, social anxiety, separation anxiety, performance anxiety, agoraphobia/panic, somatic complaints, school

aversion, aggression, problems with peers, problems with teachers, dislike of a specific school, problems within the family and problems with parents.

For each subscale, a symptom and an impact score are computed. The items are formulated as statements and answered on a 4-point scale ranging from "never" to "always". The symptom score reflects the strength of the specific symptom, and the impact score is the degree of functional impact each symptom has on school non-attendance. Internal consistency of the ISAP has demonstrated psychometric adequacy ($\alpha = .75-.88$) (Knollman et al., 2018).

Descriptive functional analysis of school refusal behavior. The School Refusal Assessment Scale-Revised (SRAS-R; Kearney, 2002) is a 24-item self- and parent-report scale used to assess the primary function of a child's school refusal behavior. The items are presented on a Likert scale ranging from 0 (never) to 6 (always). In the B2S program, the descriptive functional analysis derived from the scale is used to guide the treatment focus. The scale measures four functions that have been derived factor analytically. The four factors are 1) avoidance of school-related stimuli that provoke general negative affectivity (negative reinforcement); 2) escape from aversive social and/or evaluative school situations at school (negative reinforcement); 3) the pursuit of attention from significant others (positive reinforcement); and 4) the pursuit of tangible reinforcement outside of school (positive reinforcement). The factor with the highest score (child and parent combined) is the primary function of the child's school-refusing behavior. Both the child version (SRAS-C-R) and the parent version (SRAS-P-R) were administered in this study. Both measures have demonstrated rather questionable psychometric properties with just below acceptable within-scale internal consistency (SRAS-C-R: $M = .67$; SRAS-P-R: $M = .54$) and test-retest reliability (SRAS-C-R: $M = .67$; SRAS-P-R: $M = .67$) (Kearney, 2006).

Self-efficacy. For measuring youth self-efficacy regarding situations related to the school environment, the Self-efficacy Questionnaire for School Situations (SEQ-SS; Heyne et al., 1998) was used. The SEQ-SS consists of 12 items regarding school situations that are highly related to self-efficacy cognitions, the situations are derived from the school refusal literature and clinical experience. The items are answered on a 5-point Likert scale (1–5), and the sum of the scores lands on two factors: academic/social stress and separation/discipline stress. The combination of the two factors creates a total score between 12 and 60, with a higher score indicating a higher level of self-efficacy. The original validation studies of the measure demonstrated good psychometric properties with high internal consistency for both the two subfactors (alpha .81) and the total score (alpha .85) (Heyne et al., 1998). The test-retest reliability also reached good levels of agreement ($r = .79-.91$) (Heyne et al., 1998).

The self-efficacy questionnaire for responding to school attendance problems (SEQ-RSAP; Heyne et al., 2007) was used to assess parental self-efficacy in responding to their child's school

attendance problems. We used the longer 25-item version of the measure, not to be confused with the 13-item version that is also found in the literature (Heyne et al., 2016). The content of the items is about the parents' beliefs about their capability to handle and have a positive influence on the child's school attendance. The items are answered on a 4-point Likert scale (1-4), with the possible total score ranging from 25 to 100. The SEQ-RSAP has demonstrated adequate internal consistency ($\alpha = .91$) and test-retest reliability ($r = .67$) in an unpublished master's thesis (Lavooi, 2010).

Family functioning. For assessing family functioning, we used the general family functioning subscale (12 items) of the broader McMaster's family assessment device (FAD; Epstein et al., 1983) (60 items). The scale consists of claims regarding the family's overall functioning and possible problems. The items are responded to with a four-point Likert-scale, with a total score computed as the mean score of each claim. A higher total score reflects a higher degree of problems in family functioning, with a score of 2 and over as a cut-off point for considerable problems. The general functioning scale has shown validity in the realm of predicting maladjustment and suicidal behavior among children, and a capacity to identify dysfunctional families with a higher risk for juvenile maladjustment. The general family functioning scale of the FAD has demonstrated excellent internal consistency ($\alpha = .92$) (Miller et al., 1985) and adequate test-retest reliability ($r = .71$) (Epstein et al., 1983).

Personal experience of being bullied. The personal experience checklist (PECK; Hunt et al., 2012) was used to assess the youths' personal experiences of being bullied at school. The instrument consists of 32 items that measure various forms of peer victimization, creating four separate factor-analytically derived factors: relational-verbal bullying, cyberbullying, physical bullying, and bullying based on culture. The PECK scales have demonstrated adequate psychometric properties with good to excellent internal consistency ($\alpha = .78-.91$) and acceptable test-retest reliability ($r = .61-.86$) (Hunt et al., 2012).

Measures of feasibility

As previously claimed, the primary objective of this study was to assess the overall feasibility of the Back2School program in a Finnish context and to determine the suitability of the intervention and its processes for a future intervention study with stronger scientific rigor, such as a randomized controlled trial (RCT). Inspiration for measuring feasibility was taken from the feasibility study conducted in Aarhus by Lomholt et al., Our main areas of interest were 1) sample characteristics; 2) data collection procedures and outcome measures; 3) treatment satisfaction; 4) acceptability and study procedures; and 5) treatment effects. As recruitment was conducted by a third party (the KouluKunnossa project), we were not able to evaluate the different stages of the recruitment process. However, important differences between the recruitment process in this study and other trials within the SAP field will be discussed in the context of sample characteristics.

Sample characteristics

Sample characteristics of the participating child, the client's family, the treating clinician, and the schoolteacher were gathered at the baseline data collection point with the background questionnaires as the primary source of data. The parents filled out a 41-item background questionnaire with questions regarding basic demographic information, the child's familial structure and situation, the child's social, cognitive, and physiological developmental history, potential developmental, psychiatric, or medical deviations, ongoing medications or other forms of treatments, and familial psychiatric and medical history. The questionnaire also contained questions regarding the child's school attendance/non-attendance, collecting data for the measurement of the primary outcome measure of absenteeism. The teachers also filled out an 11-item background questionnaire before treatment, with questions regarding the cooperation with the child's parents and an evaluation of the child's educational situation, such as academic success and the need for special educational support. The clinical characteristics of the sample, such as the primary target for the intervention (anxiety, depression, or behavior problems) and clinically meaningful symptomatology were reviewed with the data gathered in the semi-structured background interview and the psychopathological interview.

Functional assessment, conducted with the SRAS-R, was also considered in the reviewing of sample characteristics. Information about the clinician's educational and occupational background was gathered by a questionnaire before treatment. The questionnaire also included one qualitative question regarding the clinician's attitudes towards the intervention and two self-report questions about the clinician's 1) motivation to work adherently to the intervention manual and 2) current ability to work accordingly to the B2S program. The questions were answered on a 1-10 scale (1= no motivation/ability, 10= full motivation/ability).

Data collection procedures and outcome measures

Outcome measures were assessed at each data collection point, as was the response rate for the completion of the questionnaires. The response rate at the different data collection points and between the different respondent groups is used in this study as a measure of the feasibility of the data collection procedure.

Treatment satisfaction

Treatment satisfaction was measured at the post-intervention data collection point with a self-report questionnaire filled out by the youth, parents, and the teacher as a subjective measure and the registered drop-out rate, session attendance, and intervention duration as objective measures. Qualitative data on treatment satisfaction was also gathered from each counterpart (child, parent, and schoolteacher).

Acceptability and study procedures

Acceptability for the intervention and the study procedures were examined with a questionnaire completed by the clinicians at the post-intervention measurement point with self-report questions regarding 1) utility and applicability of the treatment and its manual; 2) time management resources and appropriate background knowledge to implement the treatment; 3) evaluation of the B2S training program; and 4) satisfaction with the intervention outcome. Qualitative data was also gathered with two open questions answered by the clinicians. The first question asked the clinician to evaluate the utility of the included background and outcome measures, and the second question regarded the strengths and weaknesses of the B2S intervention.

Treatment effect

Changes in primary (absenteeism) and secondary (psychiatric symptoms and related psychosocial variables) outcome measures between baseline and post-intervention were measured as indicators of treatment response. A follow-up data collection point 3 months after the completion of the intervention was included for assessing the maintenance of treatment effects. Following the research questions at hand, we examined the treatment effects on school absenteeism and measures of psychiatric symptoms. Considering the literature on constructs mediating treatment effects, we also examined change in youth and parental self-efficacy across our three measurement points.

Data analysis

The gathered data contained both quantitative and qualitative variables. Sample characteristics, treatment satisfaction, and clinician-reported acceptability were all analysed using descriptive statistics (M (SD), %). Treatment satisfaction included several variables, both objective (session attendance, dropout rate, and the percentage of completed questionnaires) and self-report measures (youth, parents, and teacher).

Qualitative data were gathered by a section for free comments included in the treatment satisfaction questionnaires as well as in the post-intervention acceptability questionnaire that was answered by the clinicians. For the comments gathered with the treatment satisfaction questionnaire, qualitative analyses were done by the author following the qualitative description design used in Lomholt et al. (2020). The data was coded and divided into four themes that were identified in the data. The results are reported following the identified themes. The qualitative data from the clinician acceptability questionnaire was not analysed with a description design, instead, the results are reported according to the specific questions asked in the questionnaire. This is because the themes of the qualitative answer were decided a priori with the questions in the acceptability questionnaire being more focused, while the questions were more open in the treatment satisfaction questionnaire, allowing for different themes to emerge in the participants' answers.

Treatment effects were evaluated by examining the interaction between time and the participants' scores on the outcome variables. Effect sizes (Cohen's *d*) were calculated both for the change between baseline and post-intervention, as well as for the change between baseline and the 3-month follow-up. The existing guidelines (Cohen, 2013) for interpreting Cohen's *d* were followed, with 0.2, 0.5, and 0.8 considered as small, medium, and large effects. Changes in the primary and secondary outcome measures, operationalizing treatment effect, were analysed using Mixed Linear Models (MLM). Because of MLM's ability to manage missing values, we were able to include the intent-to-treat sample of $N=16$ in our statistical models. This provides a more accurate and realistic representation of clinical practice that also includes dropouts. We replicated the two-level hierarchical structure of the models that were reported in Lomholt et.al (2020), with time (level 1) being nested within individuals (level 2), and with using a random intercept for each of the models.

A random intercept was used in the analyses as it was deemed reasonable to assume that the baseline level of the measures would vary between individuals. We tested every model with a random as well as a fixed slope. The slope that produced the best model fit was used for the final analysis. We used Hurvich and Tsai's criterion (AICC; Hurvich & Tsai, 1989) for evaluating the different models' goodness-of-fit, with models producing lower AICC values being chosen over models with higher AICC values. AICC is corrected for model complexity and specifically designed for smaller sample sizes, and therefore used in our study instead of the -2LL fit statistics (Heck et al., 2013) that is used in Lomholt et.al (2020). Variance components (VC) were used as the standard covariance structure in our models. In a similar way as in the Lomholt study, we used First-Order Autoregressive structure [AR (1)] or Heterogeneous First-Order Autoregressive structure [ARH(1)] in case the model fit improved with either of these covariance structures. See Table 1 for a summary of the mixed models conducted in this study.

Table 1*Overview of the mixed linear models*

Outcome	Respondent	Method	Covariance Type	Parameters	Model
School absenteeism, %	Parent	REML	VC	4	Random intercept and fixed slope
RCADS Anxiety	Youth	REML	VC	5	Random intercept and random slope
	Parent	REML	ARH(1)	6	Random intercept and random slope
RCADS Depression	Youth	REML	VC	4	Random intercept and fixed slope
	Parent	REML	VC	5	Random intercept and random slope
RCADS Internalizing	Youth	REML	VC	4	Random intercept and fixed slope
	Parent	REML	VC	4	Random intercept and fixed slope
ISAP Social anxiety (symptom)	Youth	REML	VC	4	Random intercept and fixed slope
ISAP Social anxiety (function)	Youth	REML	ARH(1)	6	Random intercept and random slope
ISAP Depression (symptom)	Youth	REML	VC	4	Random intercept and fixed slope
ISAP Depression (function)	Youth	REML	VC	4	Random intercept and fixed slope
ISAP School aversion (symptom)	Youth	REML	VC	4	Random intercept and fixed slope
ISAP School aversion (function)	Youth	REML	VC	4	Random intercept and fixed slope
SDQ Emotional symptoms	Youth	REML	VC	4	Random intercept and fixed slope
	Parent	REML	VC	4	Random intercept and fixed slope
	Teacher	REML	AR(1)	5	Random intercept and random slope
SDQ Conduct problems	Youth	REML	VC	4	Random intercept and fixed slope
	Parent	REML	VC	5	Random intercept and random slope
SDQ Hyperactivity/inattention	Teacher	REML	VC	4	Random intercept and fixed slope
	Youth	REML	VC	4	Random intercept and fixed slope
	Parent	REML	VC	4	Random intercept and fixed slope

	Teacher	REML	VC	4	Random intercept and fixed slope
	Youth	REML	VC	4	Random intercept and fixed slope
SDQ Prosocial behavior	Parent	REML	VC	4	Random intercept and fixed slope
	Teacher	REML	VC	4	Random intercept and fixed slope
	Youth	REML	VC	5	Random intercept and random slope
SDQ Problems with peers	Parent	REML	VC	4	Random intercept and fixed slope
	Teacher	REML	VC	4	Random intercept and fixed slope
	Youth	REML	VC	4	Random intercept and fixed slope
SDQ Total difficulties	Parent	REML	VC	4	Random intercept and fixed slope
	Teacher	REML	VC	4	Random intercept and fixed slope
	Youth	REML	VC	4	Random intercept and fixed slope
SMFQ	Parent	REML	VC	4	Random intercept and fixed slope
SEQ_SS Total	Youth	REML	VC	4	Random intercept and fixed slope
SEQ-RSAP total	Parent	REML	VC	4	Random intercept and fixed slope

Note. REML= Restricted Estimate Maximum Likelihood Method; VC= Variance Components; ARH(1)= First-Order Autoregressive structure with heterogenous variances; AR(1)= First-Order Autoregressive structure; RCADS= Revised Children’s Anxiety and Depression Scale; ISAP= Inventory of School Attendance Problems; SDQ= The Strengths and Difficulties Questionnaire; SMFQ= Short Mood and Feelings Questionnaire; SEQ_SS= The Self-efficacy Questionnaire for School Situations; SEQ-RSAP= Self-Efficacy Questionnaire for Responding to School Attendance Problem.

Results

Sample characteristics

A total of 16 families, constituting the intent-to-treat sample, participated in the initial clinical evaluation, completed the baseline measures, and started the intervention. The mean age of the sample was 14.0 (SD= 1.7) with girls constituting majority of participating youths (69%). At the time of assessment, 56% of the youths surpassed Kearney's criteria for the threshold of problematic school absenteeism (>25% absenteeism for the last two weeks). Of the sample, 53% was absent 10%-50% of expected school attendance during the last two weeks before the start of treatment. Of the participating youths, 80% had participated in prior treatment for SAP, with a school psychologist being the professional most consulted (60%). Seven youths had a prior psychiatric diagnosis (44%) with anxiety disorders as the most prevalent diagnostic category (38%). A similar trend was evident in the semi-structured psychopathological interview, where anxiety symptoms were the most reported type of psychopathology (47%) followed by depressive (40%) and ADHD (33%) symptomatology. Two cases (13%) reported no symptoms in the psychopathological interview. Based on the initial evaluation, the anxiety module was the most commonly chosen aim for the intervention (50%), followed by behavior problems (25%) and depression (13%). For a comprehensive list of sample characteristics, see Table 2.

The five clinicians who participated in this study consisted of one psychologist, one occupational therapist, one special education teacher, and two bachelor's of social services with one of them also being a registered nurse. Three (60%) of the clinicians reported work experience surpassing 7 years. The remaining two clinicians had 4–6 years of experience in intervention work either in the therapeutic or special education realm. See Table 3 for a summary of clinician demographics.

Table 2*Sociodemographic and clinical variables of the intent-to-treat sample (N= 16)*

Variable	Participants
Age, mean (<i>SD</i>)	14.0 (1.7)
Gender, girl, <i>n</i> (%)	11 (69%)
School absenteeism, <i>n</i> (%)	
2 weeks before the onset of treatment	
10% absenteeism	1 (7%)
11%–30% absenteeism	6 (40%)
31%–50% absenteeism	2 (13%)
51%–70% absenteeism	3 (20%)
71%–99% absenteeism	2 (13%)
100% absenteeism	1 (7%)
Lives with both parents, <i>n</i> (%)	
Yes	10 (62%)
No	6 (38%)
Siblings living at home, <i>n</i> (%)	
0	2 (12%)
1–3	7 (44%)
>3	4 (25%)
Missing value	3 (19%)
Chronic illness, <i>n</i> (%)	
Yes ^a	2 (13%)
No	14 (87%)
Developmental anomalies, <i>n</i> (%)	
Yes ^b	3 (19%)
No	12 (75%)
Can't say	1 (6%)
Academic level (teacher-reported), <i>n</i> (%)	
Significantly lower than average	1 (6%)
Lower than average	2 (13%)
Average	8 (50%)
Higher than average	2 (13%)
Significantly higher than average	0 (0%)
Missing value	3 (18%)

Receives special education (teacher-reported), <i>n</i> (%)	
Yes	7 (44%)
No	4 (25%)
Missing value	5 (31%)
Mother education, <i>n</i> (%)	
Primary school	1 (6%)
High school/vocational education	12 (75%)
Academic/university of applied sciences	1 (6%)
Missing value	2 (13%)
Father education, <i>n</i> (%)	
Primary school	3 (19%)
High school/vocational education	8 (50%)
Academic/university of applied sciences	2 (13%)
Missing value	3 (18%)
Regular medication, <i>n</i> (%)	
Yes ^c	6 (38%)
No	10 (62%)
Disability related to learning, <i>n</i> (%)	
Yes	3 (19%)
No	11 (69%)
Can't say	2 (12%)
Parental self-reported mental health problems, <i>n</i> (%)	
Mother	4 (25%)
Father	5 (31%)
Prior treatment for SAP, <i>n</i> (%)	
Any treatment	13 (80%)
School psychologist	10 (62%)
Private psychologist	3 (19%)
Physician	9 (56%)
Specialist physician	2 (12%)
Psychiatrist	4 (25%)
Social worker	5 (31%)
No prior treatment	3 (19%)
Diagnosed psychiatric or developmental abnormality	
Learning difficulties	2 (12%)
Autism spectrum	1 (6%)
ADHD	2 (12%)
Depression	4 (25%)

Anxiety	6 (37%)
OCD	2 (12%)
Clinically meaningful symptomatology reported in the psychopathological interview	
Anxiety symptoms	7 (47%)
Panic attacks	2 (13%)
Social anxiety	7 (47%)
Generalized anxiety	5 (33%)
Obsessive-compulsive symptoms	2 (13%)
Obsessions	2 (13%)
Compulsions	1 (7%)
PTSD symptoms	1 (7%)
Depressive symptoms	6 (40%)
Low mood/irritability	3 (20%)
Decreased interest or pleasure	4 (27%)
Fatigue or energy loss	5 (33%)
Hypomanic symptoms	2 (13%)
Use of alcohol	1 (7%)
Tic symptoms	1 (7%)
ADHD	5 (33%)
Conduct disorder	1 (7%)
Psychotic disturbances	3 (20%)
Auditory hallucinations	2 (13%)
Visual hallucinations	1 (7%)
Thought disorder	3 (20%)
Delusions	2 (13%)
Autism spectrum disorder	1 (7%)
No symptoms reported	2 (13%)
Interview data missing	1 (6%)
SRAS ^d	
Function 1: Avoidance of school-related stimuli provoking general negative affectivity (NR)	8 (50%)
Function 2: Escape from aversive social and/or evaluative situations at school (NR)	1 (6%)
Function 3: Pursuit of attention from others (PR)	4 (25%)
Function 4: Pursuit of tangible reinforcement outside of school (PR)	3 (19%)
Aim for intervention	
Anxiety	8 (50%)
Depression	2 (13%)
Behavior problems	4 (25%)
Anxiety and behavior problems combined	1 (6%)

Missing value

1 (6%)

^a Asthma (n = 1), no answer (n = 1).^b Autism spectrum disorder (n = 1), language impairment (n = 1), no answer (n = 1).^c Sertraline (n = 3), Methylphenidate (n = 1), Fluoxetine (n = 1), Quetiapine (n = 1), Hydroxyzine (n = 1), Salbutamol (n = 1).^d Highest combined score by the youths and parents is considered the dominating factor.**Table 3***Clinician background variables, n (%)*

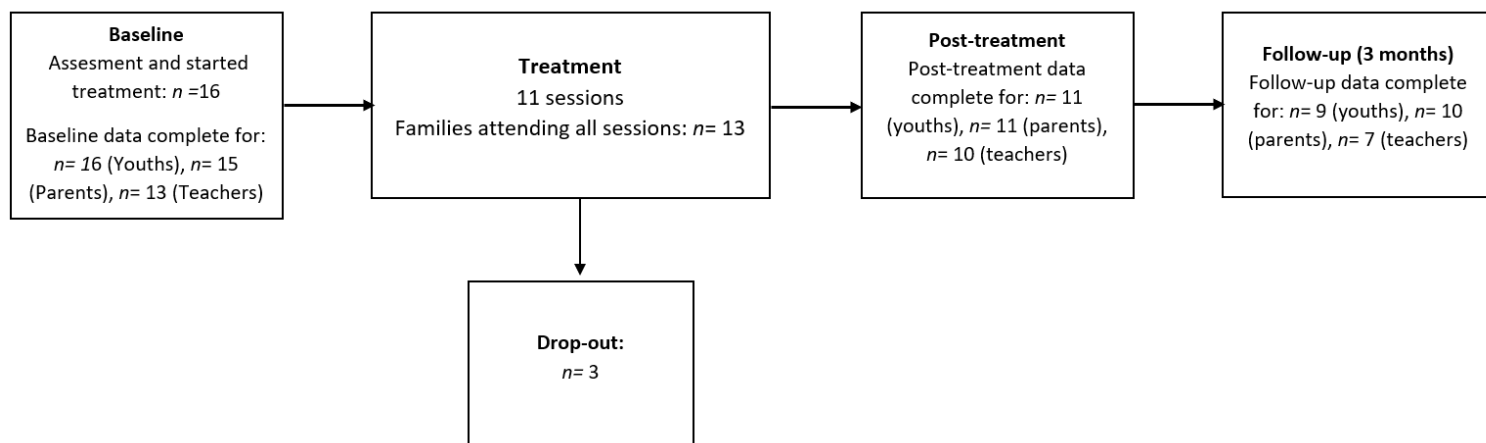
Variable	Clinicians
Education,	
Psychologist	1 (20%)
Occupational therapist	1 (20%)
Bachelor of social services	1 (20%)
Nurse	1 (20%)
Special education teacher	1 (20%)
Experience of therapeutic/special education intervention work	
4–6 years	2 (40%)
7+ years	3 (60%)
Employment	
Municipality social services	2 (40%)
The private sector	2 (40%)
Other	1 (20%)

Data collection procedures and outcome measures

As stated, the outcome measures were completed at three measurement points: baseline, post-intervention, and a 3-month follow-up. All 16 youths and parents in the intent-to-treat sample completed the baseline outcome measures, the background interview, and the semi-structured psychopathological interview. However, for one of the families, the data from the background interviews were not reported back to the researchers. The proportion of completed outcome measures declined to 75% (both youths and parents) at the post-intervention measurement point, with three cases having dropped out and one family leaving the questionnaires unanswered. The percentage of cases that completed the outcome measures at the 3-month follow-up was 56% of the youths and 63% of the parents. With regard to the teachers, 88% completed the baseline questionnaires; this declined to 56% at post-intervention, and further to 25% at the 3-month follow-up. See Figure 2 for an overview of the data collection process.

Figure 2

Overview of the collected data by respondent group



Treatment satisfaction

Three of the 16 families included dropped out mid-intervention, constituting a drop-out rate of 18.8%. One of the families dropped out after the second session with the reported reason being a high degree of stress within the family. With the second family, the intervention was terminated after the third session. Although the family reported motivation for continuing the intervention process, time-management issues made it difficult to arrange the work adherently to the manual. The third family dropped out after the second session due to the stress load being too high within the family. The family was also scheduled to begin work with the child protection services. 12 of the 13 families that completed the intervention participated in all 11 sessions with one family completing nine sessions. The amount of school consulting meetings among the families completing the intervention varied between two and four. Three families completed two meetings (23%), four families completed three meetings (31%) and six families completed all four meetings (46%). The mean number of days between the baseline assessment point and the 11th session was 99 days (range: 66–158).

Results on the treatment satisfaction questionnaire, completed by the youths, their parents, and the teachers at the post-intervention measurement point, showed a somewhat high-to-high degree of satisfaction among all respondent groups. For example, a majority of participants in every respondent group answered "certainly true" (73% (youths), 100% (parents), 78% (teachers)) to the question "I would recommend Back2School to others with similar problems". The satisfaction with the school meetings was also high, with 91% of the parents and 67% of the teachers answering "certainly true" to the question regarding the usefulness of the meetings. A lesser degree of

satisfaction with the school meetings could be observed among the youths, with 67% responding "partly true" and 25% "certainly true". The same applied to the questions regarding the adequacy of the amount of information received about B2S before treatment and the items "*I trusted the therapist*" and "*the therapist understood our worries and concerns*", with the youths reporting a somewhat lesser degree of satisfaction compared to parents and teachers.

See Table 3 for further data from the treatment satisfaction questionnaire.

Table 3

Treatment satisfaction questionnaire

Item	Respondent [n]	Response options		
		<i>Not true</i>	<i>Partly true</i>	<i>Certainly true</i>
I got enough information about the content and purpose of Back2School before start	Youth [12]	1 (8%)	5 (42%)	6 (50%)
	Parent [11]	0 (0%)	3 (27%)	8 (73%)
	Teacher [9]	1 (11%)	2 (22%)	6 (67%)
I trusted the therapist	Youth [12]	0 (0%)	3 (25%)	9 (75%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [9]	0 (0%)	0 (0%)	9 (100%)
The therapist understood our worries and concerns	Youth [12]	0 (0%)	5 (42%)	7 (58%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [8]	0 (0%)	0 (0%)	8 (100%)
We were helped by the Back2School program and the therapist	Youth [12]	1 (8%)	5 (42%)	6 (50%)
	Parent [11]	0 (0%)	2 (18%)	9 (82%)
	Teacher [9]	0 (0%)	3 (33%)	6 (67%)
The meetings at the school were useful	Youth [12]	1 (8%)	8 (67%)	3 (25%)
	Parent [11]	0 (0%)	1 (9%)	10 (91%)
	Teacher [9]	0 (0%)	3 (33%)	6 (67%)
I would recommend Back2School to others with similar problems	Youth [11]	1 (9%)	2 (18%)	8 (73%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [9]	0 (0%)	2 (22%)	7 (78%)

Acceptability and study procedures.

Before the beginning of treatment, all of the five clinicians reported high motivation to work adherently to the intervention manual (scores ranging between 8–9 of 10) and somewhat high-to-high ability to work accordingly to the program (scores ranging between 7–9 of 10). In the qualitative answers regarding the clinicians' first impression of the treatment program, they reported exclusively favourable impressions, emphasizing the intervention's modular and manualized structure and the clinical and societal need for this kind of intervention.

The intervention acceptability questionnaire, completed at the post-intervention data collection point by the clinicians (N= 5), showed an overall high degree of satisfaction with the manual. Especially related to the appropriateness of the time and effort demanded by the manual and the overall utility of the intervention, with 100% of the clinician answering "certainly true" on the items "*the time and effort the program demands is in balance with its benefits*" and "*would you recommend the B2S intervention to a colleague, acquaintance or a family in need of support*". A slightly lower degree of acceptability was reported concerning the item "*The B2S intervention was easy to implement*" with 60% answering "partly true" and 40 % answering "certainly true". A majority of the clinicians (60%) were satisfied with the help the client families received with school absenteeism, the overall psychological well-being of the youths, and family functioning. Further results from the questionnaire are presented in Table 4.

Table 4*Acceptability questionnaire*

Item	Response options		
	<i>Not true</i>	<i>Partly true</i>	<i>Certainly true</i>
The B2S intervention was easy to implement	0 (0%)	3 (60%)	2 (40%)
The time and effort the program demands are in balance with its benefits	0 (0%)	0 (0%)	5 (100%)
I am satisfied with the help the client families received concerning:			
School absenteeism	0 (0%)	2 (40%)	3 (60%)
The psychological well-being of the youth	0 (0%)	2 (40%)	3 (60%)
Family functioning	0 (0%)	2 (40%)	3 (60%)
Was the one-week B2S training enough to use the program?	0 (0%)	1 (20%)	4 (80%)
Would you recommend B2S interventions to a colleague, acquaintance or family in need of support?	0 (0%)	0 (0%)	5 (100%)
	<i>Poor</i>	<i>Moderate</i>	<i>Good</i>
Evaluate your ability to work according to the intervention	0 (0%)	1 (20%)	4 (80%)

Qualitative feedback*Youths, parents, and teachers*

Theme 1: Collaboration between multiple stakeholders. Both parents and teachers expressed satisfaction with the involvement of and the collaboration between the school and the family during the intervention. The importance of collaborative work was especially highlighted concerning the overall effect of the intervention. This was emphasized both by parents and teachers. One parent commented: *"The B2S therapist's communication between the adults working with the young person was smooth and helped the young person to increase school attendance"*. One teacher made the same connection between the quality of the collaborative relationship, and increased school attendance: *"Cooperation with the family was functional and close which was important in terms of effectiveness"*. Some parents and teachers also experienced the collaboration as reassuring and as a factor that enhanced the understanding of the child's situation and experience. Examples of such comments: *"I think it was useful that there was a group that worked on getting the student back to school. (teacher)"*. *"It was great that we worked with the family. As a teacher, I also gained an understanding of what my students' absenteeism challenges are about (teacher)." "It was positive that the parents were so involved in the process. You had a good idea of what was being worked on and what progress was being made (parent)." As an area for improvement, one parent pointed out practical difficulties with scheduling the meetings with many different timetables that needed to be taken into consideration.*

Theme 2: The clinicians' professional competence and working alliance. The clinicians received exclusively positive feedback from parents and teachers alike. Both parents and teachers were satisfied with the clinicians' competence and skill set. One teacher commented: *"An expert therapist who had good resources to focus on the student's situation."* One parent expressed satisfaction with the clinician's judgment and case formulation within the heavily manualized course of the intervention: *"The program required a lot of time, but without the therapist, we would not have succeeded in getting the child's school attendance back on track. The therapist understood the problem areas well and guided us flexibly within the framework of what seems to be a strictly regulated program."* Parents also appreciated the therapeutic relationship and considered the working alliance to be an important aspect of the intervention: *"We found common ground with the therapist, so it was really easy to talk to her. She knew how to talk to my daughter well, and that's how she gained her trust. It's great that we were chosen for this."* Another parent emphasized the clinician's ability to consult the family concerning further care: *"The therapist was knowledgeable and helped us move forward in solving our challenges. As a parent, I received personal support from the therapist in addition to improvements in school cooperation, but also in moving things forward on the treatment path. The program was useful and helped us to understand our child's situation"*.

Theme 3: Therapeutic techniques. Many parents and teachers were satisfied with the specific factors of the intervention, with comments emphasizing the helpfulness of different "tools" and "tips". The parents reported benefits for the youth, as well as personal ones: *"Without this journey, I'm not sure if my daughter would have gotten her elementary school certificate. I wouldn't be sure what her mood would be like. We all got a lot of tips and insights."* Another parent further emphasized the benefits for the parents: *"The B2S program gave us many good and useful tools to help us parents act correctly when the child was having a hard time and couldn't manage to go to school"*. One teacher explicitly mentioned the exposure techniques, emphasizing their usefulness as well as the challenges in implementing them in a classroom with many other students. Some youths implied that the program was not always age appropriate. One youth commented: *"The experience was good. However, I would recommend the program for elementary school age or those who have just started middle school."* Other youths also touched upon the content of the exercises, possibly implying age- inappropriateness: *"It helped quite a lot, and I became more motivated to go to school and it was nice to get candy. Some of the questions were ridiculous and stupid"* and *"A little annoying, but I guess it helped a little. Strange steps and examples. I guess it helped a bit"*. One youth with anxiety-driven school absenteeism expressed insight into the mechanisms of exposure techniques: *"I have understood why I should go to school even though I could do school work at home"*.

Theme 4: Treatment effect. The qualitative data indicated a tangible degree of variation concerning changes in school attendance during the intervention. A noteworthy proportion of the participating parents and teachers reported a lack of effect on school attendance. These comments were often attributed to external factors such as the covid-19 pandemic or changes happening slowly and gradually. One parent reported an overall worsening of the youth's physical and mental well-being: *"The young person's physical and mental health has deteriorated during the spring and it shows in their school attendance. For this reason, the B2S program has not been implemented as well as it could have been"*. One teacher reported that the youth wasn't part of the intervention's target group: *"Actually, the student was already "back to school" when the program started"*. Some parents and teachers also noted the possible mechanisms of change, one teacher emphasizing cognitive change as a mediator: *"Absenteeism has decreased during the program. There has been a clear change in the student's thinking, realistic thinking has increased"*. One parent noted on the other hand an increase in positive emotion and overall mood: *"With B2S, school attendance increased considerably. The child became more positive and talkative in every way."* One teacher reported secondary positive effects of the intervention, even though no change in attendance could be observed: *"It's great that we worked with the family. As a teacher, I also gained an understanding of what my students' attendance problems are about. However, there are still as many absences as before the B2S program"*

Clinicians

Theme 1: Assessment and outcome measures. The clinicians provided both positive and negative feedback regarding the initial clinical assessment and the included outcome measures. Every clinician pointed out that the assessment process and the battery of instruments are extensive and require a lot of effort by the participants and the clinicians alike. Besides the heavy workload, the clinicians also appreciated the clinical utility of the assessment package and the outcome measures. One clinician commented: *"There were a lot of them, a heavy chore (printing, finding the right ones in the stack, scoring, interpretation), but they did provide good supplementary information."* Another clinician experienced a discrepancy between the clinical and the academic utility of the measures: *"Certainly useful for research purposes, but for many quite heavy to fill out. So, for treatment purposes only, you can easily slim them down quite a bit."* One clinician touched upon the validity of one client's self-report answers: *"They [the measures] are useful. Although in my case, the child filled out all the initial questionnaires with "no symptoms/0", but the parent questionnaires and the interview did bring out the challenges at hand. The child had answered more honestly about his feelings on the post-intervention questionnaires, and this may reflect the situation in a distorted way if you only look at the before-after comparison."* One clinician described ISAP and SRAS-R as particularly useful instruments for SAP treatment. As general

recommendations from the clinicians, it emerged that the measurement process could benefit from completing them digitally. It was also commented that it could be useful to complete them together with the family so that the instructions are with certainty correctly explained. One clinician also expressed a wish for more training regarding the interpretation of the psychometric instruments.

Theme 2: Strengths and weaknesses of the B2S intervention. Common themes of strengths that emerged in the clinicians' open answers were the intervention's structure and manualized course, the evidence base surrounding CBT and the goal-oriented style of work. One clinician noted that according to her experience, B2S is more suitable for anxiety problems compared to other functions underlying SAP: *"Based on my four clients, I would say that B2S works best with anxiety problems (compared to depression/lack of motivation). The clients have also been primary school students, so maybe it also works better with younger students (where the problem may not have been as strongly entrenched)".* Even though the assessment process was unanimously experienced as very extensive, the case formulation and the background interview received positive feedback for playing a central role in treatment planning and for creating a mutual understanding with the clients' families. According to one clinician, the manual does not sufficiently consider how other instances of help should be included in the intervention process, e.g. if the family also engages in family work. The clinician points out that the family service's participation at the school meetings is not enough, and that it would be beneficial to integrate the family work more actively and get them more intertwined in the B2S program. It was also commented that the intervention requires at least a satisfactory level of family functioning and available resources to be efficient. One clinician experienced a discrepancy between the manual's perception of the school's capacity and what is practiced in the Finnish school system: *"In Finland, as a rule, schools have more functionality and flexibility than the manual suggests. The Finnish schools stretch and bang a lot, come up with creative solutions, etc. Of course, this is not always the case, but the format of school meetings does not exactly fit the Finnish tradition of working together".* One comment brought up the question of the practical utility of "flexibility within fidelity" when working in a manualized way. The clinician experienced this as particularly challenging when working with families that have big challenges with adhering to the techniques described in the manual.

Treatment effects

As presented in Figure 3, the average school absenteeism of 43% at baseline was reduced to 27% post-intervention but returned to approximately baseline level at the 3-month follow-up (42%). The effect of time was non-significant ($p= 0.842$).

At post-intervention, four youths (31%) did not surpass our inclusion criteria of >10% school absenteeism anymore. This number declined to one (10%) youth at the 3-month follow-up.

Three youths (23%) were absent more than 50% of expected school attendance at post-intervention, compared to eight youths (53%) at baseline. At the 3-month follow-up measurement, two youths were absent 100% of the time in the last two weeks before follow-up, with eight youths (80%) attending school more than 50% of the time. Nine youths at baseline (56%), four youths at post-intervention (31%), and six youths (60%) at follow-up met Kearney's criteria for problematic school absenteeism (>25% absenteeism during the last two weeks). See Figure 4 for further information.

The mixed linear models for our secondary outcome measures showed a significant effect of time for three variables: teacher-reported hyperactivity, teacher-reported prosocial behavior, and parental self-efficacy. These changes over time demonstrated a large effect. Several statistically non-significant medium-to-large effects can be observed in the data, regarding for example the SDQ total difficulties scale (parent-reported) and the SDQ prosocial behavior scale (parent-reported). When evaluating the descriptive data of our secondary outcome measures, elevations can be noted on the child versions of several key measures when comparing post-intervention to baseline. This concerns particularly anxiety and depression, as measured by the RCADS, and the SDQ total difficulties scale. Although these effects lie in the medium range, they are statistically non-significant. See table 5 for the complete summary of the mixed models for the secondary outcome measures.

Figure 3

Mean school absenteeism (%)

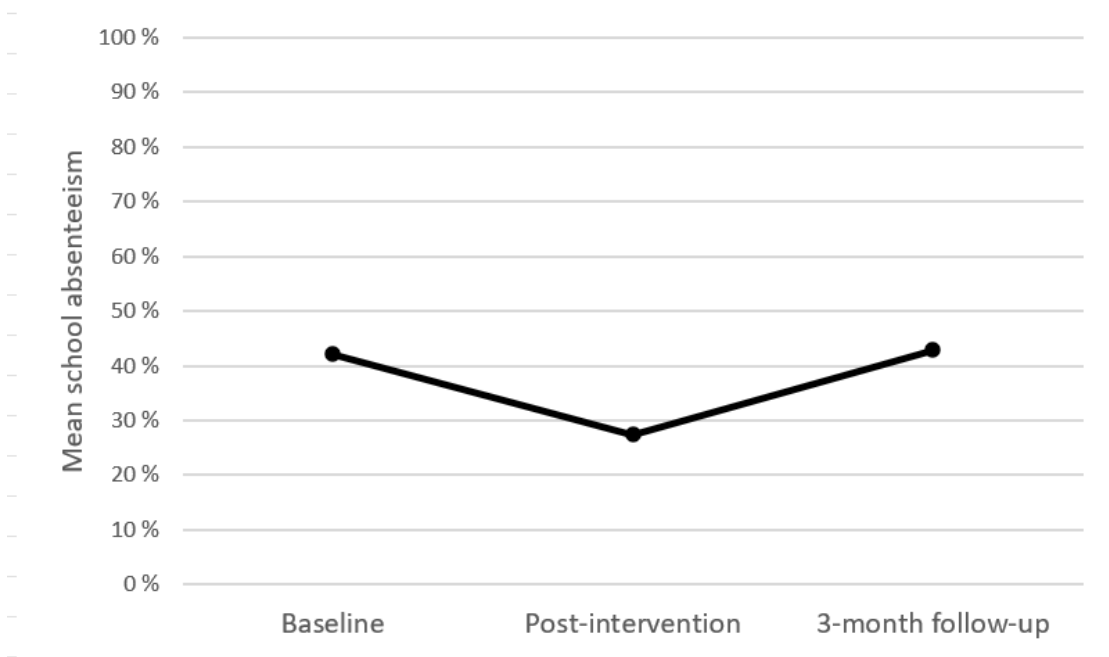


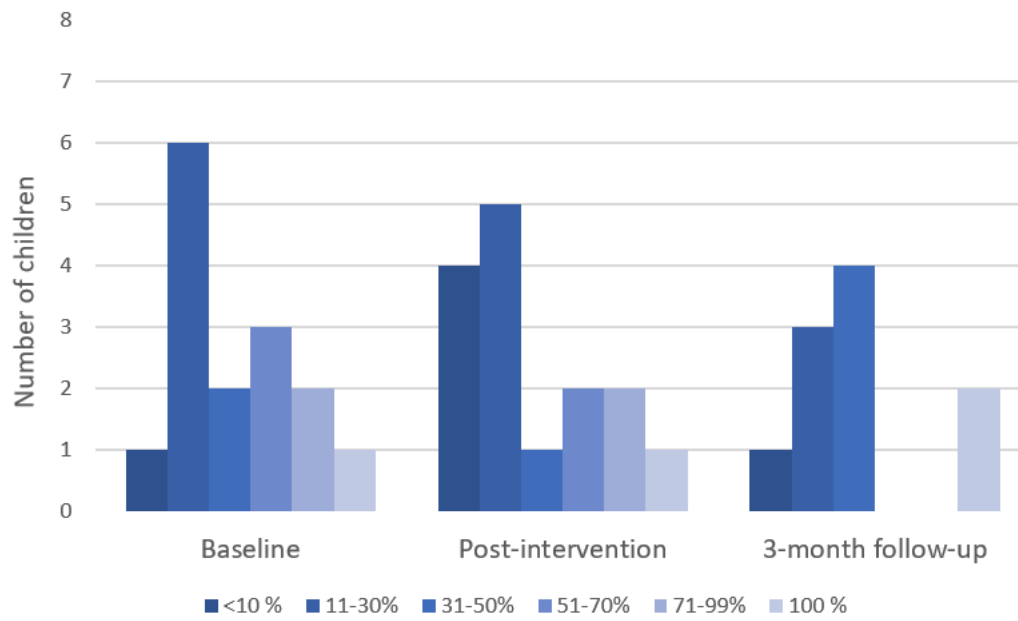
Figure 4*Levels of school absenteeism per data collection point*

Table 5*Primary and secondary outcome variables*

Outcome	Respondent	Baseline	Post-intervention	3-Month follow-up	Time x intervention effect
School absenteeism, %	Parent	43.12 (28.21) [15] ^a	27.38 (26.70) [11]	42.90 (33.39) [10]	$F = 0.040, p = 0.842, d_1^b = 0.463, d_2^c = 0.004$
RCADS anxiety	Youth	18.06 (20.17) [16]	23.27 (20.32) [11]	15.44 (10.69) [9]	$F = 0.803, p = 0.394, d_1 = 0.548, d_2 = 0.252$
	Parent	17.00 (13.60) [15]	16.18 (10.89) [11]	12.50 (7.55) [10]	$F = 2.115, p = 0.173, d_1 = 0.132, d_2 = 0.634$
RCADS depression	Youth	7.70 (6.03) [16]	10.45 (5.79) [11]	8.78 (4.74) [9]	$F = 0.001, p = 0.974, d_1 = 0.529, d_2 = 0.450$
	Parent	7.33 (4.10) [15]	6.82 (4.29) [11]	6.20 (4.54) [10]	$F = 0.436, p = 0.522, d_1 = 0.065, d_2 = 0.353$
RCADS Internalizing	Youth	25.75 (25.32) [16]	33.73 (25.90) [11]	24.22 (14.30) [9]	$F = 1.236, p = 0.280, d_1 = 0.566, d_2 = 0.126$
	Parent	24.33 (17.12) [15]	23.91 (15.01) [11]	18.70 (10.77) [10]	$F = 1.384, p = 0.253, d_1 = 0.044, d_2 = 0.599$
ISAP Social anxiety (symptom)	Youth	0.72 (0.81) [15]	0.80 (0.71) [11]	0.84 (0.82) [9]	$F = 0.054, p = 0.818, d_1 = 0.160, d_2 = 0.200$
ISAP Social anxiety (function)	Youth	0.49 (0.62) [15]	0.46 (0.48) [10]	0.33 (0.35) [9]	$F = 3.426, p = 0.073, d_1 = 0.100, d_2 = 0.400$
ISAP Depression (symptom)	Youth	0.88 (0.74) [15]	1.10 (0.61) [11]	0.86 (0.73) [9]	$F = 0.297, p = 0.591, d_1 = 0.314, d_2 = 0.033$
ISAP Depression (function)	Youth	0.71 (0.69) [15]	0.61 (0.65) [10]	0.57 (0.66) [9]	$F = 3.884, p = 0.063, d_1 = 0.250, d_2 = 0.333$
ISAP School aversion (symptom)	Youth	1.25 (0.79) [15]	1.22 (0.94) [11]	1.16 (0.82) [9]	$F = 0.166, p = 0.688, d_1 = 0.043, d_2 = 0.129$
ISAP School aversion (function)	Youth	0.74 (0.60) [15]	0.54 (0.65) [10]	0.53 (0.55) [9]	$F = 2.917, p = 0.103, d_1 = 0.500, d_2 = 0.700$
SDQ Emotional symptoms	Youth	3.38 (2.66) [16]	4.45 (2.21) [11]	4.33 (2.60) [9]	$F = 0.886, p = 0.357, d_1 = 0.486, d_2 = 0.413$
	Parent	3.67 (1.95) [15]	2.82 (2.04) [11]	2.80 (1.69) [10]	$F = 1.898, p = 0.183, d_1 = 0.405, d_2 = 0.483$
	Teacher	3.38 (2.26) [13]	3.70 (2.16) [10]	3.57 (2.76) [7]	$F = 0.082, p = 0.778, d_1 = 0.267, d_2 = 0.053$
SDQ Conduct problems	Youth	1.75 (1.30) [16]	2.45 (1.70) [11]	1.67 (1.00) [9]	$F = 0.219, p = 0.644, d_1 = 0.318, d_2 = 0.089$
	Parent	2.73 (2.87) [15]	1.73 (1.56) [11]	1.50 (1.58) [10]	$F = 0.551, p = 0.473, d_1 = 0.476, d_2 = 0.820$
	Teacher	0.85 (1.21) [13]	0.60 (0.97) [10]	1.00 (0.82) [7]	$F = 0.034, p = 0.855, d_1 = 0.208, d_2 = 0.083$
SDQ Hyperactivity/inattention	Youth	4.31 (2.50) [16]	4.73 (2.10) [11]	5.11 (2.10) [9]	$F = 0.763, p = 0.402, d_1 = 0.233, d_2 = 0.615$

	Parent	3.53 (2.17) [15]	3.27 (1.79) [11]	2.60 (1.71) [10]	$F = 3.060, p = 0.095, d_1 = 0.217, d_2 = 0.344$
	Teacher	3.69 (2.96) [13]	2.80 (3.05) [10]	2.57 (3.21) [7]	$F = 6.408, p = 0.021, d_1 = 0.989, d_2 = 0.533$
	Youth	6.94 (1.44) [16]	7.27 (1.10) [11]	7.89 (0.78) [9]	$F = 3.551, p = 0.071, d_1 = 0.194, d_2 = 0.500$
SDQ Prosocial behavior	Parent	6.33 (2.77) [15]	6.82 (2.75) [11]	8.10 (1.97) [10]	$F = 3.569, p = 0.073, d_1 = 0.445, d_2 = 0.983$
	Teacher	4.38 (2.26) [13]	6.10 (2.64) [10]	6.57 (1.51) [7]	$F = 6.804, p = 0.018, d_1 = 1.147, d_2 = 1.217$
	Youth	2.25 (1.57) [16]	2.36 (2.16) [11]	2.67 (2.50) [9]	$F = 0.208, p = 0.658, d_1 = 0.092, d_2 = 0.247$
SDQ Problems with peers	Parent	3.00 (2.42) [15]	2.18 (2.23) [11]	2.10 (1.45) [10]	$F = 1.804, p = 0.194, d_1 = 0.586, d_2 = 1.000$
	Teacher	2.62 (2.10) [13]	2.60 (1.96) [10]	2.00 (1.41) [7]	$F = 0.268, p = 0.611, d_1 = 0.018, d_2 = 0.413$
	Youth	11.69 (6.21) [16]	14.00 (5.08) [11]	13.80 (5.80) [9]	$F = 1.057, p = 0.316, d_1 = 0.471, d_2 = 0.515$
SDQ Total difficulties	Parent	12.93 (7.10) [15]	10.00 (5.40) [11]	9.00 (4.35) [10]	$F = 3.518, p = 0.076, d_1 = 0.698, d_2 = 1.092$
	Teacher	10.54 (5.17) [13]	9.70 (4.60) [10]	9.14 (4.63) [7]	$F = 0.540, p = 0.472, d_1 = 0.336, d_2 = 0.222$
	Youth	6.81 (6.40) [16]	6.27 (4.69) [11]	5.11 (4.17) [9]	$F = 1.441, p = 0.242, d_1 = 0.075, d_2 = 0.293$
SMFQ	Parent	4.67 (4.82) [15]	3.82 (4.64) [11]	2.70 (2.41) [10]	$F = 0.966, p = 0.337, d_1 = 0.202, d_2 = 0.410$
SEQ_SS Total	Youth	48.10 (7.45) [16]	47.18 (9.70) [11]	47.56 (6.62) [9]	$F = 0.009, p = 0.924, d_1 = 0.107, d_2 = 0.084$
SEQ-RSAP total	Parent	76.07 (9.52) [15]	84.00 (7.71) [11]	85.60 (10.06) [10]	$F = 15.969, p < 0.001, d_1 = 1.017, d_2 = 1.305$

Note. RCADS= Revised Children's Anxiety and Depression Scale; ISAP= Inventory of School Attendance Problems; SDQ= The Strengths and Difficulties Questionnaire; SMFQ= Short Mood and Feelings Questionnaire; SEQ_SS= The Self-efficacy Questionnaire for School Situations; SEQ-RSAP= Self-Efficacy Questionnaire for Responding to School Attendance Problems

^a Data presented as mean (SD) [n]

^b Effect between baseline and post-intervention

^c Effect between baseline and 3-month follow-up

Discussion

The aim of this study was to evaluate the feasibility of the Back2School intervention in the Finnish context to provide helpful guidelines for future studies with more rigorous designs (e.g. RCT).

Feasibility was evaluated on five parameters: 1) sample characteristics; 2) data collection procedures and outcome measures; 3) treatment satisfaction; 4) acceptability and study procedures; and 5) treatment effects. The results are discussed according to these feasibility parameters.

Sample characteristics

The included intent-to-treat sample of N= 16 was a shortcoming of our initial goal of including 26 families. With the recruitment being done by a third party, further evaluations of the recruitment process cannot be appropriately done by the author. However, one fundamental difference in the recruitment process should be mentioned, in contrast to the Lomholt et al. (2020) study. In the Lomholt et al. study, families were able to independently reach out and express their wish to participate in the study according to the presented inclusion criteria. In our study, this kind of recruitment was not possible. Therefore, the families were recruited via the schools in the municipality. This possibly affected the characteristics of the included sample, with the inclusion criteria being more loosely adapted, and with higher-functioning families being included in comparison to the Lomholt et al. study. Our sample has features of a convenience sample where potential clients were contacted and invited to participate by the recruiting agency. The procedure of Lomholt et al. was in that way more ecologically valid, with the client families exhibiting care-seeking behavior, which may also be a reason why their sample was more representative on several clinical variables.

This is evident in the sample's relatively high level of school attendance at the baseline measurement point with $\approx 60\%$ registering $\leq 50\%$ absenteeism during the two weeks before the intervention, compared to 38% in the Lomholt et al. study. The same applies at the higher end of absenteeism: 20% of our sample was absent 71% - 100% of the time two weeks before treatment, compared to 42% in the Lomholt et al. sample. Similar indicators are observable in the psychometric data gathered at baseline for the secondary outcome measures. For example, the mean scores of the RCADS internalizing scale (child-reported: M= 25.75, cut-off score: 48p-54p for boys & 58p-66p for girls), SMFQ (child-reported: M= 6.81, cut-off score: 8p) and SDQ total score (child-reported: M= 11.69, the cut-off for abnormal score: 16p-40p) all lie below the respective clinical cut-off scores that are found in the literature (Angold et al., 1995; Chorpita et al., 2015; He et al., 2013). From a psychometric viewpoint, these parameters point to an atypically low level of psychiatric symptoms compared to clinical samples found in the SAP literature (e.g. Hannan et al., 2019; Heyne et al., 2011; Lomholt et al., 2020; Reissner et al., 2015; Strömbeck et al., 2021). A

consequence of this is a more restricted range for possible change and improvement compared to the Lomholt et al. study, and other intervention trials found in the SAP intervention literature.

In the psychopathological interview, 87% of the participants reported some kind of symptomatology. Of the participants, 47% reported any kind of anxiety symptoms, which can be considered a low level of prevalence compared to the Lomholt et al. study (75%). Anxiety was also the most prevalent form of psychopathology reported, followed by depression (40%) and ADHD (33%), displaying heterogeneity with regard to externalizing and internalizing psychopathology accompanying SAP, which is in line with the prevalence data found in the literature. A similar degree of variation can be found for the SRAS-R showing that participants were evenly distributed regarding the primary underlying function, with both negative and positive reinforcement schedules present in the sample.

For future randomized controlled studies in the Finnish context, two changes in the procedure can be recommended to obtain a sample better suited for evaluation of treatment effect: 1) modification of the recruitment process to one more resembling the procedure used in Lomholt et al. where families in need themselves seek care, instead of being recruited directly by a third party and/or 2) tightening of the inclusion criteria by, for example, raising the threshold for inclusion to Kearney's 25% absenteeism during the last two weeks. Our results also raise questions about applying a threshold for inclusion based on the secondary outcome measures, to avoid floor effects at the baseline measurement point. Following these recommendations, future studies would better ensure a sample that more accurately reflects the clinical characteristics shown by the SAP population in the literature, which would increase the validity of statistically analyzing treatment effects.

Data collection procedures and outcome measures

The percentage of completed questionnaires at baseline was excellent at the baseline measurement point, with all respondents filling out 100% of the measures. Compared to the Lomholt et al. study, a lower degree of completion can be observed among the parents at the post-intervention measurement point (80% vs 100%), and a higher degree of completion among the youths (80% vs 55%). The proportions recorded at the 3-month follow-up (youths: 60%, parents: 66%) can be considered low, especially with regard to the parents when compared to the Lomholt et al. study (95%). This can be attributed to several factors. Firstly, the data collection procedures in our study were rather complex. The questionnaires were to be completed with pen and paper by the participants, then returned to the clinician who copied the answers to an Excel sheet that was returned to the research team via an encrypted file-sender application. The different steps with their increase in workload and demand on organizational skills can be considered risk factors for omitted answers. As a recommendation for future trials, the author underlines the feedback gathered by one

of the clinicians: the data collection procedure could benefit from the questionnaires being filled out electronically together with the clinician. This would facilitate smoother data gathering, and possibilities for a higher percentage of completed measures, with the clinicians being able to supervise and monitor the data gathering. Secondly, the overall feedback of the participants and the clinicians, both in our and Lomholt et al.'s study, touches upon the extensive width of the measurement package. Several of the clinicians reported difficulties in gathering the data, especially at the 3-month follow-up, despite reminding the client's families several times. Based on our qualitative data, this could reflect a motivational problem that can be attributed to the extensive battery of measures. For future Finnish trials that involve a control group, inspiration could be taken from the RCT study protocol in Denmark (Thastum et al., 2019), with shorter versions of the assessment battery and monetary incentives provided to the control group. Completed baseline assessment could also be included as an inclusion criterion and regular reminders arranged for non-responsive families.

Data for our primary outcome measure of school absenteeism was gathered week-by-week at every session and reported back to the researchers via the session-by-session questionnaire. The decision not to gather the data straight from the school registry was due to technical impracticalities. School attendance for the last two weeks was also gathered at each measurement point as part of a parent questionnaire. However, the data reported in the questionnaire was often either omitted or not in line with the proportion reported in the session-by-session questionnaire that was filled out by the clinician. Therefore, the final data was exclusively taken from the session-by-session questionnaire, to ensure consistency in our data-gathering procedures. However, this could indicate a possible validity problem of our absenteeism data, with different percentages reported in different forms. For future trials, a more structured, coherent, and less extensive gathering of absenteeism data can be recommended, limiting reports to two weeks before each measurement point. This could allow consultation with the school register at each measurement point, since three or four data-gathering points are more manageable for the school compared to our design of a session-to-session basis. As recommended in the Lomholt et al. study, the school registry data could also be included to ensure maximal validity.

Regarding the secondary outcome measures, future modifications of the manual could consider which psychometric instruments should be included as measures of psychiatric symptomatology. Although instruments such as RCADS and SMFQ are psychometrically sound both in terms of reliability and validity, their level of measurement is relatively general. Instead, ISAP (Knollmann et al., 2019) could be considered instead, which measures both symptom strength and function in direct relation to SAP.

Treatment satisfaction

All in all, parents, teachers, and youths alike reported a high degree of treatment satisfaction. The dropout rate of 18.8 percent was higher than the corresponding rate of 8% reported by Lomholt et al. 80% of the families attended every session, which is also a slightly lower proportion of families compared to Lomholt et al. (86%). The overall treatment satisfaction was satisfactory among all respondent groups. Compared to the Lomholt et al. study, a higher proportion of youths (73% vs 50%), parents (100% vs 75%), and teachers (78% vs 56%) answered "certainly true" to the question " *I would recommend Back2School to others with similar problems*". A slightly lesser degree of satisfaction could be observed among the youths compared to the parents and the teachers, this trend was reflected in items touching upon the adequacy of the information provided before treatment, the overall helpfulness of the intervention, and the usefulness of school meetings. Based on the gathered youth-reported qualitative feedback, this could reflect an experience of the intervention content not always being age-appropriate. Given that 25% of our sample were 9th graders, and thus at a maximum threshold with regard to our inclusion criteria, the content of the intervention may be more appropriate for younger children. This was also an experience that one of the clinicians reported in the post-intervention acceptability questionnaire. It is also possible that the slightly lesser degree of satisfaction among the youths echoes the higher baseline level of functioning that our sample demonstrated compared to other clinical samples. This can be noted both in the relatively low level of school absenteeism and psychiatric symptoms that was observed in the assessment data. Therefore, one could ask if the included sample as a whole can be considered a target population of the Back2School intervention, or if the moderate level of treatment satisfaction among the youths could partly be understood in the context of the manual assuming broader difficulties and lower levels of functioning than what was the case in our sample.

In the treatment satisfaction questionnaire, one item regarding the usefulness of the school meetings showed a greater degree of variation in satisfaction compared to other items. This could have affected fidelity in the sense of omitted school meetings. Nevertheless, 77% of the client families attended three or four school meetings, which could be considered a satisfactory proportion when taking external factors such as time management into account.

Acceptability and study procedures

Overall, the clinicians rated the B2S to have high acceptability. This is illustrated, for example, in the fact that 100% of the clinicians answered "certainly true" to the questions "*the time and effort the program demands is in balance with its benefits*" and "*would you recommend the B2S intervention to a colleague, acquaintance or a family in need of support.*" In the qualitative feedback, it appears that several clinicians experienced the intervention process as somewhat laborious and extensive. This applies above all to the wide battery of questionnaires that are

expected to be filled in at each measurement point. Another indicator of a lower level of acceptability when it comes to the outcome measures was the low response rate among some respondent groups, especially at the 3-month follow-up. It is also possible that the procedure we followed, which required some extra work efforts by clinicians, was a reason why the data collection in this study was perceived as difficult. As written earlier, we recommend future studies to consider a digital filling in of questionnaires, and a reduction of the length or number of forms for a potential control group.

It is worth noting that this study also included measurement instruments that were included out of academic interest in the evaluation of treatment effect and that are not included in the actual treatment manual. Of the included outcome measures, this applied to FAD, PECK, and ISAP. Thus, the feedback we received regarding the scope of the battery of measurement instruments should rather be interpreted as feedback for the research design, instead of the intervention itself. Possibly, the data gathering process would have been perceived as more manageable, had we only included the measures that are part of the manual. Thus, future studies should consider including only the measures recommended by the manual, to evaluate fidelity in a more ecologically valid way.

One issue highlighted in the clinicians' feedback was the manual's lack of guidelines for how other treatment entities, such as family work, can be integrated into the treatment. The wish was to get tools to be able to extend the treatment principles of the B2S intervention to other support and treatment contacts that a family may have in addition to B2S. This feedback is recommended to be considered in future modifications of the manual.

Treatment effects

School absenteeism dropped from 43% to 27% between baseline and post-intervention. However, this change was not maintained at the 3-month follow-up, with the mean level of absenteeism returning to a level approximating baseline (42%). Non-maintained treatment effects on school attendance are a commonly reported phenomenon in the SAP intervention literature, with a significant proportion of clients returning to problematic levels of school absenteeism between the post-intervention and follow-up measurement points (Heyne, 2022a; Heyne 2022b; Maynard et al., 2018). All in all, the effect of time on change in school absenteeism was non-significant ($p= 0.842$) in our study. Similarly, our statistical analyses showed minimal effects on secondary outcome measures: only three variables reached statistical significance (teacher-reported hyperactivity/inattention, teacher-reported prosocial behavior, and parental self-efficacy).

As previously described in this text, our sample displayed high baseline functioning on both our primary and secondary outcome measures. The baseline level of 57% school attendance is not only high compared to the corresponding 33% in Lomholt et al. (2020) but also in comparison to other clinical trials of interventions targeting SAP at the same tier as Back2School, considered from

a response to intervention perspective (Kearney & Graczyk, 2014). For example, in a non-randomized trial of the @school intervention (Heyne et al., 2011) the average level of school attendance was 15% at baseline.

Considering our results, it can be stated that this study does not replicate Lomholt et al.'s results regarding treatment responses. This applies both to the maintenance of the treatment effect for the primary outcome variable of absenteeism at 3-month follow-up and to the effect of time on the secondary outcome measures. However, a comparison becomes problematic as the baseline data demonstrates that our sample is not necessarily comparable to Lomholt et al.'s sample, whose characteristics are more similar to the target group for which the Back2School intervention was created. Because of the small sample size, the clinically low levels of school absenteeism, and baseline psychometric data below clinical cut-off values, robust analyses of treatment effects become challenging. Furthermore, it makes comparisons to other trials difficult, since the sample characteristics do not represent the same target group accurately enough. Statistically, the analyses become limited by floor effects that give rise to a restriction of range problem.

Another reason why the effects demonstrated in the study by Lomholt et al. were not found in our results could be that Lomholt et al. also included younger children. While our age limit was drawn at 12 years, Lomholt et al. had 7-year-olds as the youngest possible age included. The literature has shown age-specific differences in treatment outcomes regarding CBT for school refusal (Heyne, 2022a; Heyne, 2022b). Generally, 7–11-year-olds have a stronger treatment response compared to 14-year-olds and older. One possible conclusion that has been made is that CBT for school refusal is more effective for children than for adolescents, which would be in line with our findings. Heyne lists school refusal severity, the complexity of the clinical presentation, developmental challenges, and lack of developmental sensitivity in the planning and execution of treatment as four possible reasons for the poorer response demonstrated among school-refusing adolescents (Heyne, 2022a; Heyne, 2022b).

Evaluation of feasibility and further recommendations

Based on the results in this study, the Back2School intervention is considered feasible for a randomized controlled trial in a Finnish context with regard to both the study procedures and the intervention itself. This is supported by the following findings: 1) feasible data collection procedures; 2) acceptable participation rate; 3) high treatment satisfaction; 4) high clinician acceptability; 5) generally positive qualitative feedback by all respondent groups; and 6) reduced school absenteeism between baseline and post-intervention.

In addition to the inclusion of a control group and the recruitment of a larger sample to improve statistical power for analyses of treatment effects, the following modifications to the study design are recommended for future trials:

1) Stricter inclusion criteria and a recruitment process where the participants themselves can apply for care. This would ensure a more representative sample.

2) Facilitating the data collection process by creating electronic forms whose answers go directly to the research team in a data-secure manner. This would make the data collection process less laborious for both the families and the clinicians, which would ensure a higher percentage of answered outcome measures.

3) Future studies should consider a reduction in the amount of outcome measures to reduce the workload for participants and clinicians. An alternative would be to use only the measures included in the manual. If other measures are included for academic interest, consideration should be given to using shorter versions of the questionnaires for the control group, who lack the same incentives of the treatment group to complete the questionnaires.

4) A future research design should include an additional follow-up data collection point 12 months after the end of the intervention. Based on the lack of treatment effect demonstrated in our results, additional meetings could also be considered between post-intervention and follow-up to support sustained treatment effects.

In addition to these guidelines for future research, modifications of the treatment manual are also recommended to consider the results and feedback that emerged from this study.

Limitations

This study has several limitations that affect the validity and generalizability of the findings. Firstly, the main limitation, with regard to evaluating treatment effects, was the small sample size and lack of a control group. The small sample increases the risk of random results and non-representative sample characteristics, while the non-randomized design means that we cannot necessarily infer changes over time to be an effect of the intervention. This limitation is emphasized at the follow-up measurement point where the response rate, especially among the teachers, was relatively low. The reason for having a design with rather low statistical power was that the primary purpose of the study was not to perform an efficacy trial, but to evaluate the feasibility of a future larger randomized controlled study. Thus, although the design is a limitation from a statistical point of view, the small sample and non-randomized design do not necessarily militate against the aim and purpose of the study.

Secondly, another limitation of this study is not only the low number of participants but also the sample's high level of baseline functioning on important clinical variables such as school attendance and psychiatric symptoms described earlier in the text. With less room for improvement, the validity of the mixed linear models becomes poorer.

Thirdly, the validity of the school absenteeism data was questionable for some families, with teachers and parents reporting different levels of absenteeism. Although we exclusively used

parent-reported data in our final analyses, the data for the absenteeism variable may contain an extra degree of measurement error. This limitation is magnified in a study such as this with a sample whose statistical power is already limited by the small sample size.

Conclusions

Overall, the results of this study suggest that the Back2School (B2S) intervention is feasible for a future randomized controlled trial in a Finnish context. The high treatment satisfaction among all respondent groups, high acceptability among the clinicians, feasible data collection procedures, and the initial reduction in school absenteeism between baseline and post-intervention suggest that B2S has the potential to be a beneficial contribution to the gap in the literature on transdiagnostic interventions targeting the clinical heterogeneity of school attendance problems. Our statistical analyses of treatment effect failed to adequately replicate the results in Lomholt et al.'s pilot study, however, the validity of our statistical models is limited because of the small sample size and non-representative sample characteristics. In comparison to Lomholt et al.'s trial, our study also shows lower proportions of completed outcome measures, due to a higher degree of complexity in our data collection procedures.

By modifying the recruitment process, data collection procedures and the course of the intervention in accordance with the recommendations described in this study, future trials can increase the likelihood of robustly evaluating the treatment effect of B2S with a sample that more representatively characterizes the target population for which B2S is created.

Summary in Swedish – Svensk sammanfattning

Genomförbarhet av Back2School-interventionen i en finsk kontext: En transdiagnostisk kognitiv beteendeterapi för skolfrånvaroproblem

Prevalensen av skolfrånvaroproblem (Eng. *School attendance problems* [SAP]) uppskattas vara mellan 2 och 3 % i finska skolor (Määttä m.fl., 2020). Svårigheterna är oftast kroniska med en varaktighet som i snitt varar över två år. Litteraturen rapporterar ett brett spektrum av socioemotionella, akademiska och psykologiska komplikationer i samband med skolfrånvaro, såsom försämrad skolframgång, tidigt skolavhopp, framtida arbetslöshet och olika former av psykopatologi (Attwood, & Croll, 2006; Carroll, 2010; Egger m.fl., 2003; Gershenson m.fl., 2017). Olika riskfaktorer har identifierats när det gäller SAP, bland annat faktorer som berör individen, familjen, skolan och samhället (Heyne, 2006; Maynard m.fl., 2018; Thambirajah m.fl., 2008). Trots oro för den ökade graden av skolfrånvaro och den stora relevansen skolnärvaro har för barns psykosociala funktionsförmåga, finns det en brist på vetenskapligt validerade psykosociala insatser i finsk elevvård och specialiserad hälsovård (Määttä m.fl., 2020).

Kliniskt manifesterar sig SAP med olika svårighetsgrad, symptom och etiologiska faktorer. Litteraturen tyder på ett brett och heterogent spektrum av ackompanjerande symtomatologi med olika utlösande och vidmakthållande faktorer (Heyne m.fl., 2019; Kearney 2008; Lomholt m.fl., 2020). Olika försök har gjorts att formulera en lämplig tröskelnivå mellan normal och problematisk frånvaro (Gentle-Genitty m.fl., 2015; Kearney, 2003) och att skilja mellan olika specifika typer av skolfrånvaroproblem (Atkinson m.fl., 1985; Broadwin, 1932; Heyne, 2019). Kearneys modell (Kearney, 2008) är den som ligger närmast konsensus bland forskare för att identifiera tröskeln för en problematisk nivå av skolfrånvaro. Modellen består av tre separata indikatorer: 1) barnet har missat minst 25 % av den totala skoltiden under minst två veckor, 2) betydande svårigheter att gå i skolan under minst två veckor och en betydande negativ inverkan på barnets eller familjens dagliga funktionsförmåga och 3) minst tio dagars frånvaro från skolan under 15 veckor, exklusive lov och helger.

Heterogeniteten hos SAP har historiskt gjort det svårt att begreppsliggöra problemen i separata beskrivande underkategorier, främst på grund av semantiska faktorer om terminologin, men också som en följd av kvantitativt överlappande kategorier inom SAP-spektrumet (Heyne, 2019; Kearney, 2005; Lyon & Cotler, 2007). Olika termer har använts inkonsekvent på ett vis som inte beaktar kontexten, vilket lett till förvirring bland kliniker och forskare. Det finns ett behov av att nå en gemensam överenskommelse om definitionen och kategoriseringen av SAP för att planera lämpligt riktade interventionsinsatser.

Traditionellt har kognitiv beteendeterapi (KBT) varit den mest studerade typen av intervention för SAP, särskilt för skolvägrarbeteende med dess funktionella relation till

internaliserande symtom (Heyne m.fl., 2019; Maynard m.fl., 2018). En distinktion mellan skolnärvaroproblem med inslag av skolvägran jämfört med frånvaroproblem med inslag av skolkl är dock viktig när man granskar interventioner för SAP. Detta beror på de olika sekundära svårigheterna som associeras med skolvägran och skolkl samt de olika kliniska metoderna som vanligtvis används för dessa typer av SAP (Keppens & Spruyt, 2020; Maynard m.fl., 2018).

Historiskt har en mängd olika behandlingsformer testats för skolvägran (t.ex. Blagg, 1987; Sahel, 1989; Wu m.fl., 2013). Under den senare delen av utvecklingen har beteendeterapeutiska, kognitiva och kognitiva-beteendeterapeutiska interventioner framträtt som de mest framstående formerna av behandling (t.ex. Bernstein m.fl., 2000; Blagg & Yule, 1984; Hannan m.fl., 2019; King m.fl., 1998; Last m.fl., 1998). Tidiga beteendeterapeutiska interventioner skapades i hög grad enligt principerna för klassisk och operant betingning med hjälp av tekniker som exponering, avslappningsträning, träning av sociala färdigheter och förstärkningsmetoder. Nyare interventioner med en beteendemässig grund har alltmer integrerat kognitiva komponenter i behandlingen med inslag av kognitiv omstrukturering, fokus på förvrängda föreställningar och psykoedukativa insatser (Maynard m.fl., 2018). I dagens läge har de flesta evidensbaserade interventionerna sin teoretiska grund i kognitiv beteendeterapi (KBT) som integrerar både beteendemässiga och kognitiva arbetssätt. Behandlingen har utvecklats från standardiserade manualer till modulära och individuellt anpassade insatser som bygger på individuella fallformuleringar (Heyne & Rollings, 2002; Heyne m.fl., 2008; Tolin m.fl., 2009). Ett aktivt engagemang av barnets familj och skolpersonal anses också vara väsentligt för dagens KBT-baserade interventioner (Heyne m.fl., 2008; Lomholt m.fl., 2008; Reissner m.fl., 2019).

Minst sex olika KBT-manualer för skolvägran finns i litteraturen (Heyne & Rollings, 2002; Heyne m.fl., 2008; Kearney & Albano, 2000; Last, 1993; Strömbeck m.fl., 2021; Tolin m.fl., 2009). Det finns en viss grad av variation mellan dessa manualer med skillnader på områden såsom hur svåra problem interventionen lämpar sig för, antalet träffar och grad av manualiserat förlopp. Det som varje manual har gemensamt är en individuell behandlingsperiod, involvering av föräldrar och skolpersonal samt integration av centrala kognitiva-beteendemässiga principer i behandlingen. I den hittills mest omfattande genomgången av kognitiv beteendeterapi för skolvägrarbeteende, en metaanalys gjord av Maynard m.fl. (2018), framkom det preliminär evidens för KBT när det gäller att öka skolnärvaron hos skolvägrande ungdomar. Även om det saknas studier som använder den gyllene standarddesignen för interventionsstudier, den randomiserade kontrollerade studien (eng. *randomized controlled trial* [RCT]), tyder evidensen på en generell positiv effekt av KBT på skolnärvaro bland skolvägrande ungdomar. Effekten är generell i den aspekten att ingen särskild KBT-intervention konsekvent har fått överlägset empiriskt stöd i jämförelse med någon annan KBT-intervention. Resultaten har gett upphov till diskussion om vilka förändringsmekanismer som

är verksamma i KBT för skolfrånvaroproblematik (Maynard m.fl., 2018). Även om förändringsmekanismerna i KBT för skolvägran är något oklara, har studier tytt på att barns självförmåga är ett centralt medierande kognitivt konstrukt för positiva behandlingsresultat (Heyne m.fl., 2015; Maric m.fl., 2013).

I motsats till skolvägran och dess funktionella relation till internaliserande symptom, kännetecknas skolk av bristande motivation att gå i skolan och engagemang i aktiviteter utanför skolan som upplevs vara belönande av ungdomen (Heyne m.fl., 2019). Det finns en brist på forskning om insatser för skolkande barn och ungdomar jämfört med litteraturen om skolvägran. I skolklitteraturen hittas endast en översikt av existerande interventioner för skolkande barn och ungdomar (Keppens & Spruyt, 2020). I översikten framkommer att insatser som riktar sig mot skolk är, trots heterogena effektstorlekar, någorlunda effektiva, men att enbart förlita sig på belöning och bestraffning är otillräckligt. För bättre resultat behövs insatser på flera nivåer riktade mot det enskilda barnet, med engagemang av skolan, samhället och övriga intressenter. Operanta beteendepprinciper kan fungera när det finns en hög grad av skolengagemang, med en koordinator som organiserar interventionens olika faser. Studierna i översikten är dock varierande avseende urvalsstorlek, metodologisk kvalitet och inkluderade resultatmått. Således kan det konstateras att mera rigorösa studier behövs för att fastställa effektiviteten av interventioner för skolkande barn och ungdomar.

Utifrån evidensen om skolfrånvaroproblemets heterogena kliniska bild har transdiagnostiska insatser som kan anpassas till enskilda fall övervägts (Lomholt m.fl., 2020; Reissner m.fl., 2019). Modulära behandlingar med olika behandlingsstigar baserade på den individuella kliniska utredningen har också uppvisat överlägsna resultat i behandlingsstudier om ungdomspsykopatologi (Weisz m.fl., 2012). Modular Manual for the Treatment of Problematic School Absenteeism (MT; Reissner m.fl., 2019) är ett tyskt interventionsprogram som inriktar sig på skolvägran och skolkbeteende. MT har visat en 60 % ökning av skolnärvaro och minskning av depressiva symtom i en randomiserad kontrollerad studie (Reissner m.fl., 2015). Den andra interventionen som hittas i litteraturen är den transdiagnostiska, modulära kognitiva beteendeterapeutiska intervention Back2School (B2S; Thastum & Kjerholt, 2020). B2S följer ett liknande förlopp som MT, med individuellt KBT-, föräldra- och skolarbete, och olika behandlingsmoduler som väljs ut baserat på den individuella fallkonceptualiseringen.

B2S utvecklades av Århus Universitet som en intervention för att öka skolnärvaro och minska samtidig psykopatologi, såsom ångest, depression och beteendeproblem. Interventionen försöker adressera 1) problemet med heterogenitet som framkommit i skolfrånvarolitteraturen och 2) bristen på bredare transdiagnostiska insatser på fältet. B2S antar ett funktionellt tillvägagångssätt, och interventionen inleds med en standardiserad bedömningsperiod följt av en behandlingsperiod

som utnyttjar olika terapeutiska mekanismer och strategier beroende på innehållet i den individuellt anpassade fallkonceptualiseringen och den deskriptiva funktionella analysen. B2S består av elva individuella sessioner med barnet, föräldern eller båda tillsammans samt regelbundna skolmöten för att på många områden verkställa en plan för barnets återgång till skolan.

I en dansk genomförbarhetsstudie (eng. *feasibility-study*) uppvisade B2S positiva initiala behandlingsresultat och adekvat genomförbarhet i den danska skolkontexten (Lomholt m.fl., 2020). Studien visade både en signifikant reduktion av skolfrånvaro och grad av ångest, depression och beteendeproblem. Mått på ungdomars och föräldrars självförmåga inkluderades också, med en signifikant ökning för både ungdomar och deras föräldrar under interventionens gång. Studien hade ett lågt avhopp, positiv kvalitativ feedback och hög behandlingstillfredsställelse som rapporterats av föräldrar och ungdomar. De mest signifikanta begränsningarna var relaterade till det lilla samplet ($N = 26$) och avsaknaden av en kontrollgrupp. Syftet med studien var i första hand att lägga grunden för en framtida randomiserad kontrollerad studie och genomföra förändringar i interventions- och studieprocessen i enlighet med vad resultaten indikerade.

Vår studie försöker replikera Lomholt m.fl.:s studie i en finsk kontext. Studien syftar till att minska på klyftan i riktlinjer för evidensbaserad praxis och tillgängliga evidensbaserade manualiserade interventioner för behandling av skolfrånvaroproblem i Finland. Studien replikerar designen i den danska genomförbarhetsstudien och samlar in både kvantitativa och kvalitativa data för utvärdering av studiens genomförbarhet och behandlingens effekt. Studien syftar till att undersöka om B2S-programmet är genomförbart i en finsk kontext och om interventionen verkar öka skolnärvaro och minska på samtidiga psykiatriska symtom. Studien undersöker också interventionens effekt på andra relevanta psykologiska variabler, till exempel självförmåga. Det långsiktiga syftet med studien är att formulera användbara riktlinjer och skapa en grund för framtida interventionsstudier med en mer rigorös design (t.ex. randomiserad kontrollerad studie) för att testa behandlingseffekterna av B2S-interventionen i Finland.

Metod

Deltagare

Med inspiration från Lomholt m.fl. (2020) var denna studies mål att inkludera 25 familjer, jämnt fördelade på tolv kliniker utbildade i B2S. Det inkluderade samplet bestod slutligen av 16 familjer och fem kliniker från Lojo kommun i södra Finland. Varje kliniker behandlade mellan två och sex familjer. Tre familjer hoppade av under interventionen, vilket innebar att 13 familjer slutförde interventionen. Ungdomarna var i åldrarna 10 till 16 ($M = 13,9$ år, flickor 71 %). Fyra av de deltagande fem klinikerna bidrog med klientdata medan den femte endast svarade på frågeformulär om interventionen. Studien omfattade fyra informantgrupper: ungdomar, föräldrar, kliniker och lärare.

Inklusionskriterium

Våra inklusionskriterier för deltagande i studien baserades på den danska genomförbarhetsstudien (Lomholt m.fl., 2020) och Kearneys kriterier för problematisk skolfrånvaro (Kearney, 2008).

Ungdomarna skulle vara 1) inskrivna i en av sju möjliga skolor i sydvästra Finland, 2) i åldern 10–16 år och gå i årskurserna 4–9 (andra terminen i nian exkluderad), 3) ha en föräldrarapporterad skolfrånvaro på >10 % under de senaste 3 månaderna, 4) besitta flytande språkkunskaper i finska eller svenska och 5) ge samtycke för att delta i bedömnings- och interventionsförfaranden samt bidra med skriftligt medgivande för deltagande från vårdnadshavarna.

Procedur

Datainsamlingen genomfördes i samarbete mellan Åbo Akademi och projektet Skolskick under läsåret 2021–2022. Elva kliniker deltog på det fyra dagar långa utbildningsseminariet. Av klinikerna krävdes engagemang för att arbeta enligt B2S-programmet, erfarenhet av kliniskt arbete med familjer och grundläggande kunskaper i KBT-principer och KBT-tekniker. Fem av dessa kliniker deltog i studien och behandlade totalt 16 familjer. Data samlades in vid tre olika punkter: före interventionen (baslinje), efter interventionen och efter tre månader. Resultatmätt fylldes i av ungdomarna, föräldrarna och lärarna vid varje mätpunkt, och resultaten rapporterades tillbaka till forskarna via färdigställda Microsoft Excel-ark och mjukvaran Question Pro Survey Analytics.

Intervention

Back2School-interventionen är ett KBT-baserat program för behandling av skolfrånvaroproblem. Manualens innehåll är inspirerat av olika existerande interventioner mot ångest, depression och beteendeproblem (Forgatch, 2016; Heyne m.fl., 2008; Jeppsen, 2018; Kearney & Albano, 2000; Lyneham m.fl., 2003; McCauley m.fl., 2016). Programmet är modulärt och transdiagnostiskt med ett skräddarsytt tillvägagångssätt baserat på den kliniska bedömningen. Interventionen består av elva sessioner med barnet och/eller föräldrarna, följt av en uppföljningsträff tre månader efter interventionens avslut. Skolpersonalen deltar i interventionsprocessen, med minst tre möten som hålls för att stödja en snabb återgång till skolan. De första sex sessionerna är desamma för alla klienter. Interventionens andra halva är skräddarsydd utifrån den individuella fallformuleringen och utvalda förändringsmekanismer.

Utredning

Semi-strukturerad bakgrundsintervju

Den semistrukturerade bakgrundsintervjun är en omfattande bedömning som görs i två delar: den första delen med endast föräldrarna och den andra delen tillsammans med både föräldrarna och

ungdomen. Intervjun täcker bland annat familjeläget, ungdomens utvecklingshistoria, förmåga att gå i skola och hemmiljö samt hälsa och motivation.

Semistrukturerad psykopatologisk intervju

Den semistrukturerade psykopatologiska intervjun utvärderar närvaron av klinisk signifikant psykopatologi. Den täcker ett brett spektrum av psykiatrisk problematik med hjälp av deskriptiva symptomlistor. De diagnostiska kategorierna kräver närvaron av nyckelsymtom som orsakar signifikant negativ påverkan på ungdomens funktionsförmåga. De diagnostiska kategorierna som utvärderas i intervjun är panikångest, separationsångest, social ångest, specifika fobier, agorafobi, tvångssymptom, traumatiska stressreaktioner, generell ångest, depression, självskadebeteende, hypomani/mani, substansanvändning, tic-symptom, hyperaktivitet och impulsivitet, beteendeproblem, psykotiska upplevelser, ätstörning och utvecklingspatologi.

Primära utfallsmått

Skolfrånvaro

Frånvarodata samlades in via föräldrarnas och lärarnas rapporter vid baslinjen, efter intervention och vid uppföljningen tre månader efter interventionen. Antalet timmar som ungdomen förväntades vara i skolan och antalet timmar som ungdomen faktiskt var i skolan rapporterades. Frånvaro operationaliserades som den procentuella andelen av förväntad skolnärvaro under en tvåveckorsperiod.

Sekundära utfallsmått

Ångest

För bedömning av ångestproblematik användes Revised Child Anxiety and Depression scale (RCADS; Chorpita m.fl., 2000). RCADS är ett självskattningsformulär med 47 frågor som mäter ungdomars internaliserande symptom med sex subskalor. Både barn- och föräldraversionerna användes. RCADS har visat acceptabel till god intern reliabilitet (0,78–0,88) (Chorpita m.fl., 2005) och adekvat retest-reliabilitet (0,65–0,80) (Chorpita m.fl., 2000).

Emotionella, beteendemässiga, och sociala svårigheter

För bedömning av emotionella, beteendemässiga och sociala svårigheter användes The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). SDQ är ett frågeformulär med 25 påståenden som mäter känslomässiga, beteendemässiga och sociala problem hos barn och unga. Formuläret fylls i av ungdomen, föräldrarna och läraren på en tregradig Likert-skala. Den finska versionen har visat acceptabel intern reliabilitet och interbedömarreliabilitet (Koskelainen m.fl., 2000).

Depression

Den korta versionen av Mood and Feelings Questionnaire (SMFQ; Angold m.fl., 1995) användes för att mäta centrala depressiva symptom. Den består av 13 frågor och fylldes i av både ungdomen

och föräldrarna. En total poäng av depressiva symtom, från 0 till 26, beräknades. SMFQ har god intern konsistens och ett kliniskt gränsvärde på 8 eller mer har visat 60 % sensitivitet och 85 % specificitet med psykiatriska diagnosen egentlig depression (Angold m.fl., 1995).

Förekomst och funktion av skolfrånvarorelaterade symptom

The Inventory of School Attendance Problems (ISAP; Knollmann m.fl., 2019) användes för att mäta närvaron och funktionen av skolfrånvarorelaterade symptom. ISAP är ett självskattningsformulär med 48 påståenden och 13 subskalor som avspeglar externaliserande och internaliserande symptomatologi. Den mäter både symptomens förekomst och styrka, samt det funktionella sambandet mellan dessa symptom och skolfrånvaro. Påståendena besvaras på en 4-gradig skala och för varje delskala beräknas ett symptom och ett funktionspoäng. ISAP har demonstrerat god intern reliabilitet ($\alpha = .75-.88$) (Knollman m.fl., 2018).

Skolfrånvarons funktioner

The School Refusal Assessment Scale-Revised (SRAS-R; Kearney, 2006) användes för att kartlägga skolfrånvarons funktion. SRAS-R är ett frågeformulär med 24 frågor som mäter den primära funktionen av barnets eller ungdomens skolfrånvarobeteende. Den mäter fyra faktoranalytiskt härledda funktioner. Faktorn med högst poäng anses vara den primära funktionen. Både barn- och föräldraversioner användes. SRAS-R har uppvisat tvivelaktiga psykometriska egenskaper med relativt svag intern konsistens och retest-reliabilitet (Kearney, 2006).

Självförmåga

För att mäta ungdomars självförmåga i skolrelaterade situationer användes det 12 frågor omfattande Self-efficacy Questionnaire for School Situations (SEQ-SS; Heyne m.fl., 1998). SEQ-SS besvaras på en 5-gradig Likert-skala. Den producerar två faktorer: 1) akademisk/social stress; och 2) separations-/disciplinär stress. Högre poäng indikerar högre grad av självförmåga. SEQ-SS har visat goda intern konsistens i de ursprungliga valideringsstudierna ($\alpha = .85$) (Heyne m.fl., 1998).

Föräldrars självförmåga när det gäller att hantera sitt barns problem med skolnärvaro bedömdes med SEQ-RSAP. Formuläret består av 25 frågor, som har visat adekvat intern konsistens ($\alpha = 0,91$) och retest-reliabilitet ($r = 0,67$) (Lavooi, 2010).

Familjefunktion

Vi använde den generella familjefunktionsskalan från McMaster's family assessment device (FAD; Epstein m.fl., 1983). Skalan har tolv påståenden, högre poäng indikerar mer signifikanta problem. Skalan har visat sig kunna predicera missanpassning och suicidalt beteende hos barn samt identifierar dysfunktionella familjer som löper högre risk för negativa utfall. Den har hög intern konsistens ($\alpha = .92$) (Miller m.fl., 1985) och adekvat retest-reliabilitet ($r = .71$) (Epstein m.fl., 1983).

Upplevelser av mobbning

För att kartlägga upplevelser av mobbning användes The Personal Experience Checklist (PECK; Hunt m.fl., 2012). Den har 32 påståenden som mäter verbal, cyber, fysisk och kulturell mobbning. PECK har visat god intern konsistens ($\alpha=.78-.91$) och acceptabel retest-reliabilitet ($r=.61-.86$) (Hunt m.fl., 2012).

Mått på genomförbarhet

Denna studie syftade till att bedöma genomförbarheten av Back2School-programmet i ett finskt sammanhang och dess lämplighet för en framtida randomiserad kontrollerad studie.

Genomförbarheten utvärderades baserat på granskning av samplets egenskaper, datainsamlingsprocedurer, behandlingstillfredsställelse, acceptans och studieprocedurer samt initiala behandlingsresponsen.

Samplets egenskaper

Information om samplets egenskaper samlades in via enkäter från föräldrar och lärare, den semistrukturerade intervjun och den psykopatologiska intervjun. Föräldraenkäten innehöll 41 frågor som täckte bland annat demografisk information, medicinsk historia och skolfrånvarohistoria. Lärarenkäten hade elva frågor om bland annat akademisk framgång och stödundervisning. Enkäten för klinikerna samlade information om klinikernas professionella bakgrund och attityder till interventionen.

Datainsamlingsprocedur

Svarsfrekvenser för resultatmått utvärderades vid varje mätpunkt för att bedöma genomförbarheten av datainsamlingen. Klinikerna utvärderade den kliniska nyttan av interventionen och dess komponenter med ett frågeformulär efter interventionens avslut.

Behandlingstillfredsställelse

Behandlingstillfredsställelse mättes vid mätpunkten efter interventionen med ett frågeformulär som fylldes i av ungdomarna, föräldrarna och lärarna som ett subjektivt mått. Den registrerade avhoppsfrekvensen, sessionsnärvaro och interventionslängd samlades in som objektiva mått. Kvalitativa data om behandlingstillfredsställelse samlades också in av varje motpart (ungdom, föräldrar och lärare).

Acceptans och studieprocedurer

Klinikernas acceptans av interventionen och studieprocedurerna bedömdes efter interventionen genom ett självskattningsformulär. Frågorna berörde behandlingens och manualens användbarhet, tidshanteringsresurser, behövd bakgrundskunskap för att implementera behandlingen, utvärdering av B2S-utbildningsprogrammet som helhet och tillfredsställelse med behandlingsresultaten.

Kvalitativa data samlades in via två öppna frågor angående mätinstrumenten och allmänna styrkor och svagheter med B2S-interventionen.

Behandlingsrespons

Vi mätte förändringar i primära (frånvaro) och sekundära (psykiatriska symtom och relaterade psykosociala variabler) resultatmått för att bedöma behandlingsrespons. Data för resultatvariablerna samlades in vid samtliga mätpunkter och behandlingseffekt mättes med jämförelser mellan för- och eftermätningarna. Evaluering av bibehållna behandlingsrespons mättes med uppföljningsmätningarna tre månader efter interventionens avslut.

Dataanalyser

Data som analyserades inkluderade både kvantitativa och kvalitativa variabler. Deskriptiv statistik användes för att analysera samplets egenskaper, behandlingstillfredsställelse och klinikerrapporterad acceptans. Kvalitativa data samlades in av ungdomarna och föräldrarna genom fria kommentarer på frågeformulär om behandlingstillfredsställelse och av klinikerna genom acceptansenkäten efter intervention. Kvalitativ analys följde en design som användes i Lomholt m.fl., (2020), med data kodat och indelat i fyra identifierade teman. Behandlingseffekter utvärderades med hjälp av Mixed Linear Models (MLM) med varianskomponenter som standard kovariansstruktur. Hurvich and Tsai's criterion (AICC; Hurvich & Tsai, 1989) användes för att utvärdera modellanpassning med förstaordningens autoregressiv struktur [AR (1)] eller heterogen förstaordningens autoregressiv struktur [ARH(1)] som kovariansstrukturer ifall de förbättrade modellanpassningen. Cohen's d användes för att utvärdera effektstorlek.

Resultat

Samplets egenskaper

16 familjer slutförde baslinjemåten och påbörjade interventionen. Majoriteten av deltagarna var flickor (69 %) och 56 % överträffade Kearneys kriterier (Kearney, 2008) för problematisk skolfrånvaro. Av deltagarna hade 80 % genomgått tidigare SAP-behandling och ångeststörning var den vanligaste psykiatriska diagnosen i samplet. Ångest var också det vanligaste målet för intervention (50 %), följt av beteendeproblem (25 %) och depression (13 %). Av de fem kliniker som deltog i studien hade tre mer än sju års erfarenhet av kliniskt arbete.

Datainsamlingsprocedur

Resultatmåten fylldes i före och efter intervention samt vid uppföljningsmätningen tre månader efter interventionen. Alla 16 ungdomar och föräldrar fyllde i samtliga formulär före interventionens början. Färdigställandegraden minskade till 75 % efter intervention och 56 % vid 3-månadersuppföljning för ungdomar och 75 % respektive 63 % för föräldrar. Lärarnas slutförandegrad minskade från 88 % vid interventionens början till 56 % efter interventionen och ytterligare till 25 % vid tre månaders uppföljning.

Behandlingstillfredsställelse

Tre av 16 familjer (18,8 %) hoppade av under interventionens gång. Tolv av 13 avslutande familjer deltog i alla elva sessioner. Det genomsnittliga antalet dagar mellan baslinjebedömningen och den elfte sessionen var 99 dagar. Resultat från frågeformuläret om behandlingstillfredsställelse visade en hög grad av tillfredsställelse bland alla respondentgrupper med en majoritet som rekommenderade programmet till andra med liknande problem. Ungdomarna rapporterade dock en något mindre grad av tillfredsställelse jämfört med föräldrar och lärare.

Acceptans och studieprocedurer

Efter interventionen fyllde fem kliniker i frågeformuläret om acceptans, vilket visade hög tillfredsställelse med manualens lämplighet i fråga om tid och ansträngning som interventionen krävde och den övergripande användbarheten av interventionen. Alla kliniker rapporterade hög motivation och förmåga att arbeta med interventionsmanualen. De rapporterade goda intryck av programmets modulära och manuella struktur och betonade dess kliniska och samhällliga relevans. Alla kliniker rekommenderade interventionen och 60 % av klinikerna var överlag nöjda med hjälpen familjerna fick med hjälp av manualen.

Kvalitativ feedback

Föräldrarna, lärarna och ungdomarna

Kvalitativ feedback samlades in från föräldrarna, lärarna och ungdomarna angående B2S-programmet. Feedbacken är indelad i fyra teman.

Samarbete mellan flera intressenter. Både föräldrar och lärare uttryckte tillfredsställelse med involveringen av och samarbetet mellan skolan och familjen under behandlingsperioden.

Klinikernas professionella kompetens och arbetsallians. Klinikerna fick uteslutande positiv feedback från både föräldrar och lärare som var nöjda med klinikernas kompetens och professionella färdigheter.

Terapeutiska tekniker. Många föräldrar och lärare var nöjda med de specifika faktorerna för interventionen med kommentarer som betonade nyttan av olika "verktyg" och "tips". Vissa ungdomar antydde dock att programmet inte alltid var åldersenligt.

Interventionseffekt. Svaren på de kvalitativa frågorna indikerade en påtaglig grad av variation avseende förändringar i skolnärvaro under interventionen. En anmärkningsvärd andel av de deltagande föräldrarna och lärarna rapporterade en utebliven effekt på skolnärvaro, dock tillskriven externa faktorer som covid-pandemin eller förändringar som sker långsamt och gradvis.

Kliniker

Klinikerna gav feedback på utredningsmetoderna och resultatmått. De noterade utredningsprocessernas omfattande arbetsbelastning men uppskattade också resultatmåttens kliniska användbarhet. Interventionen i sin helhet fick beröm för sin struktur, evidensbas och målinriktade arbetssätt. Vissa kliniker ansåg att interventionen var mer lämpad för ångest än andra problem. Fallformuleringen och bakgrundsintervjun ansågs vara till hjälp för behandlingsplanering och för att skapa en gemensam förståelse tillsammans med familjen.

Behandlingsrespons

Skolfrånvaron minskade från 43 % till 27 % efter intervention men steg igen till 42 % vid tre månaders uppföljning. Endast tre variabler visade signifikant förbättring: lärarrapporterad hyperaktivitet, prosocialt beteende och föräldrars självförmåga. Det fanns flera medelstora till stora effekter som var statistiskt icke-signifikanta. Jämförelser mellan före och efter interventionen visade förhöjda poäng på ångest- och depressionsmått som var ifyllda av ungdomarna. Dessa förändringar var dock statistiskt icke-signifikanta. Nio ungdomar uppfyllde kriterierna för problematisk skolfrånvaro vid baslinjen, fyra efter interventionen och sex vid uppföljningen.

Diskussion

Samplets egenskaper

Vår sampelstorlek på N=16 var mindre än vårt initiala mål att inkludera 26 familjer. Rekryteringen via skolor i stället för att låta familjerna på eget initiativ uppsöka vården kan ha lett till att högre fungerande familjer inkluderades. Detta återspeglas i relativt hög skolnärvaro och låga nivåer av psykiatriska symtom jämfört med andra kliniska studier (Hannan m.fl., 2019; Heyne m.fl., 2011; Lomholt m.fl., 2020; Reissner m.fl., 2015; Strömbeck m.fl., 2021). Medan 87 % av deltagarna rapporterade symptomatologi i den psykopatologiska intervjun, visade prevalensen av ångest (47 %), depression (40 %) och ADHD (33 %) heterogenitet i ackompanjerande psykopatologi med SAP. SRAS-R visade också en jämn fördelning av dominerande underliggande funktion.

Datainsamlingsprocedur

Baslinjefrågeformulärens slutförandegrad var 100 %. Vid mätpunkten efter interventionen observerades dock en lägre grad av slutförandegrad bland föräldrar jämfört med studien gjord av Lomholt m.fl. (2020) (80 % vs 100 %), medan en högre grad av slutförande registrerades bland ungdomar (80 % vs 55 %). När det gäller tre månadersuppföljningen hade både ungdomar och föräldrar lägre slutförandegrad än Lomholt m.fl.:s studie (ungdomar: 60 % vs 95 %; föräldrar: 66 % vs 95 %). Dessa proportioner kan anses vara låga, särskilt för föräldrarna. Komplexa datainsamlingsprocedurer och ett omfattande batteri av mätinstrument kan ha bidragit till låga slutförandegrader. Elektroniska frågeformulär som möjliggör klinikerns övervakning av

datainsamlingsprocessen rekommenderas för framtida studier. Uppgifter om skolfrånvaro samlades in på varje session, informationen från föräldrarnas frågeformulär var ofta inkonsekventa. För framtida studier rekommenderas därför strukturerad insamling av frånvarodata i samråd med data ur skolregistret.

Behandlingstillfredsställelse

Sammantaget rapporterade föräldrar, lärare och barn att de var nöjda med behandlingen. Jämfört med Lomholt m.fl.:s studie rekommenderade en högre andel av samtliga respondentgrupper interventionen. Ungdomar rapporterade något lägre tillfredsställelse jämfört med föräldrarna och lärarna, potentiellt på grund av den relativt höga funktionsförmågan som noterades vid baslinjemätningarna.

Acceptans och studieprocedurer

Kliniker rapporterade hög acceptans för B2S-interventionens procedurer och 100 % av klinikerna rekommenderade interventionen för skolfrånvaroproblem. En betydande andel av klinikerna tyckte dock att processen var mödosam, särskilt den omfattande mängden frågeformulär. Vissa respondentgrupper hade låga svarsfrekvenser och datainsamlingen upplevdes som svår på grund av de extra arbetsinsatserna som krävdes av klinikerna. Feedback på utfallsmåtten kan dock tolkas som feedback på forskningsdesignen och inte nödvändigtvis på själva interventionen. Klinikerna önskade riktlinjer för hur man integrerar familjearbete i behandlingen. Framtida modifieringar av manualen bör beakta denna feedback.

Behandlingsrespons

Skolfrånvaron minskade från 43 % till 27 % efter interventionen men återgick till baslinjenivåerna (42 %) vid tre månaders uppföljning. Effekterna på sekundära utfallsmått var begränsade, således replikerade inte denna studie den danska studiens resultat, möjligen på grund av skillnader i urvalet och rekryteringsprocessen. Studien hade ett litet sampel och hög funktionsförmåga vid baslinjen vilket gav upphov till golfeffekter. Detta gjorde det utmanande att utföra robusta statistiska analyser. Framtida studier bör modifiera rekryteringsprocessen och skärpa inklusionskriterierna för att bättre återspegla de kliniska egenskaperna hos SAP-populationen. Inklusionskriterier baserade på sekundära utfallsmått kunde också inkluderas för att undvika golfeffekter vid baslinjen.

Slutsatser och begränsningar

På basis av våra resultat bedöms Back2School-interventionen vara genomförbar för en randomiserad kontrollerad studie i en finsk kontext. Följande resultat stöder denna slutsats: 1) hög behandlingstillfredsställelse; 2) hög acceptans av klinikerna; 3) generellt positiv kvalitativ feedback från alla respondentgrupper; 4) minskning av skolfrånvaro från baslinjen till efter intervention; och 5) genomförbara datainsamlingsförfaranden.

För att förbättra studiedesignen görs följande rekommendationer: 1) strängare inklusionskriterier för att säkerställa ett mer representativt urval; 2) förenkling av datainsamlingen genom att använda elektroniska formulär vilket skulle minska arbetsbördan för deltagare och kliniker; 3) minskning av antalet mätinstrument; och 4) en till uppföljningsmätning 12 månader efter att interventionen avslutats och ytterligare träffar mellan uppföljningarna för att stödja vidmakthållna behandlingseffekter. Förutom dessa förslag för framtida forskning rekommenderas framtida modifieringar av behandlingsmanualen att beakta denna studies resultat.

Resultaten i denna studie begränsas bland annat av den uteblivna kontrollgruppen och samplers bristande representativitet vilket sänker validiteten i våra statistiska modeller. Den icke-randomiserade designen hindrar en från att dra kausala slutsatser, särskilt när det gäller behandlingseffekten. Validiteten i uppgifterna om skolfrånvaro kan ifrågasättas på grund av skillnader mellan lärarnas och föräldrarnas rapporter. Även om vi uteslutande använde föräldrarapporterade data för analysen är risken för mätfel i skolfrånvarovariabeln betydande. Denna begränsning förstärks av den lilla urvalsstorleken, vilket ytterligare minskar den statistiska styrkan. En ytterlig begränsning var svarsfrekvensen vid uppföljningsmätningen som var relativt låg, särskilt bland lärarna.

References

- Angold, A., Costello, E.J., Messer, S.C., Pickles, A., Winder, F., & Silver, D. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescence. *International Journal of Methods in Psychiatric Research*, 5, 237- 249.
- Attwood, G., & Croll, P. (2006). Truancy in secondary school pupils: Prevalence, trajectories, and pupil perspectives. *Research papers in education*, 21(4), 467-484.
<https://doi.org/10.1080/02671520600942446>
- Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. Penguin.
- Beck, J. S. (2020). *Cognitive behavior therapy: Basics and beyond*. Guilford Publications.
- Berg, I., Nichols, K., & Pritchard, C. (1969). School phobia: Its classification and relationship to dependency. *Child Psychology & Psychiatry & Allied Disciplines*.
<https://psycnet.apa.org/doi/10.1111/j.1469-7610.1969.tb02074.x>
- Berg, I., Butler, A., Hullin, R., Smith, R., & Tyrer, S. (1978). Features of children taken to juvenile court for failure to attend school. *Psychological Medicine*, 8(3), 447-453.
<https://doi.org/10.1017/S0033291700016123>
- Berg, I. (1992). Absence from school and mental health. *The British Journal of Psychiatry*, 161(2), 154-166. <https://doi.org/10.1192/bjp.161.2.154>
- Berg, I. (1997). School refusal and truancy. *Archives of disease in childhood*, 76(2), 90-91.
<http://dx.doi.org/10.1136/adc.76.2.90>
- Bernstein, G. A., Borchardt, C. M., Perwien, A. R., Crosby, R. D., Kushner, M. G., Thuras, P. D., & Last, C. G. (2000). Imipramine plus cognitive-behavioral therapy in the treatment of school refusal. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(3), 276-283. <https://doi.org/10.1097/00004583-200003000-00008>
- Birioukov, A. (2016). Beyond the excused/unexcused absence binary: Classifying absenteeism through a voluntary/involuntary absence framework. *Educational Review*, 68(3), 340-357.
<https://doi.org/10.1080/00131911.2015.1090400>

- Blagg, N. R., & Yule, W. (1984). The behavioural treatment of school refusal—a comparative study. *Behaviour research and therapy*, 22(2), 119-127. [https://doi.org/10.1016/0005-7967\(84\)90100-1](https://doi.org/10.1016/0005-7967(84)90100-1)
- Bools, C., Foster, J., Brown, I., & Berg, I. (1990). The identification of psychiatric disorders in children who fail to attend school: A cluster analysis of a non-clinical population. *Psychological Medicine*, 20(1), 171-181. <https://doi.org/10.1017/S0033291700013350>
- Broadwin, I. T. (1932). A contribution to the study of truancy. *American Journal of Orthopsychiatry*, 2(3), 253. <https://psycnet.apa.org/doi/10.1111/j.1939-0025.1932.tb05183.x>
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, 32(7), 513. <https://psycnet.apa.org/doi/10.1037/0003-066X.32.7.513>
- Bronfenbrenner, U., & Morris, P. A. (2007). The bioecological model of human development. *Handbook of child psychology*, 1.
- Carroll, H. C. M. (2010). The effect of pupil absenteeism on literacy and numeracy in the primary school. *School Psychology International*, 31(2), 115-130. <https://doi.org/10.1177/0143034310361674>
- Chorpita, B. F., Yim, L., Moffitt, C., Umemoto, L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A revised child anxiety and depression scale. *Behaviour research and therapy*, 38(8), 835-855. [https://doi.org/10.1016/S0005-7967\(99\)00130-8](https://doi.org/10.1016/S0005-7967(99)00130-8)
- Chorpita, B. F., Weisz, J. R., Daleiden, E. L., Schoenwald, S. K., Palinkas, L. A., Miranda, J., ... & Gibbons, R. D. (2013). Long-term outcomes for the Child STEPs randomized effectiveness trial: a comparison of modular and standard treatment designs with usual care. *Journal of consulting and clinical psychology*, 81(6), 999. <https://psycnet.apa.org/doi/10.1037/a0034200>
- Chorpita, B. F., Ebesutani, C., & Spence, S. H. (2015). Revised children's anxiety and depression scale. <https://www.childfirst.ucla.edu/publications/>
- Chronis, A. M., Jones, H. A., & Raggi, V. L. (2006). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Clinical psychology review*, 26(4), 486-502. <https://doi.org/10.1080/15374416.2013.850700>

- Christle, C. A., Jolivette, K., & Nelson, C. M. (2007). School characteristics related to high school dropout rates. *Remedial and Special education, 28*(6), 325-339.
<https://doi.org/10.1177/07419325070280060201>
- Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*. Academic press.
- Coolidge, J. C., Hahn, P. B., & Peck, A. L. (1957). School phobia: Workshop, 1955: School phobia: Neurotic crisis or way of life. *American Journal of Orthopsychiatry, 27*(2), 296.
<https://doi.org/10.1111/j.1939-0025.1957.tb05493.x>
- David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 62-104.
<https://doi.org/10.1080/15374410701817865>
- Egger, H. L., Costello, J. E., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(7), 797-807. <https://doi.org/10.1097/01.CHI.0000046865.56865.79>
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of marital and family therapy, 9*(2), 171-180. <https://doi.org/10.1111/j.1752-0606.1983.tb01497.x>
- Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of clinical child & Adolescent psychology, 37*(1), 215–237. <https://doi.org/10.1080/15374410701820117>
- Flakierska, N., Lindström, M., & Gillberg, C. (1988). School refusal: A 15–20-year follow-up study of 35 Swedish urban children. *The British Journal of Psychiatry, 152*(6), 834-837.
<https://doi.org/10.1192/bjp.152.6.834>
- Forgatch, M. S., & Kjøbli, J. (2016). Parent management training—Oregon model: Adapting intervention with rigorous research. *Family process, 55*(3), 500-513.
<https://doi.org/10.1111/famp.12224>
- Gentle-Genitty, C., Karikari, I., Chen, H., Wilka, E., & Kim, J. (2015). Truancy: a look at definitions in the USA and other territories. *Educational studies, 41*(1-2), 62-90.
<https://doi.org/10.1080/03055698.2014.955734>

- Gershenson, S., Jackowitz, A., & Brannegan, A. (2017). Are student absences worth the worry in US primary schools? *Education Finance and Policy*, 12(2), 137-165.
https://doi.org/10.1162/EDFP_a_00207
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of child psychology and psychiatry*, 38(5), 581–586. <https://doi.org/10.1111/j.1469-7610.1997.tb01545.x>
- Gottfried, M. A. (2014). Chronic absenteeism and its effects on students' academic and socioemotional outcomes. *Journal of Education for Students Placed at Risk (JESPAR)*, 19(2), 53-75. <https://doi.org/10.1080/10824669.2014.962696>
- Hannan, S., Davis, E., Morrison, S., Gueorguieva, R., & Tolin, D. F. (2019). An open trial of intensive cognitive-behavioral therapy for school refusal. *Evidence-Based Practice in Child and Adolescent Mental Health*, 4(1), 89-101.
<https://doi.org/10.1080/23794925.2019.1575706>
- He, J. P., Burstein, M., Schmitz, A., & Merikangas, K. R. (2013). The Strengths and Difficulties Questionnaire (SDQ): the factor structure and scale validation in US adolescents. *Journal of abnormal child psychology*, 41, 583-595. <https://doi.org/10.1007/s10802-012-9696-6>
- Heck, R. H., Thomas, S. L., & Tabata, L. N. (2013). *Multilevel and longitudinal modeling with IBM SPSS*. Routledge.
- Heyne, D., King, N., Tonge, B., Rollings, S., Pritchard, M., Young, D., & Myerson, N. (1998). The self-efficacy questionnaire for school situations: development and psychometric evaluation. *Behaviour Change*, 15(1), 31-40. <https://doi.org/10.1017/S081348390000588X>
- Heyne, D., & Rollings, S. (2002). *School refusal*. Blackwell.
- Heyne, D. (2006). School Refusal. In J. E. Fisher & W. T. O'Donohue (Eds.), *Practitioner's guide to evidence-based psychotherapy* (pp. 600–619). Springer Science + Business Media.
- Heyne, D., Maric, M., & Westenberg, P. M. (2007). Self-Efficacy Questionnaire for Responding to School Attendance Problems. *Unpublished Measure*. Leiden: Leiden University.
- Heyne, D., Sauter, F. M., & Van Hout, R. (2008). The@ school program: Modular cognitive behaviour therapy for school refusal in adolescence. *Unpublished treatment manual*. Leiden, the Netherlands: Faculty of Social and Behavioral Sciences, Leiden University.

- Heyne, D., Sauter, F. M., Van Widenfelt, B. M., Vermeiren, R., & Westenberg, P. M. (2011). School refusal and anxiety in adolescence: Non-randomized trial of a developmentally sensitive cognitive behavioral therapy. *Journal of anxiety disorders*, 25(7), 870-878. <https://doi.org/10.1016/j.janxdis.2011.04.006>
- Heyne, D., Sauter, F. M., Ollendick, T. H., Van Widenfelt, B. M., & Westenberg, P. M. (2014). Developmentally sensitive cognitive behavioral therapy for adolescent school refusal: Rationale and case illustration. *Clinical Child and Family Psychology Review*, 17, 191-215. <https://doi.org/10.1007/s10567-013-0160-0>
- Heyne, D., Sauter, F., & Maynard, B. (2015). Moderators and mediators of treatments for youth with school refusal or truancy. In M. Maric, P.J.M. Prins, & T.H. Ollendick (Eds.), *Moderators and mediators of youth treatment outcomes* (pp. 230–266). New York: Oxford University Press
- Heyne, D., Maric, M., and Totsika, V. (2016). Self-Efficacy Questionnaire for Responding to School Attendance Problems – 13 Item Version. Unpublished measure. Leiden, The Netherlands: Leiden University.
- Heyne, D., Gren-Landell, M., Melvin, G., & Gentle-Genitty, C. (2019). Differentiation between school attendance problems: Why and how? *Cognitive and Behavioral Practice*, 26(1), 8-34. <https://doi.org/10.1016/j.cbpra.2018.03.006>
- Heyne, D. (2022a). Practitioner Review: Signposts for Enhancing Cognitive-Behavioral Therapy for School Refusal in Adolescence. *Zeitschrift für Kinder-und Jugendpsychiatrie und Psychotherapie*. <https://doi.org/10.1024/1422-4917/a000899>
- Heyne, D. (2022b). Developmental Issues Associated with Adolescent School Refusal and Cognitive-Behavioral Therapy Manuals. *Zeitschrift für Kinder-und Jugendpsychiatrie und Psychotherapie*. <https://doi.org/10.1024/1422-4917/a000881>
- Hiatt, J. S. (1915). The Truant Problem and the Parental School. *United States Bureau of Education, Department of the Interior*, 29, 656. <https://eric.ed.gov/?id=ED541858>
- Hunt, C., Peters, L., & Rapee, R. M. (2012). Development of a measure of the experience of being bullied in youth. *Psychological assessment*, 24(1), 156. <https://psycnet.apa.org/doi/10.1037/a0025178>

- Hurvich, C. M., & Tsai, C. L. (1989). Regression and time series model selection in small samples. *Biometrika*, 76(2), 297-307. <https://doi.org/10.1093/biomet/76.2.297>
- Jeppesen, P. (2017). Transdiagnostic, Cognitive and Behavioral Intervention for in School-aged Children With Emotional and Behavioral Disturbances (MindMyMind RCT)
- Kahn, J. H., & Nursten, J. P. (1962). School refusal: a comprehensive view of school phobia and other failures of school attendance. *American Journal of Orthopsychiatry*, 32(4), 707. <https://psycnet.apa.org/doi/10.1111/j.1939-0025.1962.tb00320.x>
- Kearney, C. A., & Silverman, W. K. (1990). A preliminary analysis of a functional model of assessment and treatment for school refusal behavior. *Behavior Modification*, 14(3), 340-366. <https://doi.org/10.1177/01454455900143007>
- Kearney, C. A. (2001). *School refusal behavior in youth: A functional approach to assessment and treatment*. American Psychological Association.
- Kearney, C. A. (2002). Identifying the function of school refusal behavior: A revision of the School Refusal Assessment Scale. *Journal of psychopathology and Behavioral Assessment*, 24, 235-245. <https://doi.org/10.1023/A:1020774932043>
- Kearney, C. A. (2003). Bridging the gap among professionals who address youths with school absenteeism: Overview and suggestions for consensus. *Professional Psychology: Research and Practice*, 34(1), 57. <https://psycnet.apa.org/doi/10.1037/0735-7028.34.1.57>
- Kearney, C. A. (2006). Confirmatory factor analysis of the School Refusal Assessment Scale-Revised: Child and parent versions. *Journal of Psychopathology and Behavioral Assessment*, 28, 139-144. <https://doi.org/10.1007/s10862-005-9005-6>
- Kearney, C. A. (2008). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational psychology review*, 20, 257-282. <https://doi.org/10.1007/s10648-008-9078-3>
- Kearney, C. A., & Graczyk, P. (2014). A response to intervention model to promote school attendance and decrease school absenteeism. In *Child & Youth Care Forum* (Vol. 43, pp. 1-25). Springer US. <https://doi.org/10.1007/s10566-013-9222-1>
- Kearney, C. A., & Albano, A. M. (2018). *When children refuse school: Therapist guide*. Oxford University Press.

- Kearney, C. A., & Silverman, W. K. (1993). Measuring the function of school refusal behavior: The School Refusal Assessment Scale. *Journal of Clinical Child Psychology*, 22(1), 85-96. https://doi.org/10.1207/s15374424jccp2201_9
- Kearney, C. A., & Silverman, W. K. (1999). Functionally based prescriptive and nonprescriptive treatment for children and adolescents with school refusal behavior. *Behavior Therapy*, 30(4), 673-695. [https://doi.org/10.1016/S0005-7894\(99\)80032-X](https://doi.org/10.1016/S0005-7894(99)80032-X)
- Keppens, G., & Spruyt, B. (2017). Towards a typology of occasional truancy: an operationalisation study of occasional truancy in secondary education in Flanders. *Research Papers in Education*, 32(1), 121-135. <https://doi.org/10.1080/02671522.2015.1136833>
- Keppens, G., & Spruyt, B. (2020). The impact of interventions to prevent truancy: A review of the research literature. *Studies in Educational Evaluation*, 65, 100840. <https://doi.org/10.1016/j.stueduc.2020.100840>
- King, N. J., Tonge, B. J., Heyne, D., Pritchard, M., Rollings, S., Young, D., ... & Ollendick, T. H. (1998). Cognitive-behavioral treatment of school-refusing children: A controlled evaluation. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(4), 395-403. <https://doi.org/10.1097/00004583-199804000-00017>
- Knollmann, M., Reissner, V., & Hebebrand, J. (2019). Towards a comprehensive assessment of school absenteeism: development and initial validation of the inventory of school attendance problems. *European child & adolescent psychiatry*, 28, 399-414. <https://doi.org/10.1007/s00787-018-1204-2>
- Koskelainen, M., Sourander, A., & Kaljonen, A. (2000). The Strengths and Difficulties Questionnaire among Finnish school-aged children and adolescents. *European child & adolescent psychiatry*, 9(4), 277-284. <https://doi.org/10.1007/s007870070031>
- Last, C. G. (1993). Therapist treatment manual for NIMH school phobia study: Exposure therapy program. *Unpublished manuscript*.
- Last, C. G., Hansen, C., & Franco, N. (1998). Cognitive-behavioral treatment of school phobia. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(4), 404-411. <https://doi.org/10.1097/00004583-199804000-00018>
- Lavooi, M. (2010). Evaluation of the Self-Efficacy Questionnaire for Responding to School Attendance Problems. Master's thesis., Leiden: Leiden University.

- Lomholt, J. J., Johnsen, D. B., Silverman, W. K., Heyne, D., Jeppesen, P., & Thastum, M. (2020). Feasibility study of Back2School, a modular cognitive behavioral intervention for youth with school attendance problems. *Frontiers in psychology, 11*, 586. <https://doi.org/10.3389/fpsyg.2020.00586>
- Lyneham, H. J., Abbott, M. J., Wignall, A., & Rapee, R. M. (2003) *The Cool Kids Anxiety Treatment Program*. Sydney: MUARU, Macquarie University.
- Lyon, A. R., & Cotler, S. (2007). Toward reduced bias and increased utility in the assessment of school refusal behavior: The case for diverse samples and evaluations of context. *Psychology in the Schools, 44*(6), 551-565. <https://doi.org/10.1002/pits.20247>
- Määttä, S., Pelkonen, J., Lehtisare, S., & Määttä, M. (2020). Kouluu käymättömyys Suomessa, Vaativan erityisen tuen VIP-verkoston tilannekartoitus. *Opetushallitus. Raportit ja selvitykset, 9*.
- Malcolm, H., Wilson, V., Davidson, J., & Kirk, S. (2003). Absence from school: A study of its causes and effects in seven LEAs. *The SCRE Centre University of Glasgow: Glasgow*.
- Maric, M., Heyne, D. A., MacKinnon, D. P., Van Widenfelt, B. M., & Westenberg, P. M. (2013). Cognitive mediation of cognitive-behavioural therapy outcomes for anxiety-based school refusal. *Behavioural and cognitive psychotherapy, 41*(5), 549-564. <https://doi.org/10.1017/S1352465812000756>
- Maynard, B. R., Heyne, D., Brendel, K. E., Bulanda, J. J., Thompson, A. M., & Pigott, T. D. (2018). Treatment for school refusal among children and adolescents: a systematic review and meta-analysis. *Research on Social Work Practice, 28*(1), 56-67. <https://doi.org/10.1177/1049731515598619>
- McCauley, E., Gudmundsen, G., Schloredt, K., Martell, C., Rhew, I., Hubley, S., & Dimidjian, S. (2016). The adolescent behavioral activation program: Adapting behavioral activation as a treatment for depression in adolescence. *Journal of Clinical Child & Adolescent Psychology, 45*(3), 291-304. <https://doi.org/10.1080/15374416.2014.979933>
- Melvin, G. A., & Gordon, M. S. (2019). Antidepressant medication: Is it a viable and valuable adjunct to cognitive-behavioral therapy for school refusal?. *Cognitive and Behavioral Practice, 26*(1), 107-118. <https://doi.org/10.1016/j.cbpra.2018.07.005>

- Melvin, G. A., Heyne, D., Gray, K. M., Hastings, R. P., Totsika, V., Tonge, B. J., & Freeman, M. M. (2019, June). The Kids and Teens at School (KiTeS) framework: An inclusive bioecological systems approach to understanding school absenteeism and school attendance problems. In *Frontiers in Education* (Vol. 4, p. 61). Frontiers Media SA.
<https://doi.org/10.3389/educ.2019.00061>
- Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., ... & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(10), 980-989.
<https://doi.org/10.1016/j.jaac.2010.05.017>
- Miller, I. W., Epstein, N. B., Bishop, D. S., & Keitner, G. I. (1985). The McMaster family assessment device: reliability and validity. *Journal of marital and family therapy*, 11(4), 345-356. <https://doi.org/10.1111/j.1752-0606.1985.tb00028.x>
- O'Neill, J. (2000). SMART goals, SMART schools. *Educational Leadership*, 57(5), 46-50.
- Reid, K. (1985). *Truancy and school absenteeism*. Hodder and Stoughton.
- Reissner, V., Jost, D., Krahn, U., Knollmann, M., Weschenfelder, A. K., Neumann, A., ... & Hebebrand, J. (2015). The treatment of school avoidance in children and adolescents with psychiatric illness: A randomized controlled trial. *Deutsches Ärzteblatt International*, 112(39), 655. <https://doi.org/10.3238%2Farztebl.2015.0655>
- Reissner, V., Knollmann, M., Spie, S., Jost, D., Neumann, A., & Hebebrand, J. (2019). Modular treatment for children and adolescents with problematic school absenteeism: Development and description of a program in Germany. *Cognitive and Behavioral Practice*, 26(1), 63-74.
<https://doi.org/10.1016/j.cbpra.2018.07.001>
- Sahel, R. A. (1989). *Group counselling/therapy as a technique to modify the undesirable school behaviour (school phobia) of children at elementary school level in the state of Kuwait*. Bangor University (United Kingdom).
- Schoeneberger, J. A. (2012). Longitudinal attendance patterns: Developing high school dropouts. *The clearing house: a journal of educational strategies, issues and ideas*, 85(1), 7-14. <https://doi.org/10.1080/00098655.2011.603766>

- Sheldon, K., K. (2015) Differences in Absenteeism Severity among Community Youth. *UNLV Theses, Dissertations, Professional Papers, and Capstones*. 2582.
<http://dx.doi.org/10.34917/8220163>
- Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 105-130. <https://doi.org/10.1080/15374410701817907>
- Strömbeck, J., Palmér, R., Sundberg Lax, I., Fäldt, J., Karlberg, M., & Bergström, M. (2021). Outcome of a multi-modal CBT-based treatment program for chronic school refusal. *Global Pediatric Health*, 8, 2333794X211002952. <https://doi.org/10.1177/2333794X211002952>
- Thambirajah, M. S., Grandison, K. J., & De-Hayes, L. (2008). *Understanding school refusal: A handbook for professionals in education, health and social care*. Jessica Kingsley Publishers.
- Thastum, M., Johnsen, D. B., Silverman, W. K., Jeppesen, P., Heyne, D. A., & Lomholt, J. J. (2019). The Back2School modular cognitive behavioral intervention for youths with problematic school absenteeism: study protocol for a randomized controlled trial. *Trials*, 20, 1-12. <https://doi.org/10.1186/s13063-018-3124-3>
- Thastum, M., & Kjerholt, C. M. (2020a). *Back2school: manual til behandling af børn med bekymrende skolefravær*. Psykologisk Institut, Aarhus Universitet
- Thastum, M., Arendt, K. B., & Kjerholt, C. M. (2020b). *Back2school: Interventio-opas lasten koulupoissaoloihin*. Psykologian laitos. Aarhusin yliopisto.
- Tolin, D. F., Whiting, S., Maltby, N., Diefenbach, G. J., Lothstein, M. A., Catalano, A., & Gray, K. (2009). Intensive (daily) behavior therapy for school refusal: A multiple baseline case series. *Cognitive and Behavioral Practice*, 16(3), 332-344.
<https://doi.org/10.1016/j.cbpra.2009.02.003>
- Vaughn, M. G., Maynard, B. R., Salas-Wright, C. P., Perron, B. E., & Abdon, A. (2013). Prevalence and correlates of truancy in the US: Results from a national sample. *Journal of adolescence*, 36(4), 767-776. <https://doi.org/10.1016/j.adolescence.2013.03.015>
- Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K., ... & Research Network on Youth Mental Health. (2012). Testing standard and modular designs

for psychotherapy treating depression, anxiety, and conduct problems in youth: A randomized effectiveness trial. *Archives of general psychiatry*, 69(3), 274-282.

Wu, X., Liu, F., Cai, H., Huang, L., Li, Y., Mo, Z., & Lin, J. (2013). Cognitive behaviour therapy combined fluoxetine treatment superior to cognitive behaviour therapy alone for school refusal. *International Journal of Pharmacology*, 9(3), 197-203.

Pressmeddelande

Genomförbarhet av Back2School-interventionen i en finsk kontext: En transdiagnostisk kognitiv beteendeterapeutisk intervention för skolfrånvaroproblem

Pro-gradu avhandling i psykologi

Fakulteten för humaniora, psykologi och teologi, Åbo Akademi

En pro-gradu avhandling i psykologi vid Åbo Akademi har undersökt genomförbarheten av den transdiagnostiska kognitiva beteendeterapeutiska interventionen Back2School för skolfrånvaroproblem i en finsk kontext. Studien undersökte genomförbarhet genom att granska följande parametrar: 1) samplets egenskaper, 2) datainsamlingsprocedurer, 3) behandlingstillfredsställelse, 4) acceptans och studieprocedur samt 5) behandlingsrespons. På basis av resultaten bedömdes Back2School-interventionen vara genomförbar för en framtida randomiserad kontrollerad studie i ett finskt sammanhang. Slutsatsen stöds av följande resultat: 1) hög behandlingstillfredsställelse, 2) hög acceptans bland klinikerna, 3) generellt positiv kvalitativ feedback, 4) reducering av skolfrånvaro från baslinjen till efter interventionen och 5) genomförbara datainsamlingsförföranden. Resultaten i studien indikerar att studiedesignen i framtida effektivitetsstudier av Back2School-interventioner bör beakta följande aspekter: 1) strängare inklusionskriterier för att säkerställa ett mer representativt kliniskt urval, 2) förverkling av datainsamlingen med hjälp av elektroniska formulär för att minska arbetsbördan för deltagarna, 3) minskning av antalet mätinstrument och 4) en ytterlig uppföljningsmätning tolv månader efter att interventionen avslutats.

Resultaten i denna studie begränsas av den uteblivna kontrollgruppen och den lilla sampelstorleken, på grund av dessa begränsningar bör kausala slutsatser inte göras på basis av studiens resultat. Samplets bristande representativitet på vissa kliniska variabler sänker också validiteten av studiens statistiska modeller.

Avhandlingen utfördes av Jakob Langenskiöld under handledning av Katarina Alanko, PsD.

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