

Integrating Behavioural Activation and Cognitive Restructuring in the Treatment of Adolescent Depression and School Refusal: A Case Report

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Abstract

Background: Adolescent depression can present through interacting affective, cognitive, behavioural, interpersonal, and somatic difficulties. When accompanied by school refusal, the resulting impairment may extend beyond academic participation to peer relationships, family functioning, and developmental adjustment.

Case/Clinical Context: Client A, an 11th-standard student, presented with persistent low mood, school refusal, reduced motivation, emotional dysregulation, anxiety, irritability, and concentration difficulties.

Intervention: Treatment integrated Behavioural Activation (functional analysis, self-monitoring, activity scheduling, and a graded return-to-school protocol) with cognitive restructuring of automatic thoughts and cognitive distortions concerning school attendance and perceived coping capacity.

Outcome: Progress was tracked through behavioural and functional indicators (school attendance, morning routine, activity engagement) alongside self-reported mood and coping. The Beck Depression Inventory-II (BDI-II) was administered at Session 1 (score = 24, moderate depression) and at Session 7 (score = 14, mild depression), indicating a 10-point reduction and a shift from the moderate to the mild depression range.

Clinical Significance: The case illustrates a functional-analytic conceptualization of school refusal as a negatively reinforced avoidance behaviour and demonstrates the combined application of Behavioural Activation and cognitive therapy within a developmentally adapted framework for an adolescent client.

Keywords: adolescent depression; school refusal; behavioural activation; cognitive behavioural therapy; cognitive distortions; behavioural avoidance; case report

1. Introduction

1.1 Clinical Background

Depression during adolescence can manifest through persistent sadness, reduced motivation, irritability, impaired concentration, fatigue, emotional sensitivity, withdrawal, and impaired academic functioning. When depressive symptoms co-occur with school refusal, functional impairment may extend across academic, peer, family, and developmental domains.

1.2 Relevant Psychological/Clinical Phenomenon

School refusal, in the present case, was conceptualized as a behavioural pattern with an identifiable antecedent-behaviour-consequence structure rather than solely as a symptom of low mood. This distinction guided the selection of a functional-analytic and Behavioural Activation approach alongside standard cognitive intervention.

1.3 Evidence-Based Intervention Rationale

Cognitive Behavioural Therapy (CBT) provides a framework for understanding the reciprocal relationship among situations, automatic thoughts, emotions, physiological responses, and behaviours, and emphasizes identifying and modifying negative automatic thoughts and maladaptive beliefs associated with depression (Martell et al., 2001). Behavioural Activation (BA) is a behavioural framework derived from functional models of depression that emphasizes withdrawal, avoidance, disruption of activity patterns, and reduced access to positive reinforcement as factors maintaining depressive presentations (Ferster, 1973; Lewinsohn, 1974). BA seeks to interrupt this cycle through increased goal-directed activity, reduced avoidance, restored routines, and increased engagement with reinforcing experiences (Addis & Martell, 2004; Jacobson et al., 2001; Martell et al., 2001).

Randomized controlled research has evaluated BA relative to cognitive therapy and antidepressant medication (Dimidjian et al., 2006), while subsequent trials and meta-analytic work have examined BA delivery by non-specialist practitioners and synthesized findings across studies (Ekers et al., 2008, 2011).

1.4 Relevant Theoretical Framework

The case was conceptualized using an integrated CBT/BA framework in which school-related demands, emotional distress, physical discomfort, and reminders of previous distressing experiences were formulated as antecedents to avoidance. Avoidance was hypothesized to produce immediate reduction in distress, thereby negatively reinforcing school refusal, consistent with functional/behavioural models of depression (Ferster, 1973; Lewinsohn, 1974).

1.5 Rationale for the Present Case

This case is of interest because (a) school refusal was identified as the primary behavioural target rather than a peripheral symptom of depression, and (b) the bulk of empirical Behavioural Activation literature is derived from adult samples, raising questions about direct applicability to an adolescent population.

1.6 Significance of the Case Report

This report aims to describe the functional-analytic formulation, integrated BA/CT intervention, and clinical course of an adolescent presenting with depression and school refusal, and to discuss the adaptation of predominantly adult-derived BA principles to an adolescent clinical context.

2. Case Presentation / Method

2.1 Client Characteristics and Presenting Concerns

Client A was an 11th-standard student referred with school refusal, persistent low mood, reduced motivation, emotional dysregulation, and difficulty tolerating sadness. These difficulties interfered with daily functioning, academic engagement, and regular school attendance. The client also presented with anxiety, irritability, concentration difficulties (described by the client as “brain fog”), fatigue, emotional sensitivity, and difficulty coping with distressing emotional experiences. Physical symptoms reported during the referral period included headache, dizziness or lightheadedness, mild abdominal discomfort or cramps, occasional breast tenderness, joint or muscle aches, bloating, and reduced energy.

2.2 Relevant Developmental History

The client reportedly attained puberty at approximately 11 years of age, with otherwise normal pubertal development. In the middle of 10th standard, the client experienced several distressing and painful life events, following which depressive symptoms emerged.

2.3 Family, Educational, and Psychosocial History

Client A lived with her parents and a younger sibling. Family relationships were reported as good overall, with the client described as having a secure relationship with the mother, who was identified as the primary source of support during treatment. The father was described as supportive; however, he was reported to be away from home for work during the treatment period, which the client described as a source of distress. No family history of psychiatric illness was reported.

The client's mother served as the primary family informant throughout treatment and was actively supportive of the intervention. Parents were requested to remain available for treatment-related discussions, and the mother indicated that she and the father would participate in a joint session when the father returned to the home area from work. The available treatment records do not confirm that a joint parental session subsequently occurred. The mother's supportive involvement was nevertheless considered an important contextual factor during treatment.

The client's educational context is limited to grade level (11th standard) and the occurrence of school refusal; no further educational history (e.g., prior academic performance, school transitions) was documented in the source material.

2.4 Precipitating and Maintaining Factors

Precipitating factors included distressing life events occurring in mid-10th standard, following which depressive symptoms emerged. The father's ongoing work-related absence from the home was also noted as a source of distress, with the client reporting that she missed him. Maintaining factors were formulated as negative reinforcement of avoidance (immediate reduction of distress following school refusal) and reduced activity and reduced access to positive reinforcement. The full Five-P formulation is summarized in Table 1.

2.5 Relevant Psychiatric History

The client had previously been assessed by a psychiatrist and was diagnosed with depression. Vitamin D supplementation was reported during the treatment period. The treating clinician requested the client's psychiatric treatment history and medication records; however, these records were not available for review at the time of preparation of this case report. Whether the client was taking prescribed antidepressant medication during the eight-session CBT intervention could not be independently verified from the available treatment record; no medication change was reported to the clinician during this period. Details regarding psychiatric follow-up and adherence to prescribed treatment could not be independently verified. No family history of psychiatric illness was reported.

2.6 Psychological Assessment and Measures

The Beck Depression Inventory-II (BDI-II) was administered as a standardized self-report measure of depressive symptom severity, scored at Session 1 (score = 24, moderate depression range) and again at Session 7 (score = 14, mild depression range).

The Beck Depression Inventory-II (BDI-II) was the only standardized assessment instrument administered; no other standardized tools (e.g., anxiety inventories, school-refusal-specific measures) were used. Assessment was otherwise based on clinical interview, self-monitoring records (mood, anxiety, physical symptoms, school attendance, and activity), and functional analysis.

Assessment Administration

The BDI-II was administered in person by the clinician at Session 1, following initial exploration of the presenting concerns. The client had received a psychiatric diagnosis prior to this assessment. Standardized administration and scoring procedures were followed. The BDI-II was re-administered at Session 7 under comparable conditions, using the same setting, instructions, administration procedures, and scoring method. This consistency supported comparison of depressive symptom severity between the initial and post-intervention assessments.

Normative Severity Cut-Offs Applied by the Clinician

- 0–13: Minimal depression
- 14–19: Mild depression
- 20–28: Moderate depression
- 29–63: Severe depression

2.7 Clinical Formulation

The formulation used an integrated Cognitive Behavioural Therapy and Behavioural Activation framework, combining cognitive restructuring with Behavioural Activation, in which school-related demands and emotional/physical discomfort were hypothesized to activate automatic thoughts (e.g., “I cannot handle this,” “I won’t be able to manage school,” “I should be able to control myself,” “Things will not get better”), generating anxiety, sadness, and emotional overwhelm, which increased the urge to avoid school. School refusal was hypothesized to produce immediate reduction in distress, negatively reinforcing the avoidance pattern and, over time, reducing academic engagement, confidence, and reinforcement availability. These cognitions were treated throughout as clinical hypotheses rather than confirmed verbatim cognitions, explored collaboratively during intervention rather than presented to the client as established facts. The functional analysis underlying this formulation is summarized in Table 3.

2.8 Diagnostic Considerations

The client had previously been assessed by a psychiatrist and diagnosed with depression, prior to the BDI-II assessment described in Section 2.6. The primary presenting concern identified by the client and her parents was persistent difficulty attending school (school refusal). The present case report describes the subsequent CBT intervention targeting depressive symptoms and school-refusal behaviour; the treating clinician did not independently establish a new psychiatric diagnosis.

2.9 Treatment Goals

- Reduce avoidance and increase graded school attendance
- Restore consistent daily/morning routine
- Increase engagement in goal-directed and reinforcing activities
- Identify and evaluate negative automatic thoughts and cognitive distortions related to school attendance and perceived coping capacity
- Support emotional regulation and tolerance of distressing affect
- Establish relapse-prevention strategies prior to termination

3. Intervention**3.1 Treatment Approach and Theoretical Rationale**

Treatment combined Behavioural Activation, targeting avoidance and reduced activity, with cognitive restructuring, targeting maladaptive predictions and appraisals concerning school attendance and coping

capacity. Behavioural Activation was selected as the principal intervention given that school refusal — rather than mood alone — was identified as the primary target behaviour.

3.2 Treatment Setting and Duration

The intervention was delivered on an outpatient basis at Loyola Counseling and Psychological Services (Loyola CAPS), Thiruvananthapuram. The client received eight individual therapy sessions, conducted once weekly, with each session lasting approximately 45–60 minutes. The overall treatment period extended over approximately three months.

3.3 Intervention Techniques

- Functional analysis of school refusal
- Self-monitoring (mood, anxiety, physical symptoms, automatic thoughts, attendance, activity, mastery)
- Activity scheduling with small, specific, achievable, measurable actions
- Graded return-to-school protocol (five stages)
- Cognitive restructuring of automatic thoughts and identification of cognitive distortions
- Behavioural experiments comparing predicted versus observed outcomes
- Relapse-prevention planning at termination

3.4 Cognitive Restructuring Components

Cognitive components addressed predictions of failure, rigid emotional-control expectations, hopeless interpretations, and perceived inability to cope, using identification of automatic thoughts, examination of cognitive distortions, and collaborative reframing.

3.5 Behavioural Activation Components

Behavioural Activation components focused primarily on school refusal and secondarily on disrupted routines, reduced academic engagement, inactivity, and withdrawal, applying functional analysis, self-monitoring, and graded activity scheduling.

3.6 Psychoeducation

The client was supported to understand the relationship between mood and behaviour, framed clinically as: “When I feel bad, I naturally want to withdraw. But withdrawing may make me feel better only for a short time.” This was used to build a shared understanding of avoidance, reinforcement, and the short-versus long-term effects of school refusal.

3.7 Cognitive Interventions

Illustrative reframes explored collaboratively (documented as clinical hypotheses, not verbatim transcript) included:

- “If I cannot manage school properly, I cannot do anything properly” → “Having difficulty with school right now does not mean that I am incapable. I can work on one difficulty at a time.”
- “I won't be able to feel better or return to school normally” → “I cannot predict exactly how things will go. I can take one step at a time.”
- “I should be able to control my sadness” → “I can learn to tolerate and regulate difficult emotions gradually.”
- “There is something wrong with me because I cannot handle my emotions” → “Having emotional difficulties does not mean that something is fundamentally wrong with me.”

Cognitive distortions identified for collaborative exploration included all-or-nothing thinking, overgeneralization, fortune telling, should statements, and personalization/self-blame.

3.8 Behavioural Interventions

The graded return-to-school protocol proceeded across five stages, summarized in Table 2. The protocol emphasized graded engagement rather than forced exposure, and reinforcement of attendance rather than academic perfection. The return-to-school intervention was implemented collaboratively with the client and her mother; no direct intervention or formal treatment coordination with school personnel was documented.

3.9 Homework / Practice Assignments

Self-monitoring (mood, anxiety, physical symptoms, automatic thoughts, attendance, activity, and mastery ratings) functioned as an ongoing between-session monitoring task. In addition, the client was encouraged to complete a brief CBT thought record between sessions, particularly when experiencing distress related to school attendance, academic demands, sadness, anxiety, or emotional overwhelm. The purpose was to increase awareness of the relationship among situations, automatic thoughts, emotions, physiological responses, and behavioural urges, and to support more balanced interpretations.

3.10 Eight-Session CBT Intervention Structure

The eight-session course (Section 3.2) followed a structured CBT format at each session, comprising an initial phase, a middle phase, and an end phase. Behavioural Activation and cognitive restructuring were integrated throughout, with school refusal maintained as the primary behavioural target. Each session concluded with a collaboratively developed Action Plan functioning as between-session homework (Section 3.9). Table 5 summarizes the phase-by-phase content of each session.

The overall procedural sequence across the eight sessions progressed as follows: assessment and engagement (Session 1) → functional analysis and activity scheduling (Session 2) → cognitive identification (Session 3) → cognitive restructuring (Session 4) → graded school re-engagement (Session 5) → consolidation (Session 6) → outcome reassessment and relapse-prevention preparation (Session 7) → termination and relapse prevention (Session 8). This sequence is consistent with the treatment techniques described in Sections 3.3–3.9 and precedes the outcome data reported in Section 4.

4. Outcome

4.1 Depressive Symptoms

Depressive symptom severity, as measured by the BDI-II, decreased from 24 (moderate depression) at Session 1 to 14 (mild depression) at Session 7, a raw-score reduction of 10 points and a shift of one severity category (Table 4). As this reflects within-treatment change on a single measure rather than a formal pre-treatment/post-treatment comparison, it should not be interpreted as proof of treatment efficacy (see Section 4.5).

4.2 School Attendance

School attendance was monitored clinically as a primary behavioural indicator, given that school refusal was the principal target behaviour. Attendance figures were derived from client and parental report via the self-monitoring records described in Section 3.9, rather than from official school attendance records. At baseline, school attendance was inconsistent, with the client attending approximately 2–3 days during a typical six-day school week. An increase in school attendance was observed during the intervention period, to approximately five days per week following Session 4. This change was observed during the course of treatment; given the single-case design and the absence of a control condition, it cannot be attributed causally to the CBT intervention alone (see Section 5.2). No post-termination follow-up attendance data were available.

4.3 Functional/Behavioural Changes

Beyond school attendance (Section 4.2), outcome domains monitored clinically included school preparation, academic engagement, reduction in avoidance, morning routine, activity level, emotional regulation, and coping. Progress in these domains was described qualitatively by the treating clinician in relation to the original formulation and treatment targets, but was not quantified using standardized measures.

4.4 Treatment Adherence / Engagement

The client completed all eight scheduled weekly sessions over the approximately three-month treatment period.

4.5 Clinically Meaningful Change

The client's progress was reviewed by the treating clinician in relation to the original formulation and treatment targets. The Beck Depression Inventory -II reduction from 24 to 14 corresponds to a shift from moderate to mild depression on conventional severity banding, which is suggestive of clinically meaningful improvement in self-reported depressive symptoms between Session 1 and Session 7 of the eight-session course. This should be interpreted cautiously: it is based on a single outcome measure administered at two within-treatment time points rather than at a clearly defined pre-treatment/post-termination pair, and no formal reliable change index was calculated. Behavioural indicators, including the observed increase in school attendance (Section 4.2) and other functional changes (Section 4.3), were also considered relevant given that school refusal was the principal target behaviour, but remain qualitatively described rather than quantified, apart from the attendance figures reported in Section 4.2.

5. Discussion

5.1 Summary of the Case

This case describes the Behavioural Activation and cognitive restructuring formulation and treatment of an adolescent presenting with depression and school refusal.

5.2 Interpretation of Treatment Response

Clinical review indicated behavioural and functional improvement consistent with the treatment targets, supported by a reduction in BDI-II-measured depressive symptom severity from the moderate to the mild range between Session 1 and Session 7, alongside an observed increase in school attendance following Session 4 (Section 4.2). Because this reflects a single measure at two within-treatment time points, without a calculated reliable change index or a clearly defined post-treatment endpoint, the finding should be interpreted as suggestive of improvement rather than as definitive evidence of treatment effect. The observed improvement occurred during the period in which CBT/Behavioural Activation was delivered, but the single-case design does not allow the observed changes to be attributed causally to the intervention. Other concurrent factors may also have contributed, including possible ongoing psychiatric care, Vitamin D supplementation, family support, natural symptom variation, developmental and contextual changes, repeated therapeutic contact, and possible changes in school circumstances; in the absence of a control condition, these influences cannot be separated from the effects of the CBT/Behavioural Activation intervention.

5.3 Relationship to Existing Psychological Theory

The formulation is consistent with functional/behavioural models emphasizing withdrawal, avoidance, and reduced reinforcement in the maintenance of depression (Ferster, 1973; Lewinsohn, 1974), and with

cognitive models emphasizing the role of negative automatic thoughts and maladaptive predictions in emotional distress (Martell et al., 2001).

5.4 Comparison with Relevant Literature

The intervention drew on evidence supporting Behavioural Activation as an efficacious treatment for depression, including comparisons with cognitive therapy and antidepressant medication (Dimidjian et al., 2006) and meta-analytic and non-specialist-delivery trials (Ekers et al., 2008, 2011). However, this evidence base is drawn predominantly from adult samples, and direct extrapolation to adolescent school-refusal presentations should be made cautiously.

5.5 Possible Mechanisms of Therapeutic Change

Hypothesized mechanisms included: reduction of avoidance leading to restored contact with academic and social reinforcement; graded mastery experiences increasing perceived self-efficacy and willingness to engage; and cognitive restructuring reducing catastrophic predictions about coping capacity, thereby lowering anticipatory anxiety prior to school attendance.

5.6 Clinical Implications

The case illustrates the value of treating school refusal as a specific, functionally analyzed behavioural target rather than only as a downstream symptom of low mood, and of combining behavioural and cognitive strategies within a single, individualized formulation.

5.7 Strengths of the Case

- Explicit functional analysis of the target behaviour (school refusal)
- Individualized, graded, stage-based return-to-school protocol
- Treatment of automatic thoughts and cognitive distortions as testable hypotheses rather than fixed facts

5.8 Limitations

This case study represents a retrospective clinical formulation based on the information available in the treatment record and should not be interpreted as evidence of treatment efficacy at an individual or population level. First, the single-case design does not permit causal inference regarding treatment effects. Second, the client had previously been diagnosed with depression by a psychiatrist and was reported to be taking Vitamin D supplementation; complete psychiatric treatment and medication records were requested but were not available for review at the time of manuscript preparation, and it could not be independently verified whether antidepressant medication was being taken during the eight-session CBT intervention; no medication change was reported to the clinician during this period, and details regarding psychiatric follow-up and treatment adherence could not be independently verified. Third, school attendance was monitored clinically but was not recorded using a standardized school-refusal measure or official school attendance records, relying instead on client and parental report. Fourth, depressive symptoms were assessed using the BDI-II at Session 1 and Session 7 rather than at a formal pre-treatment and post-treatment endpoint, and no formal reliable change index was calculated. Fifth, no long-term follow-up data were available. Sixth, family support, particularly the mother's involvement, may have contributed to the observed changes and cannot be separated from the effects of the CBT intervention. The case also does not establish a definitive psychiatric diagnosis based solely on the formulation, confirmed cognitive distortions, or a single functional explanation for every episode of school refusal. Much of the cited Behavioural Activation literature is based on adult populations with depression (Dimidjian et al., 2006; Ekers et al., 2008, 2011), and Behavioural Activation principles were therefore clinically adapted rather than applied as a directly generalized adolescent protocol.

5.9 Implications for Clinical Practice

Clinicians working with adolescent school refusal may benefit from combining functional-analytic/Behavioural Activation strategies with cognitive restructuring, tailored to the developmental and contextual needs of the individual adolescent client.

5.10 Recommendations for Future Research

- Use of standardized, validated outcome measures (depression, anxiety, school-refusal-specific instruments) at pre-, mid-, and post-treatment
- Adolescent-specific trials of Behavioural Activation for school refusal
- Longer-term follow-up to evaluate maintenance of gains and relapse rates

6. Conclusion

This case report describes an integrated Behavioural Activation and cognitive-behavioural formulation and intervention for an adolescent presenting with depression and school refusal. School refusal was conceptualized as a potentially negatively reinforced avoidance behaviour amenable to functional analysis, graded behavioural engagement, and cognitive restructuring. Given the retrospective, single-case, and non-standardized-measure nature of the available data, findings should be regarded as illustrative of a clinical formulation and treatment approach rather than as evidence of generalizable treatment efficacy.

7. Clinical Significance Statement

Clinicians, counsellors, school psychologists, and educators may draw from this case the value of: (a) treating school refusal as a specific, functionally analyzed target behaviour rather than a non-specific symptom of adolescent depression; (b) combining Behavioural Activation and cognitive restructuring within a single formulation; and (c) adapting predominantly adult-derived BA evidence to the developmental and contextual needs of adolescent clients.

8. Ethical Considerations and Consent

Treatment consent for the clinical intervention described in this case was obtained from the client's parent/legal guardian at the outset of therapy. Treatment consent and consent for publication of this case report are distinct, and the former does not substitute for the latter. Written informed consent for publication of the case report had not been obtained at the time of manuscript preparation and should be obtained from the appropriate parent/legal guardian, together with adolescent assent, prior to submission or publication, in accordance with the requirements of the target journal. The client is identified throughout as "Client A" to protect confidentiality, and identifying details not directly relevant to the clinical formulation (e.g., specific family employment, occupation, and socioeconomic details) have been minimized or omitted.

9. Declaration of Generative AI Use

Generative artificial intelligence (Claude, Anthropic) was used during the preparation of this manuscript to assist with structural organization, language editing, consistency checking (e.g., diagnostic hedging and causal-inference phrasing across sections), and formatting, under the direct supervision and iterative review of the author. The AI tool was not used to generate, alter, or infer clinical data, and did not have independent access to identifiable client information beyond what is presented in this manuscript; all

clinical content, interpretations, and judgments reported in this case remain those of the author and treating clinician. The author reviewed, verified, and takes full responsibility for the accuracy and integrity of the final manuscript, including all AI-assisted revisions.

Tables

Table 1. Five-P Clinical Formulation

Category	Formulation Content
Presenting factors	School refusal, low mood, reduced motivation, emotional dysregulation, anxiety, irritability, concentration difficulties (“brain fog”), fatigue, cyclical physical symptoms.
Predisposing factors	Adolescent developmental stage. No family history of psychiatric illness reported.
Precipitating factors	Distressing life events occurring in mid-10th standard, following which depressive symptoms emerged.
Perpetuating / maintaining factors	Negative reinforcement of school avoidance (immediate distress reduction); reduced activity and reinforcement; reduced academic confidence; anticipatory anxiety about returning to school; father's ongoing work-related absence from home, which the client reported missing.
Protective factors	Good overall family relationships; secure relationship with mother, who was the primary source of support; supportive father; client engagement in therapy; prior psychiatric assessment. No family history of psychiatric illness.

Table 2. Graded Return-to-School Protocol

Stage	Content
1. Preparation	Consistent wake-up time; morning hygiene and breakfast; preparing school materials in advance; wearing school uniform; identifying anticipated barriers.
2. School-related contact	Preparing school bag; travelling toward the school environment; brief contact with the school environment where appropriate; maintaining contact with a supportive adult.
3. Partial attendance	Attending for a manageable period; beginning with selected/lower-demand periods where appropriate; reinforcing attendance rather than academic perfection.
4. Increased attendance	Gradually increasing time at school; increasing academic participation; reintroducing peer and extracurricular engagement.

5.	Full participation	Resuming regular school schedule; monitoring early signs of avoidance; developing strategies for future periods of increased stress.
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Table 3. Functional Analysis of School Refusal

Component	Formulation
Antecedents	School mornings, academic demands, anticipated difficulties, emotional distress, physical discomfort, poor sleep, reminders of previous distressing experiences.
Internal experiences	Sadness, anxiety, fatigue, irritability, emotional overwhelm.
Possible automatic thoughts	“I cannot manage this”; “I won’t be able to cope”; “I cannot face school today.”
Target behaviour	Refusal to attend school, delaying preparation, remaining at home, withdrawal from school-related activities.
Immediate consequence	Reduction in anxiety, emotional pressure, and perceived demands.
Long-term consequence	Reduced academic participation, disrupted routine, reduced positive reinforcement, increased avoidance, reduced confidence, greater difficulty returning to school.
Possible maintaining function	Negative reinforcement through immediate reduction of distress.

Table 4. Beck Depression Inventory-II (BDI-II) Scores

Time Point	BDI-II Score	Severity Category
Session 1	24	Moderate depression
Session 7	14	Mild depression
Change	–10 points	Moderate → Mild

Note. Severity categories follow the normative BDI-II cut-offs applied by the clinician: 0–13 minimal, 14–19 mild, 20–28 moderate, 29–63 severe. The BDI-II was the only standardized instrument administered, at Session 1 and Session 7 of an eight-session course of treatment (see Section 3.2).

Table 5. Eight-Session Intervention Structure

Session	Initial Phase	Middle Phase	End Phase
1	BDI-II administered (score = 24, moderate)	Psychoeducation on depression and the	Collaborative initial Action Plan targeting manageable

	range); agenda setting; review of presenting difficulties.	maintaining role of avoidance [School Refusal]; exploration of aspirations, values, and goals; identification of the avoidance cycle and introduction of Behavioural Activation.	daily activities and routine restoration (homework); completion-likelihood check and barrier problem-solving; feedback elicited.
2	Mood/functioning review; non-judgmental review of Action Plan completion.	Review of self-monitoring records; functional analysis of school refusal; introduction of activity scheduling (Behavioural Activation).	Graded activity plan established as the Action Plan (homework); confidence and barriers assessed; summary and feedback.
3	Mood/functioning review; review of Action Plan and activity schedule; identification of successes and barriers.	Introduction of the CBT cognitive model; identification of automatic thoughts associated with school attendance (cognitive restructuring); identification of cognitive distortions (all-or-nothing thinking, fortune telling, overgeneralization, should statements, personalization).	Thought-monitoring Action Plan (homework); completion-likelihood check; summary and feedback.
4	Mood/functioning review; review of prior Action Plan and thought records; identification of changes in school-related behaviour.	Selection of a representative automatic thought; examination of evidence for and against; development of a balanced alternative thought (cognitive restructuring); introduction of a behavioural experiment testing prediction against actual outcome.	Action Plan developed (homework); likelihood-of-completion check; summary of learning and feedback.
5	Mood, activity, and school-functioning review; review of Action Plan; examination of progress and remaining avoidance.	Review of the avoidance cycle; strengthening of graded school engagement (school refusal intervention, Behavioural Activation); development of the five-stage graded return-to-school hierarchy (preparation →	Action Plan established (homework); likelihood-of-completion check; progress summary and feedback.

		school-related contact → partial attendance → increased attendance → full participation); identification of barriers and coping responses.	
6	Review of mood, school attendance, routine, and activity engagement; review of Action Plan; identification of improvements and continuing difficulties.	Review of Behavioural Activation; review of recurrent automatic thoughts; consolidation of cognitive restructuring, reinforcement of mastery experiences over perfectionistic standards.	Consolidation Action Plan, summary and feedback.
7	Current-functioning review; review of Action Plan; BDI-II re-administered (score = 14, mild range; 10-point reduction from Session 1).	Review of treatment gains across mood, activity, school engagement, avoidance, and coping; identification of remaining triggers and early warning signs; development of a relapse-prevention framework (warning signs, triggers, behavioural and cognitive responses, supports); rehearsal of coping strategies.	Action Plan for maintaining gains (homework); summary and feedback on progress and remaining concerns.
8	Current-functioning review; review of final Action Plan; collaborative review of the treatment journey.	Review of the CBT formulation (situation → thought → emotion → behaviour → consequence); review of Behavioural Activation skills; review of cognitive restructuring skills; completion of personalized relapse-prevention plan (warning signs, school-avoidance indicators, helpful activities, cognitive strategies, support persons, response steps).	Maintenance Action Plan (homework); final summary of treatment process, skills acquired, and progress; feedback on therapy experience and confidence in maintaining gains.

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