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The Inpatient Treatment Process for Severe School Refusal

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ÖZET:

Şiddetli okul reddinin yatakli serviste tedavi süreci

Okul reddinde çocuk, aile ve okul temelli pekiştireçler olduğu için bu durumun başarılı tedavisinin birçok alanı hedef alması gereklidir. Bu nedenle psikofarmakoloji, psikoeğitim, somatik teknikler, bilişsel davranışçı yeniden yapılandırma, sosyal ve iletişimi becerileri eğitimi ve ailelerle çalışmayı içeren çok boyutlu bir tedaviye ihtiyaç duyulmaktadır. Tedavinin ana parçalarından birisi okula maruziyetin sağlanması ve ödül ve cezaların belirlenmesidir. Ancak, bu hedeflere her olguda ayaktan tedaviyle ulaşılamamaktadır. Bu yazıda, rutin tedaviye yanıt vermeyen iki şiddetli okul reddi olgusu sunulmuştur. Çoklu tedavi üç aşamalı bir bilişsel davranışçı müdahale, aile terapisi, sosyal beceri eğitimi, gevşeme eğitimi, ödül ve cezaların belirlenmesi ve farmakoterapiyi içermektedir.

Anahtar sözcükler: okul reddi, yatarak tedavi, çocuk, ergen, çoklu tedavi

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ABSTRACT:

The inpatient treatment process for severe school refusal

Successful treatment of school refusal must target several areas, since there are child, parent and family based reinforcers. This requires an integrated treatment including psychopharmacology, psychoeducation, somatic management techniques, cognitive-behavioral restructuring, social and communication skills training and working with parents. A vital part of treatment is establishing rewards and punishments, contingency management and exposure to school. However, these goals cannot be achieved in every case with outpatient treatment. Here, we have presented two cases, who were hospitalized due to severe symptoms which were not responsive to routine treatment. Multimodal treatment involving a three-stage cognitive behavioral intervention, family therapy, social skills training, relaxation training, contingency management and pharmacotherapy was used.

Keywords: school refusal, inpatient treatment, children, adolescents, multimodal treatment

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INTRODUCTION

School refusal is a common complaint in children and adolescents (2-5%), which can be associated with various psychiatric disorders[1]. It may increase risk of school expulsion, delinquency, and having economical, social and marital problems[2]. School refusal may be due to psychiatric disorders, including anxiety disorders, depression, and oppositional defiant and conduct disorders[3]. Adolescents with anxiety-based school refusal also experience somatic complaints and peer-relation problems more commonly. Kearney described school refusal as a heterogeneous construct, which includes extended absences from school and intense dread about future attendance at school[2]. There are different forms of reinforcements for school refusal including avoidance of school-related stimuli which leads to anxiety or negative affect, escape from aversive social situations, increased attention from significant others and search for other reinforcers outside school (Kearney, 2008).

There are also contextual risk factors like poverty, teenage pregnancy, school violence, school connectedness, parental involvement and family functioning[2]. Treatment involves psychopharmacological and psychotherapeutic interventions. Most of the school refusal literature has focused on outpatient treatment[4]. However, some patients with more severe symptoms and comorbidity are not responsive to outpatient treatment[5]. Due to several psychosomatic complaints, a range of consultations might be necessary, which can be done more easily in an inpatient setting. In addition, symptoms can change considerably during the course of the disorder.

In this article, we will discuss the multimodal inpatient treatment of two cases with treatment resistant school refusal.

CASE 1

A fifteen year old male patient was referred to our clinic because he had lost one year of school due to absenteeism. The problems began 2 years ago. He was a moderately successful student. He was diagnosed with social phobia and attention deficit hyperactivity disorder and had been treated with methylphenidate 54 mg/day, fluoxetine 40 mg/day, alprazolam 2 mg/d and risperidone 1 mg/d for 4 months without success. Behavioral cognitive interventions were tried but the patient was not compliant. Family therapy sessions increased the cooperation of the family but did not lead to remission.

Inpatient treatment targeted all possible areas of reinforcement using several interventions in combination. In order to decrease anxiety symptoms, which led to aversion to school, pharmacotherapy (fluoxetine 40 mg/d, risperidone 1 mg/day, alprazolam 1 mg/d), psychoeducation, relaxation training, and social skills training in a group setting were initiated.

The core of the treatment was gradual attendance at school, beginning with one hour per day and increasing by one hour every day. Obviously, exposure to school targeted all areas of reinforcement; however, it could not be done by the family in an outpatient setting. One of the critical differences of exposure in the inpatient setting was the social worker, who accompanied the patient at school with his consent. This also gave us the opportunity to observe the patient's reactions first-hand. By closely cooperating with the family, discharge from the hospital was a very important incentive to attend school. The patient was very resistant to going to school and kept telling that he would leave school anyway. In the first week of treatment the patient did not talk to anyone in the class, and reported "choking feelings, palpitations, shaking, and stomach-aches". He had conversion reactions in the hospital. He tried every way to convince his parents that treatment was ineffective and he felt worse. However, his parents and treatment team stressed that he would not be discharged until the treatment goals were reached, resulting in a gradual behavioral change in the patient.

As the second stage of treatment, after the patient was able to attend school every day, the lessons where the social worker was absent were increased by one session each day. At the fourth week of the treatment, the patient was in the third stage, in which he went to school by himself but returned to the hospital every night. There was strong communication with the school during each stage and the patient was checked every hour to make certain that he was in the classroom. The patient kept a record book at each stage, about his anticipated and realized anxiety levels, when leaving hospital, going to school, in the school, leaving school and on his way back. These were used for cognitive restructuring and being in the school provided real life situations to practice the skills gained. He was discharged at week 5. He was symptom free 8 months later.

CASE 2

An eight year old female patient left school during the third grade because she was "afraid of the teachers, headmaster and other children". She also mentioned "red ghosts", which told her not to go to school. Symptoms did not change when her

changed the school or when she was on fluoxetine 20 mg/d for three months. During outpatient treatment, the parents were unable to take the child to school because she protested severely; therefore, behavioral treatment could not be applied. She was hospitalized with a diagnosis of separation anxiety disorder and the 3 stage treatment described above (adapted to her cognitive level), including a combination fluoxetine 20 mg/d, family therapy, relaxation training and social skills training, was applied. She also kept a record of her experiences like Case 1. Within the first week, she had severe somatic symptoms and was agitated from time to time. Like Case 1, a very close cooperation with the family and the social worker's presence were essential. After three weeks of treatment, her "hallucinations" and somatic symptoms decreased. She was symptom free 6 months after discharge.

DISCUSSION

School refusal is important because it can lead to several academic, occupational, relational and behavioral problems[1, 2]. Psychiatric disorders are common in school refusal cases[3]. A successful treatment must target several areas, since there are child, parent and family based reinforcers. School refusal includes behavioural (avoidance of school), affective (anxiety, phobia, depression) and physiological (e.g. headaches, nausea) components as well as cognitive errors like overgeneralizing[6]. This makes it essential to use an integrated treatment including psychopharmacology, psychoeducation, somatic management techniques, cognitive-behavioral restructuring, social and communication skills training and working with parents[2]. A vital part of treatment is establishing rewards, contingency management and exposure to school. However, these goals cannot be achieved in every case with outpatient treatment. The superiority of inpatient treatment over outpatient treatment in those subjects with more severe impairment may be due to being able to implement a significantly more intense treatment in the former setting. In fact, in these two cases reported in this article, the treatment included a whole-day program with several components. The two subjects presented were hospitalized due to severe symptoms, which were not responsive to routine treatment. Probably, one of the most important reasons for the failure to response in the outpatient setting was difficulties in implementing a behavioral intervention including exposure (attendance to school). This could be done much more effectively in the inpatient setting. Multimodal treatment involving three-stage cognitive behavioral interventions, family therapy, social skills training, relaxation training, contingency management and pharmacotherapy were applied. Keys to the success of treatment were the social worker who accompanied the patient during exposure, an understanding but firm attitude of the staff and the parents, and not discharging the subjects prematurely. Four to five weeks were necessary to complete the three stages: gradual exposure with accompaniment, gradual cessation of accompaniment and attendance followed by returning to the hospital after school. Parental compliance was essential since the cases tried every way to convince them that the treatment was not working. The inpatient setting was also helpful to increase parental compliance, since it helped them to realize the gravity of the problem more clearly. There were new symptoms which changed rapidly during the hospitalization, but all disappeared with strict adherence to the behavioral program. Another advantage of the inpatient setting was that it gave the treatment team a very good opportunity to analyze (and show to the parents and the cases) the relationship of these new symptoms with school refusal. Clearly, pharmacotherapy was helpful to decrease severe anxiety symptoms and acting-out behaviors. The long-term outcome was perfect in both subjects.

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