

Case Report

School refusal, depression and suicidality in an adolescent girl- the interplay of stress and vulnerability: a case report

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ABSTRACT

The stress vulnerability model emphasizes the interplay of genetic vulnerability, personal characteristics and psychosocial factors in the causation of mental illness. The index case highlights the genesis of psychiatric illness in an adolescent female with a family history of bipolar disorder and substance dependence leading to impaired family interaction and family dynamics. Individual psychotherapy, family therapy and pharmacological management proved beneficial in the index case.

Keywords: Depression, Mental illness, Psychosocial stress, School refusal

INTRODUCTION

Both genetic and psychosocial factors are considered important in the causation of mental illness and this interplay is highlighted in the stress vulnerability model. Studies consistently show that offspring of parents with mood disorders are at higher risk for developing mood, anxiety, and externalizing disorders when compared to offspring of control parents.¹⁻³ Apart from mood disorders substance abuse too has a major impact on wellbeing of children exposed to parental substance abuse in the home environment. Findings from the 2009, National Survey on Drug Use and Health (NSDUH) showed that a little over 8.3 million children under the age of 18 years have lived with at least one parent who abused illicit drugs or alcohol during the 12 months prior to being interviewed for the survey.⁴ These children are at increased risk for a variety of problems, such as abuse and neglect, which can negatively impact their physical and emotional well-being.⁵ In addition, parental substance abuse has been linked to ongoing behavioral

problems and emotional problems.⁶ emotional problems in school going children and adolescents may present as school refusal behavior i.e. behaviors leading to prolonged absence from school, coming back early from school.⁷ However, literature reports benefit from intensive and continued intervention at the individual and family level.⁸

CASE SUMMARY

12 years old female 8th class student presented with depressed mood, school refusal and suicidal ideas. She was second in birth order with family history of bipolar disorder and alcohol dependence in father for many years leading to interpersonal issues between parents. Mother was overprotective for patient as well as her elder brother since beginning and had formed one unit over time. She was an "obedient & sincere child", would actively participate in all extracurricular activities, was competitive by nature & overly sensitive to criticism. As per mother she would frequently complain about school,

teachers & workload at school. Parents had high expectation from her as compared to her brother and she always felt the need to be the best in whatever she undertook, which was further reinforced by parents especially father. She felt always under pressure to perform as she progressed to higher classes and was facing difficulty in coping with everything. Family environment continued the same way. Gradually, she started to complain of headache in bi-frontal region, severe, constricting especially in mornings, associated with vomiting, aggravated by inadequate sleep and relieved by rest and medications. Following this, she started to remain absent from school frequently. Simultaneously, she had fever with cough which did not settle with conservative management and was investigated for intracranial pathology i.e. meningitis/encephalitis. No abnormality was detected but she started to complain of severe backache after the lumbar puncture. The backache was so severe that she required assistance in all her daily activities and maintained a stooped posture. Multiple consultations, investigations & medications were tried but to no avail. She did not go to school for three months at a stretch, would try to complete work at home. Thereafter, she was forcibly sent to school and was able to score good marks in her final examination. She had worsening of symptoms when her brother went to a medical college on paid seat and father had worsening of his drinking pattern and was also involved in an extra - marital affair (known to patient) and further worsening of family dynamics and interpersonal issues between herself, mother and her father.

Over next few days she started voicing of difficulty in concentrating on her studies, appeared sad, refused to go to school voicing frequent headaches, got irritable on minor provocations, get tearful, did not enjoy going out, started interacting minimally with family members unlike previously. Her sleep, appetite & self-care decreased. As a result, she again started absenting from school citing physical complaints and whenever was forced to go to school, she had worsening of all her symptoms along with fainting episodes which were not seizures. She was referred to child guidance clinic from dept. of Neurology. The diagnosis kept was Moderate depressive episode, school refusal behaviour, IPR issues with father and was managed with T. Escitalopram upto 20 mg/day. She took medicines with irregular compliance and was extremely stressed due to her inability to study for midterm examination. Following this, she tried to cut her wrist & was found lying unconscious on the floor with a superficial cut on right wrist. She was hospitalised and managed accordingly. Detailed assessment of family functioning, her coping styles and ability was carried out using Ways of coping scale. She was given individual psychotherapy based on the findings of assessment, feedback was provided regularly and effective ways of coping and problem solving were discussed with the patient. Patterns of interaction were studied amongst

family members. Role plays enacted and positive reinforcement given on a suitable response.

Parents were assessed on- Dyadic adjustment scale, Perceived criticism scale, Marital forgiveness scale, New sexual satisfaction scale, had dysfunction in various spheres of marital functioning more so on Dyadic adjustment scale Perceived criticism scale and Marital forgiveness scale. The family dynamics were studied and boundaries analyzed. Parents were educated regarding illness, over involvement, expressed emotions, handling their relationship effectively. Family time was charted; certain games or tasks were given to father to increase his involvement.

Father was evaluated and started on mood stabilizer along with disulfiram. Mother too fulfilled criteria for depressive illness but refused medications. Supportive sessions were held for mother separately. Family was psychoeducated regarding the issues. She improved gradually, started going to school, family interaction between the three improved. There was improvement in the interpersonal issues between parents also and both acknowledged their responsibility to change for the better.

DISCUSSION

School refusal is a heterogeneous syndrome. There is extensive literature describing school refusal. Most common psychiatric co morbidities in school refusal include depression, dysthymia, adjustment disorder and anxiety disorder. In the index case the child presented with multiple physical symptoms resulting in school avoidance behavior. These symptoms could not be explained medically. It is known that depressive symptoms in adolescence may not present as in adults. The manifestation of depressive symptoms differs with age between children and adolescents.⁹ Adolescents frequently experience other additional symptoms which may make it more difficult to diagnose depression in this age group. The symptoms of depression in adolescents may include self-harm, loss of interest, poor scholastic performance, low self-esteem and suicidality.⁹ In the index case, in view of good scholastic performance in the past, a detailed family evaluation helped us to understand the underlying stressors and depressive illness. If the school avoidance behavior was recognized early the progression to further psychiatric disorder could have been avoided in this case. Hence school avoidance behavior mandates detailed evaluation.

CONCLUSION

A multi-pronged approach was used in managing the issues in the index case. This case highlights the role of genetic, personal and family factors in causation of mental illness in an individual. It also highlights that intensive assessment and management remains the

cornerstone in alleviating suffering if such families in distress.

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