RESEARCH ARTICLE

The Experience of Psychiatric Care of Adolescents with Anxiety-based School Refusal and of their Parents: A Qualitative Study

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Abstract

Objective: Anxiety-based school refusal in adolescence is a complex, sometimes difficult to treat disorder that can have serious academic and psychiatric consequences. The objective of this qualitative study was to explore how teens with this problem and their parents experience the psychiatric care received. Methods: This qualitative multicenter study took place in France, where we conducted semi-structured interviews with adolescents receiving psychiatric care for anxiety-based school refusal and with their parents. Data collection by purposive sampling continued until we reached theoretical sufficiency. Data analysis was thematic. Results: This study included 20 adolescents aged 12 to 18 years and 21 parents. Two themes emerged from the analysis: (1) the goals of psychiatric care with two sub-themes, "self-transformation" and problem solving; and, (2) the therapeutic levers identified as effective with two sub-themes: time and space and relationships. Conclusion: Our results show a divergence between parents and teens in their representations of care and especially of its goals. Therapeutic and research implications about the terms of return to school within psychiatric care and also the temporality of care are discussed.

Key Words: school refusal, adolescents, qualitative research, child and adolescent psychiatry, patient reported outcome

Résumé

Objectif: Le refus scolaire anxieux à l’adolescence est un trouble complexe, parfois difficile à traiter qui peut avoir de sérieuses conséquences scolaires et psychiatriques. Cette étude qualitative a pour but d’explorer comment les adolescents aux prises avec ce problème et leurs parents ressentent les soins psychiatriques reçus. Méthodes: Cette étude qualitative multicentrique a eu lieu en France, où nous avons mené des entretiens semi-structurées avec des adolescents recevant des soins psychiatriques pour un refus scolaire anxieux et avec leurs parents. La collecte de données par échantillonnage raisonné s’est poursuivie jusqu’à ce que nous atteignions la suffisance théorique. L’analyse des données était thématique. Résultats: Cette étude comprenait 20 adolescents de 12 à 18 ans et 21 parents. Deux thèmes se sont dégagés de l’analyse: (1) les buts des soins psychiatriques avec deux sous-thèmes, « se transformer » et la résolution de problème;
et (2) les leviers thérapeutiques identifiés comme étant efficaces avec deux sous-thèmes : le temps et l’espace, et les relations. Conclusion: Nos résultats montrent une divergence entre parents et adolescents dans leurs représentations des soins et surtout de leurs buts. Les implications thérapeutiques et pour la recherche des enjeux de retour à l’école dans le cadre de soins psychiatriques ainsi que la temporalité des soins sont discutées.

Mots clés: refus d’aller à l’école, adolescents, recherche qualitative, pédopsychiatrie, résultat déclaré par le patient

Introduction

Adolescent school refusal is an increasingly frequent reason for families to seek psychiatric care, especially in France. Around 90% of the adolescents refusing to go to school may have a psychiatric diagnosis (Ek & Erickson, 2013), most often a type of anxiety disorder described as anxiety-based school refusal. This diagnosis is studied worldwide and is most often associated with other anxiety, phobic, or depressive disorders (Kearney & Albano, 2004; Witts & Houlihan, 2007). This growing problem intersects with both education and public health policies because of its potentially serious academic, social, and psychiatric consequences (McCune & Hynes, 2005).

From a treatment perspective, care can often be complex and long, especially in situations in which adolescents have disconnected completely from school. Several trials have validated the use of some types of individual therapy, in particular, variants of cognitive-behavioral therapy (CBT) (Maric, Heyne, MacKinnon, van Widenfelt & Westenberg, 2013) and dialectical behavior therapy (Chu, Rizvi, Zendegui, & Bonavitacola, 2015). In practice, there are no established guidelines, and coordination between medical professionals, school staff, and family can be difficult.

At the same time, the role of patients in their medical care has evolved in recent years (Truog, 2012). Healthcare professionals must take patients’ subjective health status into consideration. A new era of clinical research has emerged: patient-reported outcomes (PROs). PROs are assessments coming directly from the patients themselves reporting their thoughts, complaints, views or perspectives about their medical care, the benefits of treatment, and the healthcare outcomes important to them (Deshpande, Rajan, Sudeepthi, & Abdul Nazir, 2011). Similarly, proxy-reported outcomes are reports for the same purposes by someone other than the patient (parents, siblings, etc.). PROs and proxy-reported outcome can be explored using either quantitative (PRO measures) or qualitative methods (Donald, Gordon, & Acquadro, 2011). Pediatric PRO assessment is an even more recent field of research, and empirical evidence about quantitative instruments within this age-specific population is still scarce (Matza et al., 2013).

Qualitative methods seek to describe and understand in depth a complex phenomenon. They are a tool of choice for focusing on the views of patients, including adolescents (Revah-levy, Birmaher, Gasquet, & Falissard, 2007; Spodenkiewicz et al., 2013). Several qualitative studies have already examined anxiety-based school refusal, in particular, the experience of parents (Brussard et al., 2015; Havik, Bru, & Ertesvåg, 2014) the viewpoint of school nurses (Torrens Armstrong, McCormack Brown, Brindley, Coreil, & McDermott, 2011), and the concerns of adolescents and mothers in this situation (Gregory & Purcell, 2014). The families included in the latter study complained that neither the school nor healthcare professionals listened to them adequately.

In adolescent psychiatry, the lived experience and the expectations of patients and their parents have a central role in treatment. To our knowledge, however, no study has yet explored how these adolescents and their parents experience the psychiatric care provided to them. This study sought to explore this experience with a qualitative method and to compare the perspectives of the adolescents and their parents. This work is an initial step in the evaluation of PROs and their role in improving the quality of care (Deshpande et al., 2011).

Methods

Setting

This exploratory multicenter study took place at three adolescent psychiatry departments: at the Hospital Center of Argenteuil, at Salvator Hospital in Marseille, and at the hospital Center of Rouen. These three centers offer similar care for the management of anxiety-based school refusal in adolescents. Each center has an outpatient unit, a day-hospital and an inpatient unit. Hospital staffs were quite similar, composed of psychiatrists, psychologists, occupational therapists, nurses, and social workers. Individual interventions and therapy groups were available to adolescents within the units. A clinical coordinator was selected in each department. The council for the evaluation of ethics approved the protocol. All patients and their parents provided written consent before inclusion in the study.

Sampling and Participants

Sampling was purposive (Patton, 2001), that is, selective and deliberate. The researchers explained the study design in detail to the clinical coordinator at each center. The clinicians then identified potential participants — adolescents and parents — whom they considered likely to provide the most information.
The inclusion criteria were: adolescents, boys and girls, aged 12 to 18 years, speaking fluent French, with anxiety-based school refusal resulting in complete school disconnection that led to treatment, begun at least six months earlier, and clinically determined to be well enough to participate in a research interview.

Anxiety-based school refusal is not recognized as an independent diagnostic category in the current classifications of psychiatric diagnoses (Kearney, 2008). Adolescents included in the study had to meet four criteria, based on the classification proposed by Berg (2002): (1) refusal to attend school (to operationalize this first criterion, adolescents were included if they had not attended school at all for at least one month before starting treatment); (2) presence of a DSM-5 anxiety disorder (except obsessive-compulsive or post-traumatic stress disorders) with emotional upset at the prospect of attending school; (3) absence of a DSM-5 conduct disorder; and, (4) parental knowledge of the adolescent’s whereabouts during the period of non-attendance. At each center, the clinical coordinator evaluated candidates during a clinical interview to assess the diagnosis and verify these criteria.

The clinicians first mentioned the study to potential participants and gave them an information sheet about it. If they expressed interest, a preliminary meeting took place, in which one of the researchers spoke with the teen and his or her parents to describe the study to them and obtain their written consent. This preliminary interview also provided the occasion to collect social and demographic data.

**Data collection**

Data came from semi-structured interviews that used an open-ended approach (Britten, 2013). The interviewers used an interactive conversational style and a list of areas of experience to explore for both adolescents and parents (table 1). Interviewers also sought to enter the interviewees’ psychological and social world and to remain open and attentive to any unknown issues that might appear. The participants were considered to be the experts on their own experience, and the interviews were conducted in a way that offered them the opportunity to recount it.

The objective of the interview was to obtain an in-depth description by participants of their experience of the treatment they received. We were not seeking to assess the effectiveness of any given treatment or intervention, which is not something that qualitative research can do; rather it makes it possible to examine closely how patients and their families experience their treatment.

A researcher interviewed each adolescent and then one or both parents. There were thus two interviews for each family, both by the same researcher. Each interview lasted from 60 to 90 minutes. They were conducted by two experienced researchers (JS, an adolescent psychiatrist, and MO, a clinical psychologist), from September 2014 through March 2015. The interviews, which have been anonymized, were recorded and transcribed word-for-word, including the participants’ expressive nuances. The transcript thus obtained was then analyzed.

Our sample size was determined according to the principle of theoretical sufficiency (Dey, 1999). That is, data collection and analysis were completed when the researchers determined that the themes obtained offered a sufficient explanatory framework for the data collected. Two further dyads have been included with no new themes emerging from analysis, to ensure theoretical sufficiency.

**Analysis**

We used thematic analysis to explore the data (Braun, Clarke, & Terry, 2014). This method enables the identification, analysis, and reporting of the themes within the data. Our thematic analysis was data-driven and used an inductive approach: a process of coding the data without any reference to theoretical notions or researcher’s preconceptions.

Table 2 summarizes the different stages of our thematic analysis. This process is dynamic and iterative, with each...
new transcript leading to the collection of additional data and to their subsequent analysis. The objective was to identify the similarities and the differences between the accounts of each participant. The researchers were thus led to discern the recurrent patterns but also to integrate the new issues that emerged from the analysis.

Three researchers (JS, MAP, and MO) independently performed this analysis with Nvivo 11 software. Moreover, results were regularly debated during research group meetings. In cases of disagreements, the discussion continued until a consensus was reached.

### Results

The study included 20 adolescents – nine girls and 11 boys – and 21 parents – 17 mothers and four fathers – for a total of 41 participants. Table 3 summarizes their characteristics. All the adolescents recruited agreed to participate. We conducted 40 separate interviews, with one pair of parents interviewed together. In all the other cases, the one parent present explained that organizational problems prevented the other (most often the father) from attending.

The teens’ ages ranged from 13 to 18 years and averaged 15.5 years. This was a clinical population with diverse anxiety disorders: separation anxiety disorder (N=7), generalized anxiety disorder (N=6), social phobia disorders (N=6), and panic disorders (N=2). Half also had a comorbid depressive disorder (N=10). The duration of psychiatric care ranged from 14 to 79 months, with a mean duration of 38.1 months. All the adolescents interviewed had been hospitalized either full-time or in the day hospital unit of their hospital’s psychiatric department. Seventeen had undergone individual psychotherapy: cognitive-behavioral therapy (N=10), psychodynamic therapy (N=7), and interpersonal therapy (N=3). Five families had participated in family therapy sessions. Sixteen young people had received pharmacological treatment: selective serotonin reuptake inhibitors (N=13) or atypical antipsychotics (N=3).

GAD: generalized anxiety disorder; DH: day hospital; IP: individualized psychotherapy; SSRI: selective serotonin reuptake inhibitor; SAD: separation anxiety disorder; FT: family therapy; AAP: atypical antipsychotics; SAD: separation anxiety disorder; FTF: full-time hospitalization

Regardless of the treatment these adolescents received, the analysis of the interviews enabled us to identify two common themes: (1) the goals of psychiatric care, with two sub-themes “Self-transformation” and “Problem-solving” and (2) the therapeutic levers identified as effective with two sub-themes, “time and space” and “relationships.” The results are presented below and relevant quotations from the transcripts in Table 4.

### 1. The goals of psychiatric care

Adolescents and parents described the goals of psychiatric care related to their understanding of their disorder. Care was judged valuable and meaningful if it dealt with the issues identified by the parents and the adolescents.
The Experience of Psychiatric Care of Adolescents with Anxiety-based School Refusal and of their Parents: A Qualitative Study

1.1 Self-transformation

Most of the adolescents considered that they themselves were the source of their problems. They mentioned internal malaise, suffering, or distress, and they used terms of psychiatric semiology to describe it: depression, anxiety, or anguish. Some also stressed their lack of self-esteem and self-confidence (Q1). This internal distress was experienced as invisible from outside. Adolescents reported that their parents, their peers, and sometimes even the healthcare professionals denied their suffering, did not believe them (Q2). School was perceived not as the cause of the disorders but as the place where their pain was expressed (Q3).

Parents also considered their child’s disorder as internal distress. Nonetheless most parents identified it only afterwards, based sometimes on the psychiatrist’s discourse (Q4 and Q5). Adolescents therefore considered that what they needed was to change and develop. Some adolescents described this change as a disappearance – diminution or absence of psychiatric symptoms – and/or a gain – more self-confidence, autonomy, and maturity, better self-knowledge (Q6), or even self-transformation (Q7).

Parents recognized this personal change and considered it beneficial. They welcomed it with surprise, without really...
relating it to the psychiatric care process, but rather to the child’s own development (Q8).

While most of the teens recognized that they had changed during the period of care, they remained uncertain about the process that led to this change. Their discourse about the pharmacological treatment illustrated this perplexity. How could they be sure that the drug was really responsible for the change (Q9)?

Other adolescents mentioned their difficulty in perceiving changes by themselves. They needed these to be identified and validated from the exterior, to be told that they were changing (Q10).

1.2. Problem solving

For parents, care essentially involved a problem-solving model. They identified problems for which psychiatric care was supposed to find solutions (Q11).

Problems with school, solution by the school. Parents’ principal worries concerned school and the academic consequences of their child’s situation. Parents were especially afraid that their children would fail a year and have to repeat it. Many also reported problems within schools and the educational system: too much pressure on students, harassment, teachers who are too strict; or with the professional staff: failure to understand individual situations, lack of flexibility of the school structure. All of these problems together motivated parents to seek care for their child (Q12).

Adolescents also mentioned these school problems, but always secondarily. They were nonetheless well aware that the issue for their parents was their education (Q13).

Parents thus considered solutions that directly affected school problems to be relevant and useful: adapting and maintaining their schooling, setting up distance courses, including class time in the day hospital schedule (Q14). Parents and, to a lesser degree, the adolescents described not having to repeat the year or not giving up as criteria to assess the efficacy of the proposed solutions (Q15). All parents associated the effectiveness of treatment with support for return to school (Q16). For many parents, as well as some adolescents, return to school and recovery were essentially the same (Q17).

Problem of social life, solution by socializing within the institution. The second problem underlined by parents was the child’s lack of a social life. Parents were particularly worried about their child’s isolation and difficulty in fitting into a peer group (Q18). Adolescents also recognized their difficulties in socializing and in interacting with others (Q19).

Parents thus considered that in-patient or day care provided a solution by enabling their children to socialize with others. They described the hospital as a place for a social life adapted to their child (Q20). Day hospitalization provided them with the advantage of giving back to the family in general and the child in particular a normal life rhythm (Q21). The adolescents also mentioned the need for a social life and social skills, but underlined especially the importance of fitting into a peer group (Q22).

2. Therapeutic levers identified as effective

2.1. Time and space

Taking time or wasting time. The adolescents considered that the time necessary for care to be effective had to be taken. First, they thought that professionals had to take the time to name and define their distress. Next, it would take time for the adolescent to “encounter” the care and the professionals providing it, that is, to adhere to the treatment activities proposed, and trust the staff. Finally, it took time to think about oneself and be able to develop (Q23, Q24).

Some parents were also very satisfied about the time given to their child to adhere progressively to treatment and to get to know the healthcare team (Q25).

Nonetheless, parents had difficulty accepting that treatment couldn’t be effective faster, that they hadn’t found the right professional, the right solution, or the right treatment from the beginning. Parents then mentioned that time was being wasted (Q26).

Teens, however, replaced this concept of wasting time with that of experimentation and trial; they considered that all the stages of care, even those that were not effective, had been useful in one way or another (Q27).

Need for a space. Parents emphasized the need and importance of the space of care. They experienced the treatment in an inpatient unit or a day-hospital as the end of wandering (Q28). Parents considered the environment where treatment occurred as a therapeutic lever (Q29). The space of care was very often compared with school and described as more benevolent, friendlier, more welcoming, and more open to the outside world (Q30).

Some adolescents described a sense of belonging within the space of care (Q31). Nevertheless, many of them valued the people they met within the psychiatric department more than the place itself (Q32).

2.2. Relationships

Participants considered relationships to be an essential therapeutic lever. They underlined the importance of being able to speak and be heard as well as the need to establish a trusting relation with hospital staff (Q33). Of the range of relationships related to this psychiatric care, adolescents and their parents had anticipated some, while others were considered unexpected and thus experienced as still more effective.

Expected relationships: with healthcare staff, family, and peers. Adolescents and parents insisted on the personal and
Table 4. Quotations

<table>
<thead>
<tr>
<th>Theme 1: The goals of psychiatric care</th>
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<tbody>
<tr>
<td><strong>1.1 self-transformation</strong></td>
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<tr>
<td>Q1 P4: I was timid and withdrawn (...) I didn’t like myself, I just stayed in my room being depressed.</td>
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<td>Q2 P8: Even when I felt bad, everyone thought I was well.</td>
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<tr>
<td>Q3 P2: Just as I was about to leave, I had trouble breathing, I had a knot in my stomach; it just came over me, it made me anxious, just thinking about it, I was stuck. In fact, it was me; I was stuck, I couldn’t even get out the door, I didn’t want to.</td>
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<td>Q4 Mother of P7: He’s a very anxious child. Doctor C. told us that she has rarely seen such anxiety in a child. It’s his temperament; we understand that now.</td>
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<td>Q5 Mother of P12: I really didn’t imagine that he was deeply depressed, in fact, and in the end, he was deeply depressed. Truly he was becoming depressed, the poor kid, and at the beginning, I didn’t believe him really, no. At the beginning, I didn’t believe it, and my husband didn’t either.</td>
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<td>Q6 P18: It is a personal development; I think I became more mature.</td>
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<td>Q7 P9: It transformed me (...) the day hospital helped me to make myself into a person. And today, all those things that I received there for two years made me the person that I am today, right now.</td>
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<td>Q8 Mother of P17: She’s become a little more responsible, she’s left that child part behind, she’s grown up.</td>
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<td>Q9 P16 After, the antidepressant, it would be a little harder to attribute the effects, to the extent that there was a change, but I can’t really say how much the antidepressant was responsible for it.</td>
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<td>Q10 P11: I was changing, but it wasn’t really clear in my head (...) In fact, there was a sort of fog, and the fog made it ... I wasn’t sure about it, and when it was gone, I saw what they were telling me, I understood that it was better.</td>
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<tr>
<td><strong>1.2 Problem solving</strong></td>
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<td>Q11 Mother of P9: I came here. Why? Because I knew that I was going to find people to talk to who were not necessarily going to give me the solution, but would help me find a solution. Either they would give it to me, or I would find it. Problems with school, solution by the school</td>
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<tr>
<td>Q12 Mother of P8: So that she wouldn’t get too far behind, I found a hospital that could give her courses in French and math and at the same time, get her to leave the house. And then she was in a world that understood her.</td>
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<td>Q13 P19 (on the subject of her father and the suggestion for full-time hospitalization): To start with, he doesn’t really like shrinks. I don’t know exactly why. He wants me to have a regular education, for me to go to middle school. So he finally agreed, but it was a little harder.</td>
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<td>Q14 Mother of P8: (What helped you the most?) When they set up the distance classes for her.</td>
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<td>Q15 Mother of P8: But when she came here to do math and French, I knew that it wasn’t at a very high level (...) But it kept her from losing touch with schoolwork and that ... that really helped.</td>
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<td>Q16 Father of P5: Today, she turned a corner. She agreed to go back to a normal school program, on condition that it’s not at her original school.</td>
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<td>Q17 Mother of P9: When he finished all his internships and had his diploma, I knew it was over. Problem of social life, solution by socializing within the institution</td>
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<td>Q18 Mother of P12: And then the contact with the others, quite simply, it was too hard for him to be in contact with the others, fear, I don’t know, a fear of people.</td>
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<td>Q19 P11: Conversation with the people around me was very complicated; I didn’t dare say anything to people. »</td>
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<td>Q20 Mother of P4: So here, there was socializing with activities, horseback riding, sports, and then he was very happy to make friends, to win at foosball.</td>
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<td>Q21 Mother of P9: It was impossible for him to stay home, all alone (...) Since I work, I couldn’t just stay home when I wanted to. I couldn’t take time off, or sick leave. I had to do something. So the doctor suggested the day hospital, where he would go in the morning and he would come home in the evening.</td>
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<tr>
<td>Q22 P1: I found my two best friends, I met them here.</td>
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emotional aspects of their relationships with staff. Adolescents looked for the person behind the function (Q32) and were sensitive to the quality of staff investment and commitment to them (Q34). On the contrary, parents and adolescents designated the psychiatrist as the professional in the healthcare system. This relationship was less emotional, more distant, more focused on the adolescent’s therapeutic management (Q35).

For the adolescents and their parents, intrafamily relationships and the adolescent-parent relationship provided support, in particular at the onset of care (Q36). Teens also mentioned that modifications of their interactions with their parents — especially around questions of autonomy — had been helpful in their care (Q37). Adolescents generally experienced their relationships with peers as positive and helpful. They were able to help each...
other, reassure each other, and talk about their problems with people their own age (Q38). Parents recognized these positive aspects but also worried about their child being in contact with “very sick” or “special-needs” teens (Q39).

**Unexpected relationships.** Besides these expected relationships linked to their psychiatric care, adolescents recognized as still more effective and helpful some unexpected relationships that they were able to establish in the course of care.

In particular, these were unexpected meetings: the taxi driver bringing them to the hospital, an intern, or an art therapist. These relationships were experienced as more therapeutic than the others (Q40). Sometimes, it was an activity offered to the adolescent and experienced as unexpected (African dance, gardening) that served this function of therapeutic lever.

In this context of anxiety-based school refusal, adolescents reported unexpected experiences with teachers in the hospital. These teachers were described as kind, patient, and altruistic. Adolescents thus had the chance to have a relationship they experienced as different and healing (Q41). Parents shared this position and considered the relationship between their child and some teachers as decisive (Q42).

**Discussion**

We first observed a divergence between the representations of the goals of care between adolescents and parents. While parents focused on the external goals, adolescents focused their care more on internal issues. The parents’ focus matches those found in the literature: studies assessing the efficacy of therapy, especially CBT, in situations of anxiety-based school refusal consider return to school, as quickly as possible, as the primary outcome and internalized behaviors or depressive features as secondary (Maric et al., 2013). Moreover, although CBT has shown some effectiveness in promoting school attendance and reducing emotional symptoms in children and adolescents with anxiety-based school refusal (King et al., 2001), a study focusing on adolescents alone reports a poorer response (Bernstein et al., 2000). As in our sample, adolescents may present more severe forms of anxiety-based school refusal and more frequent association with depressive disorders than younger children do (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011).

For many parents, return to school and recovery were essentially the same. We think that there is a risk of a cessation of care because parents would no longer consider care as necessary whereas the internal goals of care of the adolescents would not yet be achieved. This could lead to the development of an untreated internalized disorder. Authors of a recent review noted the need for long-term follow-up studies to determine whether school attendance among adolescents with anxiety school refusal ultimately leads to reduced anxiety (Maynard et al., 2015). The study by McCune & Hynes (2005) of the outcome of adolescents with anxiety-based school refusal reported that 30% had a psychiatric disorder ten years later.

Moreover, time appears in our results as an essential therapeutic lever for the teens. Here again, we identify divergences in the representations of parents and adolescents. Parents want an effective treatment as rapidly as possible, while adolescents claim the need of a treatment period sufficiently long to allow them to change and develop.

This result is consistent with the interrelation between adolescents’ development of autonomy and the process of care. Indeed, our results – “self-transformation” and taking time suggest a process of becoming within the care and especially how time is needed to enable such a process. In that respect, some authors argue that adolescent-focused CBT for anxiety-based school refusal must take into account the developmental aspect of the adolescence period (Heyne et al., 2011). To our knowledge, however, the question of the length of care in adolescent psychiatry has never been studied as a therapeutic lever but only as a variable associated with the establishment of a good therapeutic alliance (Topor & Denhoff, 2012). Further research should explore this question in depth.

Although the adolescents in our results valued the time and relationships more, the space of care appeared to be a shared therapeutic lever between parents and adolescents. The qualitative literature has already described the importance of the therapeutic milieu in adolescent mental health care (Geanellos, 2000) but the question of the therapeutic value of the place where care occurs has never been studied in adolescent psychiatry. The relational dimension of treatment is the second therapeutic lever described by adolescents and parents. The importance of relationships in adolescent psychiatry, in particular with hospital staff, is clear in the literature (Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003), especially linked to the concept of therapeutic alliance. The studies suggest that a good alliance is necessary, as much with parents as with adolescents, although these two relationships predict different outcomes (Hawley & Weisz, 2005; Kazdin, Marciano, & Whitley, 2005).

Our study reports an original result: the therapeutic value of experiencing unexpected care-linked relationships. Time, space, and relationships — the therapeutic levers found in our results — are in fact strongly intertwined. That is, we can argue that treatment must last long enough, in a place dedicated to care, to allow these youth to become involved in their care and to reflect on the personal changes they need, but also to offer them the possibility of multiple human encounters, some of which — expected or unexpected — will turn out to be determinant in their development. Our results suggest therefore two outcomes of care that might seem antagonistic: a rapid return to school for the parents,
and a sufficiently long time within care to enable a self-
transformation for the adolescents. These two outcomes are
of equal importance and psychiatric treatment should strive
to combine and coordinate them.

These results take place in a current discussion in the lit-
erature about the time and space of care in this situation, as
many authors warn against the risk of chronicity without a
quick return to school (Kearney, 2008). Some authors also
consider that a timely and well-prepared return to school
enables adolescents to develop within his or her social and
school world, a more naturalistic setting than a psychiatric
day hospital or an inpatient unit, while continuing to receiv-
ing care in an outpatient unit (Maynard et al., 2015).

Our results provide another point of view and show that, for
adolescents with severe or persistent anxiety-based school
refusal, self-transformation and another relationship with
school is possible within psychiatric care and in a psychi-
atric space. In France, this is the case for instance in psychi-
atriic units named “care study” providing day-hospital
or inpatient treatment in which the adolescent can continue
his or her academic education (Chandellier, Atger, & Peyre,
2014). Thus, our results invite us to question the space of
care, in other words the setting to be proposed in case of an
anxiety-based school refusal, especially when severe and
persistent. Further research about this specific topic appears
necessary.

Moreover, further PROs among adolescents with anxiety-
based school refusal should integrate the assessment of both
external and internal goals of care and the duration of care
and of expected and unexpected care-linked relationships.

**Limitations**

This is the first qualitative study to look at the experience of
psychiatric care for adolescents with anxiety-based school
refusal.

Nonetheless, some limitations must be taken into consider-
ation. First, it took place in France, and caution is required in
transposing our results to other places because psychiatric
care depends strongly on the organization of the medical
system as well as on the country’s economy. Second, the
population of adolescents was recruited in specialized
departments of adolescent psychiatry. Our results therefore
apply to this population receiving this kind of care in these
types of settings, but they cannot take into account other
contexts of care for the same disorder, especially outpatient
management or school-based programs (Garmy, Berg, &
Clausson, 2015). Third, this study’s objective was to un-
derstand the global experience of psychiatric care and not to
classify the experience of specific interventions. Future
qualitative research should be able to explore in depth the
experience of particular therapies in this population. No
study has yet explored the points of view of psychiatrists
and other mental health professionals about the care of
these adolescents. Such a study might make it possible to
clarify the views and perspectives of professionals about
goals of care and therapeutic levers. Finally, our study was
able to identify significant concepts regarding the experi-
ence of care in this situation, but further studies are needed
to enable an in-depth description of them, to examine them
in different situations, and to explore their relations with
other concepts already described in the literature (Morse,
2012).

**Acknowledgments / Conflicts of Interest**

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