The Aftercare of Truant Children and Adolescents: the Relevance of a Social-Psychological Perspective

Pia Anna Weber
Academic research assistant and lecturer in social psychology and general psychology, Duisburg-Essen
Verena Welling
Academic research assistant in the working group for general psychology and occupational psychology at the University Duisburg-Essen
Prof. Dr. Gisela Steins
Professor for general psychology and occupational psychology at the University Duisburg-Essen

1. Theoretical background

Transitional periods, whether biographical and/or institutional, can be perceived as a strain by children and adolescents suffering from psychological disorders. The transition between the home environment and attendance at a regular school to admittance to a psychiatric institution and the accompanying attendance of a clinic school can be experienced by pupils as an extremely critical period (Wertgen, 2009). According to Ciompi 1982 and Kuchenbecker 2002, children with psychological disorders are generally intensely vulnerable and will as a rule display a low tolerance threshold when faced with stress factors. This is compounded by a danger of potential stigmatisation processes to which children and adolescents with psychological disorders are exposed in comparison to healthy children (Haep et al., 2011). Should these pupils encounter incomprehension and negative expectations from teaching staff and/or fellow pupils, this will create disadvantageous predictors for regular attendance at school. Negative expectations and unreliable disposition attributions could result from an insufficient education (cf. Hirsch-Herzogenrath & Schleider, 2010). The school environment will continue to exert an influence on behaviour, psychological health and the recovery of children and adolescents with psychological disorders (Harter-Meyer & Weidenbach, 2001).

According to our observations from the project “Quality management in schools for sick children”, pupils lacking necessary resources find it extremely difficult to achieve regular school attendance without external help (Weber et al., 2008). In certain cases, pupils do not return to their former school following their stay in the clinic and the change to a new school can also be accompanied by significant challenges. Reintegration attempts on the part of these children and adolescents frequently fail without a supportive and reliable social environment (Steins, 2008). Within the framework of the above-mentioned research work, it was established in a questionnaire aimed at affected pupils and their parents that these parents experience the transition period between psychiatric clinic and regular school as difficult and full of risks and would welcome targeted support measures for their children (Weber et al., 2008). In some cases, anxiety and avoidance tactics have become so chronic that pupils cannot achieve reintegration without external support. The necessity for some form of supportive measures is also underlined by the fact that pupils suffering from psychological disorders have not regained complete health following the end of their stay in

the clinic and therefore have need of further help. This should not only cover the point of re-integration at school during the treatment phase, but also the period directly following the clinic stay. We have experienced that the chances of failure at school are particularly high for pupils with psychological disorders if support systems are suddenly withdrawn.

2. Participating interfaces

This project focuses on the interfaces between the child and adolescent psychiatric units and/or clinic school with the home school. Soulguard is a cooperation project organised by the Faculty of Educational Science at the University of Duisburg-Essen and the child and adolescent psychiatric unit Essen-Werden (Chief physician: Mr Christoph Arning) and received support up to February 2011 from the RWE youth foundation.

As its name suggests, “Soulguard”, a modification of the term “bodyguard” who undertakes physical responsibility for his charges, aims to safeguard the mental balance of sick children and adolescents.

Pupils with mental disorders receive support focused on the reintegration in their home schools during treatment and after their discharge from the psychiatric clinic. This support is especially directed at pupils with symptoms relating to school truancy and/or socially- and emotionally-based problems at school. This approach should help to identify reintegration problems and develop appropriate solutions. Prof. Dr. Gisela Steins is the project supervisor accompanied by her assistants Pia Weber and Verena Welling. Soulguard is a follow-up to the research project “Quality teaching for sick children”.

Our support services

As already mentioned above, the transition periods between the different institutions are experienced as problematic by parents, teachers and the pupils themselves (Steins, 2008). During reintegration, problems can arise within a single system (e.g. within the school system) and additionally between different systems (e.g. school – parental home – psychiatric clinic). This phenomenon is termed as an interface problem. Illustration 1 depicts a graphic representation of all participating interfaces and their interrelationships.

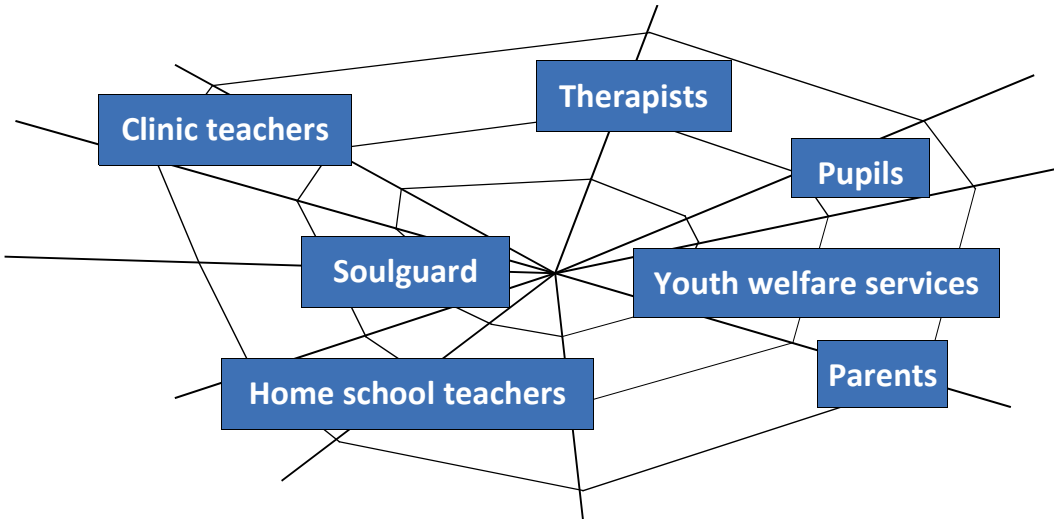

Illustration 1: Participating interfaces within the reintegration process in the research project Soulguard

Within our Soulguard project, we offer the participating systems a psychological support concept focusing on the support of the child, meaning that a targeted plan of measures to be undertaken is developed for each individual pupil. This plan is designed to encourage social competences in vivo, raise self-esteem through positive affirmation, strengthen self-effectiveness through the successive reduction of the scope of accompaniment and improve the pupil's emotional state with the aid of rational explanatory models (Ellis & Hoellen, 2004). We are able to achieve these objectives through three types of support: social, emotional and structural support.

Measures categorised under social and emotional support include for example:

- being picked up at home and accompanied to school
- support person present at school
- discussions with teachers, school social workers and school psychologists
- behavioural observation
- further individual support measures which can contribute to the solution of school-related problems
- behaviour programmes to reduce specific problems e.g. anger management (Wilde, Haep & Steins, 2010)
- mediation between child/adolescent and fellow pupils

Structural support includes all measures which help pupils to plan their school days better. This can range from help with the procurement of teaching material or printing out the current school timetable. In cases where a change of school or repeating a school year have become necessary, the pupil will receive support in the procurement of up-to-date teaching material.

3. The concept of irrational thoughts

Our support measures are based on psychological principles, particularly on the rational-emotive behavioural approach (Ellis & Hoellen, 2004). This approach is focused on the concept of irrational thoughts.

Ellis interprets the term "irrational" as unreasonable, inappropriate, unrealistic and not conducive. Irrational thoughts or actions are not expressed in emotional or emotive terms as occurs frequently in everyday language; within this context, irrational describes the lack of logic/proximity to the reality of conviction, meaning that an individual will experience this state as an obstacle blocking the path to the achievement of his or her personal goals (Ellis & Hoellen, 2004). On the basis of this approach, we demonstrate rational abilities for solving problems to pupils with psychological disorders and demonstrate the difference between self-harming emotions (irrational) and helpful feelings (rational). Illustration 2 shows rational and irrational emotions in a comparison.

Irrational		Rational
anxiety, panic	➡	solicitude, apprehension
rage, animosity, intensive anger	➡	dissatisfaction, irritation, mild anger
despondency, depression	➡	disappointment, grief
feelings of guilt, bad conscience	➡	regret

Illustration 2: Summary of appropriate and inappropriate emotions (cf. Waters et al., 2003).

We have compiled the following list of some of the frequently observed irrationally evaluated situations in everyday school life experienced by our clients:

- I don't go to school because it's often not fun!
- As soon as I feel slightly unwell, I am no longer able to attend school!
- If someone insults me, I have to attack him verbally and/or mentally!
- I can't stand it if no-one pays me any attention!
- If I get a bad mark, it means that I am useless in this subject!

What are rational convictions experienced by pupils?

- Although I don't like school, I still manage to cope with it!
- Even if I have behaved badly, this does not mean that I am a bad person!
- I don't like it when I am insulted, but if this happens, it is not a catastrophe!
- If someone insults me, this does not necessarily imply that he/she is right!
- If I participate in lessons, time passes quicker!
- If I attend school when I am not feeling all that well, it becomes even easier when I am in a healthy state!

Reintegration support utilises a variety of methods to stimulate this cognitive restructuring process. The principle of repeated and constant practice plays a central role. Pupils are alerted to irrational thoughts during joint sessions and during the accompaniment period and student personnel help with the development of rational equivalents to these thoughts. These students receive support in this challenging task in the form of a compulsory advisory system which involves among other elements weekly meetings in small groups supervised by the academic personnel. One of the aims of the clients is to deal with problems according to a solution-oriented approach. Pupils should become self-sufficient in as short a time as possible so that they are able to attend school regularly and participate in the complete lesson timetable.

They will also receive additional help with the reasonable evaluation of situations. One example is the cards they carry constantly which have been compiled together with their reintegration supervisors and are designed to bolster confidence in situations which otherwise trigger off anxiety.

4. Selected examples

At this point, we present two case studies from the Soulguard project which illustrate examples of interface problems a) within a single system and b) between different systems as exemplified by school – parental home – psychiatric clinic.

a) Interface problems within a single system – the case Sven Scholl

The 13-year-old pupil Sven Scholl has an over two-year history of school truancy and has been diagnosed as having a social phobia and an emotional disorder stemming from childhood (F 40.1, F 93). Sven was reintegrated into year seven at his home school, a secondary school.

Sven possesses a substantial history of therapy and has already experienced a number of school transfers: most recently from a secondary modern school to his current school. According to the pupil, his truancy is based on anxiety due to the bullying he experienced at secondary modern school (of both a psychological and physical nature).

This case demonstrates the problems encountered within a single system with the example school. Illustration 3 displays the coherence of this type of situation.

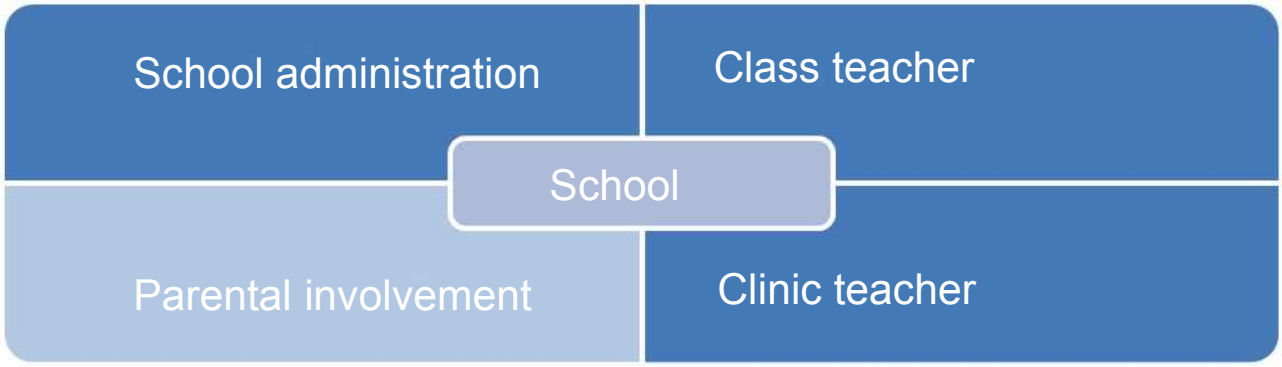

Illustration 3: Interface problems within a single system with the example of school

In Sven's case, there were ambiguities and different expectations regarding the evaluation of educational performance and insufficient consultation regarding Sven's progress to the next higher class: year 8. Although Sven only attended school on a few individual occasions, his parents expected him to be put up automatically into the next year. In a preliminary discussion on school attendance shortly before the begin of the summer holidays, the clinic teachers and class teacher of the home school came to an agreement with the parents and clinic staff that Sven should be put up a class on trial if the school administration would give their consent.

This meant for Sven that he could still be put back down to year 7 if his efforts at school proved to be insufficient. For this reason and also to demonstrate his own motivation, Sven was expected to write a number of class tests in the clinic school to catch up with the previous year, but no concrete criteria were specified as to the number of tests to be taken and when the results of these tests were to be presented.

The school summer holidays then commenced, meaning that neither the clinic teachers nor the class teacher or members of the school administration were available for consultation.
As a result, Sven was not able to take the class tests and also did not find out whether the school administration had approved his pedagogical transfer to year 8 which triggered off feelings of anxiety. Shortly before the beginning of the new school year, Sven was informed that he would be able to join his previous class as planned (i.e. year 8). As his subject teachers had however already provided him with a book list for year 8, Sven saw this as confirmation that he would not be put back down a class.

All these events had a negative effect on Sven's willingness to make a serious effort. The subject of class tests was never mentioned and Sven had learned that he was also able to achieve his objectives with minimal individual contribution, thereby not providing him with an incentive to alter his behaviour.
There are also cases of insufficient consultation between a series of different systems which is illustrated by the following case study.

b) Interface problems between different systems – the case Kathrin Porz
The case Kathrin Porz provides a further case study displaying interface problems between different systems

The 16-year-old pupil Kathrin Porz is a chronic school truant. She refused to attend school for a period of 3 months and her symptoms came to a head in the summer of 2009. She has been diagnosed as suffering from a generalised anxiety disorder and a combined emotional and social behavioural disorder (F 41.1., F 92.8). Kathrin was reintegrated in year 10 at her home school. In addition to her chronic school truancy, the pupil also only writes the required written tests following special appointment and is allocated a separate room for this purpose. Travelling by public transport continues to trigger off anxiety, bus journeys being particularly problematic.

Although the participating systems had common objectives, different approaches in the achievement of these goals became clear. The intention of all participants was to reduce the problems associated with Kathrin's disorders to permit her to attend school on a regular basis without the necessity for special treatment. The primary school target is the school leaving certificate at the end of year 10. Up to the commencement of treatment and to a certain extent during treatment, the school permits her to continue writing her tests on specially arranged dates in a separate room. Exercises were always collected by Mrs Porz from school. Although Kathrin has not attended school regularly since 2009, she received a half-yearly report in January 2010 with an average grade of 2.5. This special treatment was granted to the pupil by the school with the intention of helping her to overcome her problematic disorders, but it actually had the opposite effect and reinforced her avoidance behaviour. As the symptoms of Kathrin's disorder displayed avoidance tactics alongside her anxiety problems, the clinic determined that it was the task of the family

and the school to discontinue all forms of special treatment and special arrangements, but neither the school nor the parents were willing to give up this practice. The school continued to grant her special dates for tests and Kathrin's parents intensified her avoidance tactics through undertaking further obligations for her: they drove their daughter to school or to leisure activities, organised lesson material and negotiated special conditions for her with the school.

Through inconsistent agreements and actions, Kathrin had learned that she would be relieved of certain duties following persistent complaining and drawing attention to her psychological stress situation. These experiences also presented no incentive for Kathrin to alter her behaviour pattern.

5. Questions

We formulated the following question on the basis of research status and the extent of our knowledge:

1. How many pupils in the treatment group (pupils receiving support from Soulguard) attended school regularly, on a partial basis or not at all during the periods T1, T2 and T3 in comparison to the control group (pupils not receiving support from Soulguard)?
2. Which friction losses occur at the interfaces of psychiatry - family - home school in the context of mental illness in connection with a truancy problem and pupils with school problems?

6. Method

An increased number of interviews are currently being conducted with former patients of the child and adolescent psychiatric unit and their parents within a treatment period from 2006 to 2010 to establish a group for comparison. This comparison group currently consists of 21 former patients. Through telephone interviews with these pupils and their parents, it can be established whether the pupils attended school regularly, on a partial basis or not at all during the periods T1, T2 and T3. The three different measuring periods permits us to formulate statements on the duration of school attendance.

Qualitative methods were employed for this explorative research structure. The following results for the experimental and comparison groups were compiled through documentary analysis, interviews, observation data (behavioural observation and lesson observation for the experimental groups), self-evaluation and foreign evaluation across three periods of measurement. The first period of measurement (T1) with a longitudinal structure includes observation data and interviews with pupils and one parent during the stay in the clinic. The second period of measurement (T2) was carried out 8 weeks after the end of support and T3 5 months after discharge from the clinic. The data for T2 and T3 was collected in telephone interviews.

7. Results

The results shown in illustrations 4 to 6 relate to the treatment group. Distinctions are made between different periods of measurement.

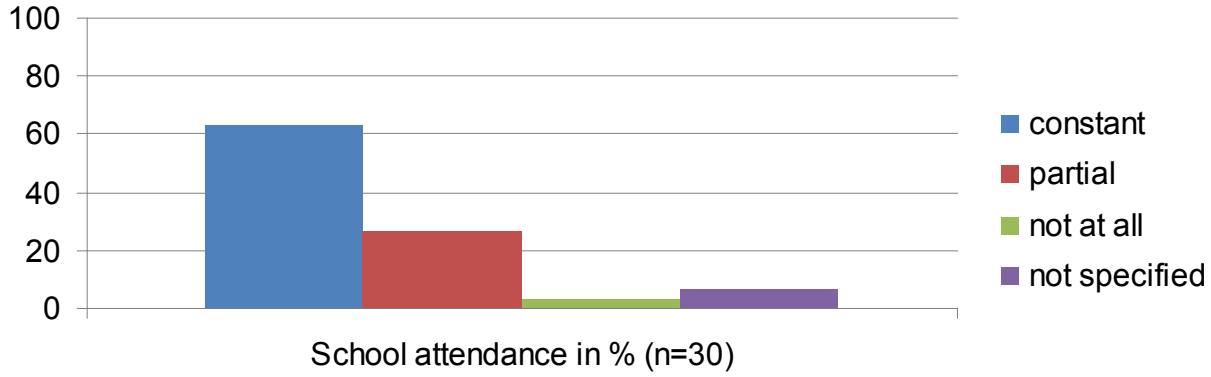

Illustration 4: school attendance at 1st point of measurement in % (accompanying phase during stay in clinic).

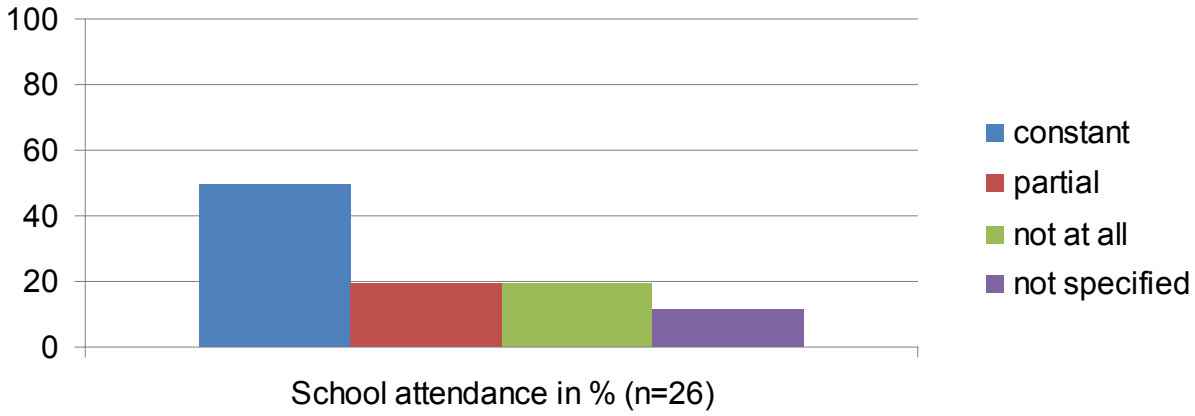

Illustration 5: school attendance at 2nd point of measurement in % (2 months after end of accompanying phase).

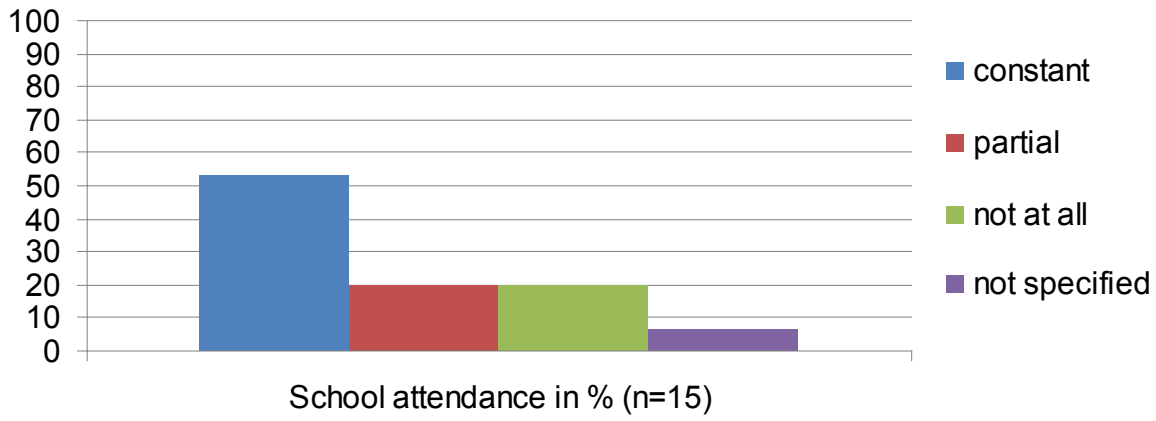

Illustration 6: school attendance at 3rd point of measurement in % (5 months after end of accompanying phase).

The results shown in illustrations 7 relate to school attendance during three periods of measurement in the comparison group.

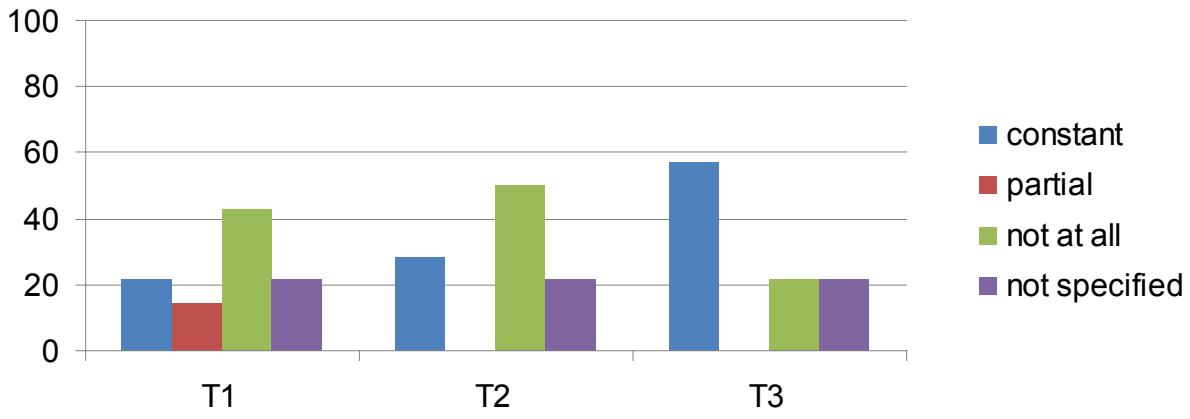

Illustration 7: school attendance at 3 points of measurement in % (n=21).

It is evident that regular school attendance in the treatment group recorded as 63.3% at the first point of measurement is three times higher than the comparison group with 21.4 %. Additionally, 3.3 % of pupils in the treatment group do not attend school at all during T1 whereas the figure for the comparison groups is 42.8%.

At T2, regular school attendance among the treatment group is 50 %, almost double the figure of 28.6% for the comparison group. At the same point, 50 % of the comparison group and 19.2% of the treatment group do not attend school at all. In the treatment group, 19.2% of pupils attend school on a part-time basis compared with none in the comparison group.

During T3, regular school attendance is observed at a similar rate in both groups: 53.3% for the treatment group and 57.7% for the comparison group. Complete absence at school is observed in T3 at a rate of 20% of pupils from the treatment group and 21.4% of pupils from the comparison group. No indication of the rate of school attendance was made by 21.4% of the comparison group during all three measurement periods. The proportion of pupils for which no information was available was measured at 6.7% (T1, T3) and 11.6% (T2) for the treatment group. The reason for this lack of data was the number of pupils and/or parents who were unavailable for contact via telephone or refused to participate in the telephone survey.

8. Discussion

The results of the school attendance survey (regular, partial or no attendance) displayed that double the number of pupils in the treatment group attended school on a regular basis in the measurement periods T1 and T2 than in the comparison group. During the first measurement period, almost 13 times as many pupils in the comparison group did not attend school at all in comparison to the experimental group. During the second measurement period, i.e. 8 weeks after T1, 2.6 times as many pupils from the comparison group did not attend school at all compared with the experimental group.

If the duration of school attendance within the period or reintegration is examined, it is clear during the third period of measurement that the experimental group displays a similar rate of attendance to the comparison group. A similar rate can be established for the dimensions of non-attendance at school. It is not clear why the positive effects from T 1 and T2 disappear during T3. A possible explanation is that the support systems have come to an end by a minimum period of 5 months following discharge from the psychiatric clinic. If this is accompanied by personal problems, the probability of irregular school attendance or truancy increases. On the basis of the results obtained, it can be established that the accompanied periods of transition – particularly during the stay in the clinic and in the first two months following discharge from the clinic – can result in a higher rate of regular school attendance in comparison to the pupils who did not receive support in their reintegration after treatment in a psychiatric clinic on their return to their normal schools. In the interpretation of these results, it must however be kept in mind that the proportion of the pupils for which no information on school attendance is available was only 6.7% (T1, T3) and 11.6% (T2) in the treatment group whereas the figure throughout all three measurement phases in the comparison group remained constant at 21.4%. The pupils not providing any data would therefore have to be divided between the items regular, partial and non attendance which would alter the results of the treatment and comparison groups and their relations to each other. Due to the longitudinal structure of the research project, the sample size of the treatment group diminishes between T 1 and T 3. Additionally, further information is currently being collected for the comparison group. A further significant topical area is currently being studied in a qualitative analysis process: What friction loss takes place between the interfaces psychiatric unit – parental home – home school within the context of psychological disorders within the framework of rejection of school attendance and pupils with school-related problems?

9. Conclusion

A large proportion of pupils receiving support during reintegration in their home schools profit from the support services available during their stay in the clinic and 2 months after discharge. In the interpretation of the results available for T 3, the variability of the sample size must be taken into account. At this moment in time, it is still difficult to estimate how successful this form of intervention really is to guarantee regular long-term attendance at school.

10. Outlook

Further research projects in the future will focus on the phenomenon of school rejection on individual, institutional and systematic levels with the overriding objective of the systemisation of this problem area on all three levels, the determination of the most serious problem fields and the generation of appropriate solutions. The intervention in the approach to this field should simultaneously permit the observation to be pursued on an individual level and investigate the effectiveness of efforts on the part of each different system.

11. Literature

Ciompi, L. (1982). Affektlogik. Über die Struktur der Psyche und ihre Entwicklung. Ein Beitrag zur Schizophrenieforschung. Stuttgart: Klett-Cotta.

Ellis, A. & Hoellen, B. (2004). Die Rational Emotive Verhaltenstherapie - Refl exionen und Neubestimmungen. Stuttgart: Pfeiffer.

Haep, A., Weber, P. A., Steins, G. & Brendgen, A. (2010). Eine Evaluation von Unterricht mit kranken Kindern und Jugendlichen und ihre Implikationen. In: Zeitschrift für Heilpädagogik, 11, 404-412.

Haep, A., Weber, P.A., Welling, V. & Steins, G. (2011). Psychopathologisierung von Kindern und Jugendlichen, die Rolle des Elternhauses und der Schule und die Relevanz einer sozialpsychologischen Perspektive. In E. Witte (Hrsg.). Sozialpsychologie, Sozialisation und Schule, 26. Hamburger Symposium zur Methodologie der Sozialpsychologie (im Druck). Berlin: Pabst Science Publishers.

Haep, A., Steins, G. & Wilde, J. (2011). Materialpaket Soziales Lernen Sekundarstufe I. Donauwörth: Auer.

Harter-Meyer, R. & Weidenbach, M. (2001). Bildung und Krankheit. Herausforderungen für Lehrkräfte. Münster: LIT Verlag.

Hirsch-Herzogenrath, S. & Schleider, K. (2010). Reintegration psychisch kranker Schülerinnen und Schüler in die Allgemeine Schule aus Sicht der Schulen für Kranke – empirische Befunde. In: Zeitschrift für Heilpädagogik, 9, 351-359.

Kuchenbecker, A. (2002). Behandlungsende und Entlassvorbereitung: die Begleitung von Abschied, Trennung und Übergang. In: Kuchenbecker, A. (Hrsg.). Pädagogischpfl egerische Praxis in der Kinder- und Jugendpsychiatrie, Dortmund, 137–153

Steins, G. (2008). Schule trotz Krankheit – Eine Evaluation von Unterricht mit kranken Kindern und Jugend-lichen und Implikationen für die allgemeinbildenden Schulen. Lengerich: Pabst Science Publishers.

Waters, V., Schwartz, D., Gravemeier, R., Grünke, M. (2003). Fritzchen Flunder und Nora Nachtigall. Bern: Huber.

Weber, P. A., Steins, G., Brendgen, A., Haep, A. (2008). Entwicklung weiterführender Maßnahmen. In: Steins Gisela: Schule trotz Krankheit – Eine Evaluation von Unterricht mit kranken Kindern und Jugendlichen und Implikationen für die allgemeinbildenden Schulen (316-353). Lengerich: Pabst Science Publishers.

Wertgen, A. (2009). Auf den Übergang kommt es an! Pädagogisch begleitet Schulrückführung als Angebot der Schule für Kranke für Schüler nach einem Psychiatrieaufenthalt. In: Zeitschrift für Heilpädagogik, 8, 308-319.