CASE REPORT

School refusal in adolescent young man: could this be an idiopathic amotivational syndrome?

Jonathan Ding,[1] Amin Muhammad Gadit,[1] Syed Bakhtiar Peer[2]

[1]Department of Psychiatry, University of Toronto, Mississauga, Ontario, Canada
[2]Department of Psychiatry, Fairview Medical Centre, Mississauga, Ontario, Canada

Correspondence to
Professor Amin Muhammad Gadit, amin.muhammad@med.mun.ca

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SUMMARY

This is the case of a 17-year-old male student who presented to an outpatient clinic with a 3-year episode of increasing anxiety and amotivation related to attending school. Initially affecting only his school work and attendance, the amotivation grew to affect his activities of daily living such as personal hygiene maintenance. There were no discernible psychosocial stressors. The patient did not report any bullying at school or any sort of abuse. At the time of presentation, there were also some depressive symptoms and visual perceptual abnormalities; both appeared subsequent to the amotivation. Escitalopram treated the depressive symptoms and risperidone minimised the perceptual disturbances; methylphenidate was not effective for this patient. The medications did not improve the patient's motivation. At the time of writing, the patient remained in stable state in terms of mood but unable to return to school.

BACKGROUND

School refusal is a heterogenous syndrome. The most common psychiatric comorbidities include depression, dysthymia, adjustment disorder and anxiety disorders such as generalised anxiety disorder, social phobia, specific phobias or panic disorder.[1–4] However, when patients presenting with chronic school refusal do not meet the criteria for major psychiatric disorders, other causes should be considered. Here, we present a case of chronic school refusal, with prominent amotivational characteristics extending to activities of daily living, in addition to depressive symptoms and some perceptual abnormalities. Amotivational syndrome is characterised by symptoms including apathy, impaired concentration and poor performance as a result of deficits in general motivation.[5 6] Initially attributed to chronic cannabis abuse, subsequent cases have highlighted other causes, such as selective serotonin reuptake inhibitors (SSRIs), schizophrenia and traumatic brain injury.[7–9] In our case, the onset appears to be idiopathic, with no discernible psychosocial stressors involved.

We hope that this case will highlight the heterogeneity of school refusal, and help other clinicians recognise the diversity of conditions that may be contributory. We also invite other clinicians to share their experiences in treating such syndromes with us.

CASE PRESENTATION

The patient is a 17-year-old male high school student, who was living with his parents and two siblings at home. He was referred to our outpatient psychiatry clinic by his family physician due to progressive amotivation related to attending school.

At the initial consultation, the patient revealed that his difficulties began 3 years ago, when he was in grade 9. He described being a stellar student in elementary school with many friends and interests; he performed well for about a month in grade 9, however, he became unable to focus on school work over a period of months. The patient would sit in front of his notebooks for hours, but could only get minimal work completed despite intending to be productive. This worsened. About a year after the symptoms initially began (and with declining grades despite a private tutor), the patient returned to school after the summer break, and performed well again for a month. The symptoms began anew, and he began cutting down on social and familial activities in order to dedicate more time to school work; however, he continued to feel unable to bring himself to study, sitting for hours with notebooks open and getting no work completed despite cognitively recognising the need to do so. He would sit in class, wanting to do work, but would be unproductive. He began withdrawing from social interactions, as he lacked the motivation to speak to others. About another year after, the patient's symptoms progressed to a point where he could not bring himself to go to school; the patient also described feeling no motivation to pray, or to maintain his own hygiene such as brushing his teeth and showering.

This patient's presentation was compounded by mood and perceptual abnormalities. At his initial presentation, the patient described a 5-month episode of declining mood, low energy, increased sleep and tearfulness. Furthermore, the patient described seeing a black figure out of the corner of his eye for about a year, whom he believed to be a spirit. There were no tactile or auditory hallucinations. There were no delusions of thought insertion, broadcasting, withdrawal or control.

He denied generalised anxiety and panic attacks. He denied suicidal or homicidal ideas.

For his symptoms, the patient had previously seen a psychologist for counselling, which he found to be unhelpful; a spiritual healer and frequent prayers had helped minimise his visual hallucinations, but did not help the patient with his motivation.

Prior to this episode, the patient had never seen a psychiatrist. He was not on any medications. He denied any major illnesses, hospitalisations or surgeries. He denied alcohol, smoking and recreational drug use.

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Socially, the patient described his family as very supportive. There was minimal parental pressure to perform in school, and there were no significant psychosocial changes that coincided with the onset of symptoms. There were no psychosocial stressors at the time of presentation. The patient did not report any bullying at school or any sort of abuse. He described not having many friends, especially since he had not been able to make himself attend school. He had no issues with the law. He denied a history of abuse as a child.

Although denied by patient, collateral information revealed family history of mental illness, most notably his mother suffered from severe anxiety disorder.

On examination, the patient was casually dressed, in no acute distress, appropriately groomed, and appeared about his stated age. He was cooperative. He maintained good eye contact and did not exhibit bizarre behaviour. He spoke at an appropriate volume and at an appropriate speed. He described low mood. His affect was flat. He endorsed visual hallucinations (as above). Otherwise, his thought contents were logical, coherent and appropriate; there was no poverty of speech or thought. He was insightful and recognised that he had a mental illness, and was seeking help appropriately. His judgement was intact.

INVESTIGATIONS

The complete blood work included complete blood picture, liver function test, thyroid-stimulation hormone test, vitamin B_{12} level which were carried out as routine investigation. The results were normal. The EEG and MRI were normal.

DIFFERENTIAL DIAGNOSIS

- Anxiety disorder—symptoms denied by patient.
- Mood disorder with depressive features—present, but unlikely the causative factor.
- Attention-deficit/hyperactivity disorder—unlikely, given the presentation.
- Psychosis not otherwise specified—possible contributing factor.
- Amotivational syndrome—unrelated to drug abuse most likely diagnosis.

TREATMENT

- Cipralex 10 mg orally every morning, later increased to 15 mg orally every morning.
- Risperidone 2 mg orally every night.
- Methylphenidate 10 mg orally per day— —this was discontinued.

OUTCOME AND FOLLOW-UP

To address the patient's depressive symptoms, we began a treatment with escitalopram 10 mg in the morning. After about a month, the patient's mood had much improved and his depressive symptoms abated. Similarly, treatment with risperidone 2 mg at bedtime helped successfully minimise the patient's visual hallucinations.

To help with the patient's attention, we offered a trial of methylphenidate 10 mg qAM after the initial trial of escitalopram and risperidone; the patient did not find this to be helpful, and methylphenidate was discontinued after 2 weeks.

At the time of writing, the patient remained unable to attend school. The patient had been a challenge both in terms of diagnosis and management.

DISCUSSION

There is extensive literature describing school refusal and its psychiatric comorbidities. However, this patient does not meet the criteria for any of the common psychiatric disorders. Amotivation appears prior to psychiatric symptoms, and indeed is the patient's main symptom. When the patient first presented to the clinic, there were some depressive symptoms and perceptual disturbances, which occurred subsequent to the symptom onset. Furthermore, while antidepressants and antipsychotics helped alleviate these symptoms, the core amotivation remained persistent since its onset 3 years ago.

Many case reports have discussed amotivational syndrome in the context of substance abuse, psychosis, iatrogenic causes and brain injury.[5–9] The patient gave a history of visual hallucinations which were more like vague perceptual experiences rather than true hallucinations. The description by him remains inconclusive and vague. He initially improved by adding risperidone which did indicate the possibility of underlying psychosis. Amotivation could possibly be a residual symptom of psychosis.

The patient remains a challenge to diagnose and manage. Based on history provided by the patient and his family, there are no significant psychosocial stressors that may be contributing to the symptoms; if anything, the family has been providing much support to the patient. The patient was socially and academically well-adjusted prior to symptom onset. The visual hallucinations alleviated by spiritual healing and praying may represent a cultural factor, but would not explain fully the current presentation. Furthermore, the management of the patient remains a dilemma. His symptoms are not related to substance use; the patient reported no improvement despite psychological counselling, SSRIs, neuroleptics and stimulants, and remains impaired in his academic functioning. The authors of this case report welcome suggestions for further management of this patient.

Learning points

- School refusal has a wide differential, including amotivational syndrome.
- It is important to consider psychosocial and organic factors when considering aetiology of school refusal and amotivation.
- Treating amotivational syndrome remains a clinical challenge.

Competing interests None.

Patient consent Obtained.

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