

Original Article

Characteristics and Outcomes of School Refusal in Hiroshima, Japan: Proposals for Network Therapy

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The authors conducted a study on children undergoing treatment at major school refusal treatment centers in Hiroshima Prefecture. On the whole, school refusal in the prefecture was found to peak between 13 and 14 years of age. By age group, the main reason for school refusal in elementary school group was parent-child relationship with separation anxiety. Given additional problems such as neglect at home and complicated social situations in their schools, junior high school students were found to present diverse symptoms from introversion and self-analysis to extroversion, neglect of studies, and delinquency. Among high school students, there were more cases suffering withdrawal and schizophrenia spectrum disorders. The major task regarding treatment seems to lie in how to treat complex cases combining different problems. We summarized herein the studies we have carried out and propose a model for a network therapy system based on functional liaisons between treatment centers. With this system, a child psychiatric medical facility plays the part of a liaison center for the overall network system.

Key words: school refusal, characteristics of different age groups, network therapy, liaisons between treatment centers

School refusal is a serious interdisciplinary problem, intersecting the areas of medical care, welfare, and education. Recently an upward trend in the number of cases each year has been noted. It has been 60 years since school phobia was first reported in the world by Johnson *et al.* [1], and 40 years since Sato first reported a case in Japan [2]. These phobias were characterized as a “neurotic refusal to attend school” (the so-called core school refuser group). Now different forms of school refusal are increasingly being reported. With a

rise in children who refuse to attend school, field reports are being made from various standpoints as stated by King, Berg, and Heyne [3-5].

Most of these reports, however, are based on the clinical views of the authors of the reports, or otherwise reflect the specialties and local characteristics of the medical facilities to which the authors are affiliated. Given diversifying clinical presentations of school refusal, these reports are considered to address only a small fraction of the actual situation of school refusal as stated by Sugiyama, Sato, McShane, and Elliott [6-9].

In the present study, we conducted a survey of children receiving treatment for school refusal at major treatment centers providing counseling regarding school

refusal in Hiroshima Prefecture, and clarified the overall picture of school refusal in the prefecture by separating children into age groups of elementary school, junior high school, and high school.

We also identified the characteristics, roles, and potential for therapeutic cooperation of each type of organization (by field), and proposed herein a network therapy system based on partnerships between organizations indispensable to the treatment of school refusal.

Materials and Methods

We conducted our study of school refusal in Hiroshima Prefecture from the spring to autumn of 1995. Nine organizations were studied: Hiroshima Prefecture Central Child Consultation Center, Hiroshima Prefecture Miyoshi Child Consultation Center, Hiroshima Prefecture Fukuyama Child Consultation Center, Hiroshima City Child Consultation Center, Hiroshima Prefecture Education Center, Hiroshima Prefecture General Mental Health and Welfare Center, Department of Pediatrics of Hiroshima City Hospital, Department of Psychiatry of Hiroshima City Child Guidance and Clinic Center, and Department of Psychiatry of Hiroshima Prefecture Hospital.

The subjects were children visiting the organizations for the first time for the treatment of school refusal in the 3 years between April 1991 and March 1994. Here, school refusal is defined as follows:

1. Absence from school for one week or more. The absence excludes partial absence such as leaving school early, coming late, and partial participation in school through a school-nurse station or counseling room, possibly as part of a recovery from school refusal.

2. The reason for absence is due not appear to be due to external factors such as physical illness, economic reasons, suspension from school, *etc.* A tendency to neglect studies is also considered school refusal.

3. Whether refusal to go to school is actually due to physical illness is determined by a doctor. Here, physical illness includes organic diseases and some functional illnesses; functional illnesses thought to be caused by psychological factors are excluded from a physical illness.

4. Psychiatric illnesses shall be regarded as factors of school refusal if a problem is caused based on schizophrenia spectrum disorder as diagnosed by the psychiatrist.

5. Those cases with developmental disorders as their basic disorder such as attention-deficit hyperactivity dis-

order (ADHD), learning disorders (LD), pervasive developmental disorders (PDD), and mental retardation (MR) were included. Concerning mental retardation those cases with moderate, severe, and very severe levels of retardation were excluded.

6. Only those cases visiting the organizations in person or whose families visited the organizations were included as subjects of the survey, while cases whose teachers only visited the organizations were excluded.

7. For the test of significance we used the χ^2 -test on contingency tables.

To clarify the overall picture of school refusal, the inclusion criteria were made less rigid than the "children on long-term absence from school" as defined by the Ministry of Education, Culture, Sports, Science, and Technology. Children meeting these more rigid criteria were also included.

The survey was composed of a questionnaire sheet, instructions on filling in the questionnaire, and a letter of request to cooperate with the questionnaire. The questions asked were: 1. State of child; 2. Family situation; 3. History of school refusal; 4. History of receiving counseling or treatment for school refusal; 5. Progress of counseling and treatment; 6. Child's condition; 7. Outcome; 8. Factors affecting outcome; and 9. Cooperation with other organizations. The replies were evaluated by the persons in charge of the organizations based on counseling records at the following points: for cases who completed treatment, at the point of completion; for ongoing cases, at the time of the investigation in December 1994.

Results

A total of 1256 children were surveyed: 193 from Hiroshima Prefecture Central Child Consultation Center, 96 from Hiroshima Prefecture General Education Center, 171 from Hiroshima Prefecture Mental Health and Welfare Center, 354 from Hiroshima City Child Guidance and Clinic Center, 241 from Hiroshima City Child Consultation Center, 39 from Hiroshima Prefecture Miyoshi Child Consultation Center, 84 from Hiroshima Prefecture Fukuyama Child Consultation Center, 34 from Hiroshima City Hospital Pediatric Department, and 44 from Hiroshima Prefecture Hospital Psychiatric Department. By age group, there were 357 elementary school children, 663 junior high school students, and 236 high school students. As the organizations surveyed were

diverse, the style and content of their counseling/treatment records also differed. Consequently, the survey was reviewed based on actual count; the total count excluding ambiguous cases was used to compute percentages and distributions for every question.

Overall picture of school refusal in Hiroshima Prefecture. The overall picture of school refusal in Hiroshima Prefecture is as follows:

- 1) There are more boys (57%) than girls; the peak of onset is at 13-14 years of age.
- 2) Eighty-six percent of the children are from a 2-parent home, and, of these, 15% have siblings with the same problem.
- 3) Forty-four percent have a history of school refusal, and 50% of these children have received treatment within 3 months of onset.
- 4) In the first visit, human relationship was examined psychophysiologically. Thirty percent were found to be withdrawn with a tendency to show strong emotional attachment to their mothers, and activities limited to their homes and vicinity; 49% belonged to the one-on-one relation group, not showing withdrawal symptoms in terms of human relationships and being capable of one-on-one relationships, but not able to express themselves in a group; and 21% were capable of participating in group activities group and able to express themselves in a group. Concerning the correlation between age group (elementary school, junior high school, and high school) and human relationships in the first visit (withdrawn, one-on-one relations, and group-relations), the results of the test were statically significant ($P < 0.01$) (Fig. 1).

- 5) Complications were found in 52% of the children. Six percent had accompanying complications of delinquency and criminal behavior (theft, property destruction), 9% manifested problematic behavior at home (domestic violence, running away from home, wandering at night), 26% showed accompanying physical symptoms (headache, stomachache, pollakisuria, fever), and 21% showed accompanying psychiatric symptoms (sleep disorder/reversal of day and night, refusal of food/bulimia, fear of emitting body odor, fear of eye-to-eye confrontation, excessive nervousness in presence of others, mysophobia, obsessive-compulsive syndrome, dysmorpophobia, hallucination/delusion, apathy, mutism). As for each complication (delinquency, problem at home, physical symptom, and psychiatric symptom), we checked the correlation between age group (elementary school, junior high school, and high school) and compli-

cations (any one or none). As for problems at home, physical symptoms, and psychiatric symptoms, the results of the test were statically significant ($P < 0.01$), whereas for delinquency the results were statistically nonsignificant (Fig. 2).

- 6) Regarding outcome, 48% completed or were continuing treatment with good progress, 22% discontinued treatment, and 30% discontinued treatment because no improvement was achieved or counseling was on a short-term basis, or due to other external factors. Concerning the correlation between age group (elementary school, junior high school, and high school) and outcome (completed with good progress, continuing with good progress, suspended, and discontinued), the results of the test were statically significant ($P < 0.01$) (Fig. 3). Here, good progress means that: i) the child started to attend school again; ii) the child showed psychological growth and development, though was not yet able to

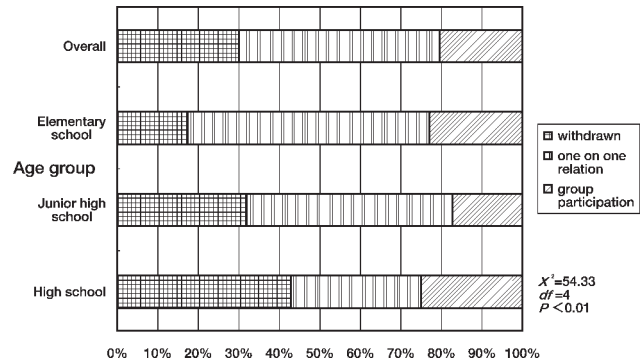


Fig. 1 Human relationship in the first vist

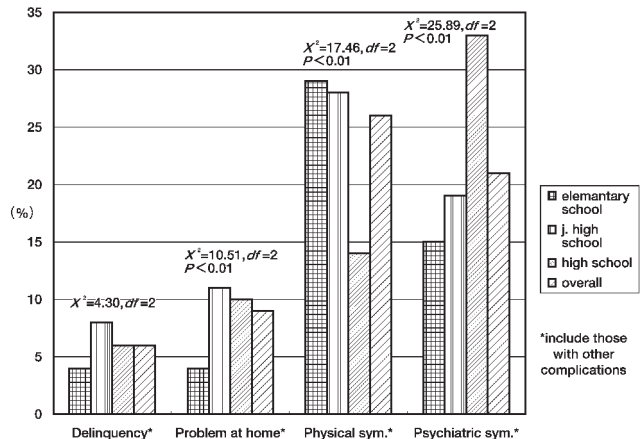


Fig. 2 Complications

attend school, iii) psychological changes and growth of family members were seen, though the child was not yet able to attend school; and iv) the child was able to pursue further education to find a job. Whether a child had completed or was to continue treatment was determined at the time of the survey in December 1994. "Discontinue" means discontinuation of treatment without confirming that treatment had been completed, and "suspended treatment" means discontinuation of treatment due to external factors such as relocation, and exceeding the age limit, *etc.*

7) Therapeutic cooperation between treatment centers was found in 227 persons (18%). In assessing 875 persons, the excluding the "suspended treatment" group, regarding the relation between outcome and therapeutic cooperation, 74% of those cases with cooperation completed or were continuing treatment with good progress. On the other hand, 68% of those cases without cooperation complete or were continuing treatment with good progress. The results of the statistical test showed this differences to be nonsignificant.

School refusal by age group. The above overall picture was classified by age group, and school refusal for the elementary school, junior high school, and high school groups was found to be as follows:

Elementary school Fifty-four percent of elementary school subjects in this survey were boys. Forty-eight percent had a past history of refusing to go to school from an early age. In the first visit, there were only a few categorized into the withdrawn group (18%) (Fig. 1). Ten-percent fewer showed complications of other problems than the junior high school and high school students. The primary complications were found to be physical

symptoms (headache, stomachache, fever, pollakisuria) (29%) (Fig. 2).

Regarding family background, most came from homes with both parents present (90%), and the percentage of working mothers was low (50%). Compared to junior high school and high school students, a concerning issue among many of the elementary school students was a tendency toward anxiety based on how they were being raised by their parents (17%). Most of the children showed good outcomes (59%) (Fig. 3).

Junior high school Fifty-eight percent were boys, and 46% had a history of refusing to go to school, which was approximately the same level as elementary school children. In the first examination, there were more withdrawn students than in the elementary school group (Fig. 1). The rate of complications was also higher than for the elementary school children. These complications consisted chiefly of physical symptoms such as headache, stomachache, fever, pollakisuria, *etc.* (28%), and more manifested themselves as external problems such as delinquency, illegal acts (8%), and domestic problems such as domestic violence (11%) (Fig. 2).

Regarding family background, fewer came from 2-parent homes compared to elementary school children (82%), and many more mothers were working (59%). Regarding how the parents were raising their children, more parents were neglecting their parental duties compared to elementary school children (19%).

At school, there were more complications such as bullying, *etc.* than for elementary school children (35%). There were also fewer cases with good outcomes (Fig. 3).

High school Fifty-nine percent were boys, and 31% had a past history of school refusal. Compared to elementary and junior high school children, many in this age group had their first onset at this age. In the first examination, there were more withdrawn students than in the elementary and junior high school groups (43%) (Fig. 1). There were fewer complications involving physical symptoms such as headache, stomachache, fever, pollakisuria, *etc.* (14%), and more psychotic symptoms such as sleep disorder, eating disorders, various neuropsychological symptoms, hallucinations and delusions, apathy, mutism, *etc.* (33%) (Fig. 2).

Regarding family background, the efforts made by parents to raise their children were less influential than for elementary and junior high school students. Cases with good outcomes were fewer than for junior high school students (Fig. 3).

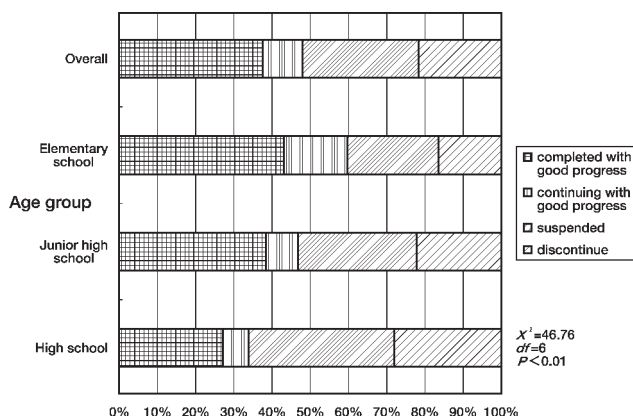


Fig. 3 Outcome

Overall picture of school refusal at treatment centers. To determine the characteristics of school refusal according to the organization, children with a problem in receiving treatment at various types of organizations in Hiroshima Prefecture were compared. Organizations were divided into welfare organizations (Hiroshima Prefecture Central Child Consultation Center, Hiroshima Prefecture Miyoshi Child Consultation Center, Hiroshima Prefecture Fukuyama Child Consultation Center, Hiroshima City Child Consultation Center), educational organizations (Hiroshima Prefecture Education Center), health and sanitation organizations (Hiroshima Prefecture General Mental Health and Welfare Center), and medical facilities. Medical facilities were further divided into pediatrics (Hiroshima City Hospital Pediatric Department), child psychiatry (Hiroshima City Child Guidance and Clinic Center Psychiatric Department), and general psychiatry (Hiroshima Prefecture Hospital Psychiatric Department).

Welfare organizations Junior high school students, who made up 61% formed the core group. In the first examination, their human relationships were categorized as either "withdrawn" or "capable of group-participation." The rate of complications was lower than for other organizations, but delinquency and illegal acts were found in 7% of students. The percentage of single-parent families was high (18%), as was the tendency for custodial care of the children.

Educational organizations The percentage of elementary school children was higher than for the other organizations at 41%. While the percentage of children seeking early treatment within 3 months from onset was high (61%), only a few of them had a history of school refusal (31%).

Health and sanitation organizations Most of the children who visited this type of organization were high school students, who constituted 63% of all students. The percentage of children with a history of school refusal or who had received treatment in the past was low, around 30%. In addition, many of the children were included in the "withdrawn" group (57%). The percentage of children who came for counseling alone was 12%, which was very low considering that a large number of them were high school students.

Medical organizations (Pediatric) Age at first examination was evenly distributed from 8-15 years. The percentage with complications was 97%, and 83% had physical symptoms. Many came with their parents.

Medical organizations (Child psychiatric) Junior high school students formed the core group. The percentage with a history of school refusal (39%) and with a history of receiving treatment in the past (50%) was higher than for general psychiatric departments. Twenty percent of the children made their first visits more than 1 year after onset, and on the whole more children made their first visits after a relatively long period of time after onset than children visiting other organizations for treatment.

Medical organizations (General psychiatric) Fifty-five percent were junior high school students, and 36% were high school students. Forty-one percent had a history of school refusal, and 63% had a history of receiving treatment in the past. Most children had received their first examinations early, within 3 months of onset (59%). Thirty percent came alone, which was a greater percentage than for other organizations.

Therapeutic cooperation between treatment centers.

Therapeutic cooperation with other organizations On the whole, 18% of the treatment centers were collaborating with other organizations in therapeutic cooperation in Hiroshima Prefecture. According to the type of organization, a high percentage of child psychiatric medical facilities participated in therapeutic cooperation (32%), while organizations having a low participation percentage included welfare organizations, educational organizations, health and sanitation organizations, and general psychiatric medical facilities.

Reasons for collaborating amongst those implementing therapeutic cooperation (227 persons) On the whole in Hiroshima Prefecture, the top reasons were "treatment options/specialty conditions" (65%), followed by "geographical conditions" (20%). Each organization showed a similar tendency in the prefecture.

Type of collaboration amongst those implementing therapeutic cooperation (227 persons) The 2 types of collaboration implemented were "simultaneous treatment at 2 or more facilities," "referral from other organizations for treatment," and "referral to other organizations for treatment," each constituting 1/3 of the whole. Though each organization had individual characteristics, "simultaneous treatment at 2 or more facilities" was more common at welfare organizations and health and sanitation organizations, "referral to other organizations for treatment" was the most common at educational organizations, and pediatric medical facilities, general psychiatric medical

facilities, and “referral from other organizations for treatment” were the most common at child psychiatric medical facilities.

Discussion

Changes in studies of school refusal in Japan, and its significance. The first study of school refusal in Japan was reported by Sato in 1959. In 1992, Kiyohara reported the history of studies of school refusal in the country, which was divided into four stages according to how psychologists, psychiatrists, and other clinical experts understood the psychological mechanisms of school refusal [10]. Specifically, Stage 1 originated from the latter half of 1950 and was predominantly focused on the theory of separation anxiety. Stage 2 began in 1960 and was characterized by criticism of the theory of separation anxiety, and proposal of the theory that neurosis plays a core role in school refusal. Stage 3 started in 1980, again criticizing its predecessor and concentrating on the theory that school pathology plays a core role. Stage 4 commenced in 1990, by shifting from the notion of school pathology to the currently accepted school refusal theory of privatization and a waning of society’s enthusiasm in leading children to school. This transition explains the changes in how school refusal is perceived and understood: individual pathology followed by family, school, and finally social pathology.

Looking at this change comprehensively, it was believed in Stages 1 to 3 that school is primarily a place that children must attend, and thus the problem lies either in the family (including the child who refuses to attend school), or in the school, or both.

However, as Takigawa pointed out in 1994, in Stage 4 the common assumption that “the school is a place that children must go” began to lose substance, as did the gradual waning of society’s enthusiasm in leading children from family to school [11]. Morita pointed out the growing tendency of children to maintain some distance in relations with people and organizations, and to secure privacy for themselves [12]. There is a large group of latent students refusing to go to school, and the problem can occur in anyone if the trigger presents itself. Therefore, the “modern-day school refusal” of Stage 4 also includes non-conflict, indifferent school refusal, where no significance is placed on the school, yet there is simultaneously a lack of other kinds of enthusiastic appeals and actions.

Qualitative changes in school refusal according to age. Going to school consists of 2 steps. The first is to leave mothers whom children depend on or home where children feel comfortable. The second step is to attend groups in schools, which they must join. Elementary school children are stumbling at the first step, and junior high school children at the second step.

Therefore most elementary school children refusing to go to school demonstrate separation anxiety as the central psychological mechanism and show conflict-induced physical symptoms, as Bernstein has pointed out [13]. As for junior high school, children show less conflict-induced physical symptoms and show more extrovert problems such as delinquency, criminal acts, domestic violence *etc.*, and therefore they require inpatient treatment, as Borchardt has pointed out [14].

On the other hand, most high school students exhibiting school refusal feel less reluctance toward school because they are given the choice to decide whether or not to attend. Therefore, the central psychological mechanism of school refusal in this age group is failing to achieve mental development tasks (characteristic of puberty) such as independence from parents and the development of self-identity, and their interest instead turns inward, leading to psychotic symptoms.

Considering such changes in symptoms with age group and the phenomenon of more first-episode school refusal in high school in high school age group than elementary and junior high school children (less history of school refusal), a qualitative inconsistency seems to exist between school refusal in junior high school and in high school students.

Challenges in present treatment of school refusal. Most of the treatments for school refusal today are carried out by current treatment facilities without referral to or cooperation with other specialty institutions. In addition, treatments do not differ significantly by organization, and treatment is provided primarily for easy cases. Accordingly, the percentage of cases with good outcomes have been restricted to 48% through Hiroshima Prefecture. The following are challenges in the treatment of untreated cases.

Inadequacies in treatment for school-phobic children with developmental disorder as their basic disorder Children with developmental disorders as their basic disorder such as attention-deficit hyperactivity disorder (ADHD), learning disorders (LD), pervasive developmental disorders (PDD), and mental retardation (MR) are

difficult to treat in just one treatment facility. These children require long-term multiple therapies combining medications for emotional stability, counseling to support the child and family, treatment and training for basic disorders, provision of a site for special education, *etc.*

Inadequacies in treatment for school-phobic children with tendencies to neglect studies There are few organizations that can approach delinquent children, a problem common in the junior high school age group, and that can deal with children who tend to neglect their studies. In particular, most organizations are unable to deal with cases for which there has been a long period since onset, and that require secondary treatment such as legal treatment due to aggravation of the problem.

High school students who carry over school refusal problems into adulthood Of all the types of counseling and treatment facilities, high school students refusing to go to school are mostly treated at locations having psychiatric departments. Students refusing school receive treatment tailored to their age group. In Hiroshima Prefecture, only 80 (34%) out of 236 students receiving treatment showed good outcomes (Fig. 3), though all were close to becoming adults. Evaluating the interpersonal relations at the final point of treatment showed that a 33% in this age group had withdrawal symptoms. With respect to this finding, Kado studied 24 follow-up survey reports, concluding that, with regard to social adaptability, 7–12% had poor outcomes when students reached adulthood after long-term treatment (9 years or more) [15]. In the follow up by the Ministry of Education, Culture, Sports, Science, and Technology, the social inadaptability of third-year junior high school students 5 years later was 23% [16]. These figures are considered to serve as references for what percentage of children refusing to go to school will suffer social withdrawal in adulthood. Flankierska has also followed up for a period of 20–29 years children refusing to go to schools, pointing out the existence of a withdrawal group with poor long-term prognosis [17]. On the other hand, Saito has stated that 90% of adults suffering social withdrawal have a past history of school refusal [18].

In addition, 33% of senior high school students have the complication of psychiatric symptoms, clearly a greater number than the 15% of elementary school children and the 19% of junior high school children (Fig. 2).

Measures for challenges To resolve these problems, existing treatment centers and treatment facilities

having little involvement in supporting children regarding the issue of school refusal should work together to provide treatment, as proposed in the following, while developing new functions of their own.

Children exhibiting school refusal with “developmental disorders as the basic disorder” should be handled by educational organizations. Educational organizations should specialize in supporting learning and focus on providing support to these children with developmental disorders as complications using special educational methodologies adopted in schools for the disabled.

Children exhibiting school refusal with “tendencies to neglect studies” should be handled by institutions to support child independence (formerly reformatory schools). This group of children has an undeveloped or weak sense of self, and therefore finds it difficult to develop stable interpersonal relations, resulting in problematic behavior. Treatment at institutions to support child independence providing solid therapeutic programs should be effective.

Children exhibiting school refusal in the senior high school group often manifest developmental problems related to independence and chronic withdrawal symptoms, which makes outpatient treatment difficult. These children require visits and house calls to their home where they have become withdrawn, followed by daycare functions that allow them to participate in moderate group activities. Such functions are available at health centers and psychiatric hospitals, which have until recently had little involvement in the treatment of school refusal.

Proposal of “medical involvement” for school refusal. *Proposal of treatment program/treatment principle models for various types of treatment sites* Treatment for school refusal concerns not only the removal of symptoms, but also the improvement of a child’s abilities to establish interpersonal relations as well as to live independently, of environments in which too much care and protection is given to the child, and of complicated situations at school, as well as other types of improvement such as changing the teacher in charge, enhancing academic skills, *etc.* Addressing the issue of school refusal requires multiple therapeutic intervention for a problem that is growing increasingly common. Counseling and treatment are currently being provided by numerous organizations, as described in this paper. A detailed review of the nature of the treatment provided, however, indicates that some therapists don’t understand the treatment by subjects, such as regarding Schizophre-

nia as withdrawal. Additionally most treatment centers implement therapies arbitrarily after their own styles, without actually reviewing the applications and contraindications of therapeutic methods such as the treatment of children exhibiting school refusal with Autism by supporting psychotherapy only. The current situation therefore calls for the universalization of therapeutic systems and principles established in the medical scene as a therapeutic model for these diverse organizations.

Cooperation between child psychiatry medical organizations Treatment for school refusal is being carried out in the same way by treatment centers lacking specialization in a particular function or role assignment, making it difficult for them to deal with diverse forms and stages of school refusal. This situation calls for the need for organizations to promote functional specialization and role assignment between themselves, and a shift to mutually complementary cooperative treatment based on this specialization. For treatment centers, functional specialization means that not all functions should be accommodated, and that deeper expertise should be developed in a particular area. Possible function range from diagnostic functions (psychotherapy, complications), therapeutic functions in the narrow sense of the word (removal of symptoms and child development, re-establishment of family ties, improvement of school environment), after-care functions (prevention of recurrence, support in learning, support in independence). Role assignment means that duplications or omissions in individual support as a result of functional specialization should be eliminated, and that the importance of coordinators in coordinating individual support should be recognized.

Moreover, it is essential for treatment centers that have not been involved in treatment for school refusal to join the general treatment system, to resolve related problems such as developmental disorder complications, tendencies to neglect studies, a growing number of high school students who refuse to go to school, and treatment focusing on child development. Models are proposed below.

a. *Establishment of cooperative child psychiatry medical organizations* (Fig. 4).

Child psychiatry medical organizations with multiple therapeutic functions in the areas of medicine, education, and welfare will be installed as liaison centers for therapy. These organizations will play the same role as a general hospital in cooperation system consisted by hospitals and private clinics of medical models. The roles of other

organizations will be determined in the overall treatment system for school refusal that comprises of 2 axes: (i) direction of complications (self-introversion and extroversion) and (ii) progress regarding school refusal. Axis (i) is concerned with whether the complication is an inward-looking problem (physical symptoms, psychological symptoms, withdrawal), or an outward-looking problem (learning disorders, hyperkinesis, acting out), while Axis (ii) concerns the stage of school refusal as seen from the onset, whether acute, chronic, multiple (aggravation stage as a result of chronic situation). Other organizations can then focus on therapeutic functions and promote specialization of these functions, as well as playing a more important role in the treatment system. And to promote cooperative treatment these organizations shall build complementary cooperative partnerships with the child

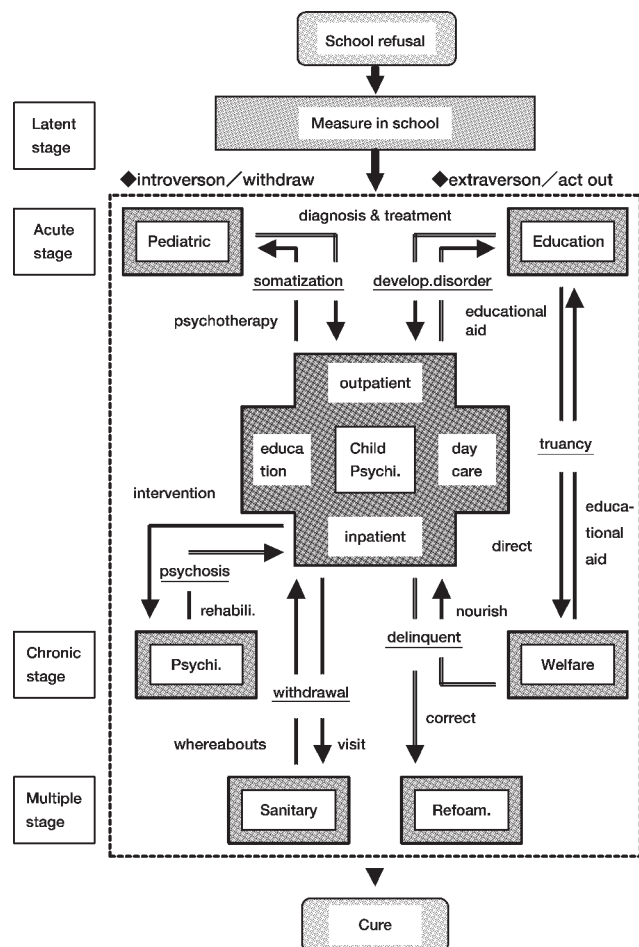


Fig. 4 Progress of school refusal and network therapy system

psychiatry medical organization (liaison center), which has multiple therapeutic functions.

b. Need for network therapy.

The need for network therapy has been pointed out by Tanaka for ADHD [19], Hasegawa for withdrawal [20], and Saito for behavioral disorders [21]. This need is a theme that encompasses all psychiatric illnesses in later childhood. It is therefore important for school refusal treatment to shift from treatment provided by only one treatment center without referral to or cooperation with other specialty institutions in their own style that focuses on eliminating symptoms rather than an attention to child development, to network treatment based on mutual cooperation between treatment centers. Based on this concept, advanced treatment models leading other areas such as ADHD, withdrawal, and behavioral disorders will be proposed in the future, and network treatment is expected to become a universal method of treatment for psychiatric illnesses in childhood.

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