

Adolescents and their parent's perspectives on multifamily treatment for school refusal

Paul Wischmeyer*

INTRODUCTION

Regularly refusing to go to school or having trouble staying in school are both considered school refusal. There are many different reasons why kids can avoid going to school to deal with stress or fear. School refusal is seen as a symptom and may be linked to a number of disorders, including adjustment disorder, social anxiety disorder, generalized anxiety disorder, specific phobias, severe depression, oppositional defiant disorder and post-traumatic stress disorder. The reasons of school rejection, as well as its assessment and management choices, are covered in this exercise. In addressing school refusal, this practice demonstrates the function of inter professional team members.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not list school rejection as a mental disorder. It is defined as a symptom that can be linked to a number of different illnesses, such as adjustment disorder, severe depression, oppositional defiant disorder, post-traumatic stress disorder, social anxiety disorder, generalized anxiety disorder and particular phobia. School refusal is a condition in which a youngster frequently refuses to attend school or struggles to remain enrolled. There are many different reasons why kids can avoid going to school to deal with stress or fear. Treatment options for this condition include medication, parent teacher interventions, educational support counseling and cognitive behavior therapy. The parents and child's psychoeducational support may also be taken into account by the providers. It's crucial to monitor drugs and send patients for consultation with more rigorous psychotherapy.

DESCRIPTION

School refusal is a current, global public health problem. It has become more prevalent in recent years and accounts for 5% of psychiatric visits in preadolescence and adolescent in France. School refusal is unique from other types of School Attendance Problems (SAP), such as truancy, school withdrawal and school exclusion, and was first referred to as "school phobia". Reasons and motivations for skipping school are vary in truancy (positives rewards).

There is no anxiety, and parents are typically not informed of absences. Young people are reluctant to attend school. Finally, behavioral problem and oppositional defiance disorder are more frequently linked to truancy as well as expulsion from school. Berg's consensus based international definition of school refusal is based on the following four criteria. In addition to emotional distress that is temporary and indicative of aversion to attendance (excessive fearfulness, temper tantrums, unhappiness, unexplained physical symptoms, etc.) or emotional distress that is chronic and impeding attendance (depressive affect; sleep issues, for example), the

young person is reluctant or refuses to go to school. Absence is the most common but not always present manifestation of these symptoms (e.g., late arrivals; missing whole school days; missing consecutive weeks, months, or years).

Since they are at home and their parents are aware of it, the young person does not try to disguise the absence from their parents, and if they had previously done so, they stopped once the absence was detected. Beyond refusing to accompany their parents when they try to enroll them in school, the young child does not exhibit serious antisocial behavior. The parents have made reasonable steps to ensure attendance at school, recently or in the past, and/or they have stated their goal for their kid to attend school full time. To evaluate school rejection, it's critical to consider if parents have made reasonable efforts.

The underlying social and educational concerns at play are not addressed by either the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) or the ICD-10 (International Classification of Diseases).

First grade classrooms and adolescence were the two main age groups where school rejection was most prevalent. Adolescents appear to have a higher prevalence than children. There is no gender, socioeconomic, or intellectual difference in prevalence. Somatic complaints account for half of all school refusals (headaches, abdominal pains, nausea, sleeping disorders).

Refusal to attend school has various co morbidities. Anxiety and depression disorders affect 50 percent of patients. Poor academic performance (31%), negative effects on peer relationships (34%), family problems (43%), school leaving (25%) alienation from peers, dangerous behaviors (addiction) and suicide attempts are among the short term effects. Anxiety, depression and personality disorders are still present in 30% to 50% of these adolescents as adults. They have fewer children, spend more on psychiatric care, spend more time at their parents' and experience more professional failure. As a result, according to some authors, returning to school is merely one predictive factor among others when considering a person's capacity for general adaptation.

CONCLUSION

As a result, school refusal is a serious problem that requires immediate attention. The prognosis depends on how much school the child misses, and early intervention is necessary. The return to school is the first goal. Adolescents may benefit from outpatient care, a day hospital, or a full hospital stay depending on the severity of their school refusal. The care is interdisciplinary. The suggestion of individual psychotherapy is made frequently; Cognitive Behavioral Therapy (CBT) has produced effective results. Anxiolytics or antidepressants are suggested as medication when necessary. Working with schools and families is also crucial.

Department of Neuroscience, University of Glasgow, Glasgow, Scotland, UK

Correspondence: Paul Wischmeyer, Department of Neuroscience, University of Glasgow, Glasgow, Scotland, UK; E-mail: Wischmeyerpaul@gmail.com

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