SAS Journal of Medicine
Abbreviated Key Title: SAS J Med
ISSN 2454-5112
Journal homepage: https://saspublishers.com

OPEN ACCESS

Medicine

Anxiety-Based School Refusal in Children and Adolescents: A Literature Review

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DOI: https://doi.org/10.36347/sasjm.2026.v12i09.027 | **Received:** 25.07.2026 | **Accepted:** 21.09.2026 | **Published:** 26.09.2026

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Abstract **Review Article**

Anxiety-based school refusal is a heterogeneous clinical phenomenon in children and adolescents, characterized by significant distress associated with school attendance and frequently associated with anxiety disorders, though not reducible to a single diagnostic entity. This narrative literature review synthesizes evidence from a corpus of 27 articles spanning systematic and scoping reviews, a community-based epidemiological study, clinical quantitative studies, psychometric studies, retrospective follow-up studies, and conceptual reviews, examining conceptualization, epidemiology and clinical profiles, associated factors, assessment, management, and prognosis. Conceptually, school refusal is distinguished from truancy, school withdrawal, and school exclusion, and is understood through a four-function behavioral model describing the mechanisms that maintain avoidance. Epidemiological data from a large community study indicate a 3-month prevalence of 2.0% for pure anxious school refusal, with substantial psychiatric comorbidity, particularly separation anxiety disorder and depression. School refusal is also more frequent among children with autism spectrum disorder, though the corpus does not permit estimating the prevalence of neurodevelopmental conditions among all young people with school refusal. Associated factors span individual anxiety and learning needs, parental psychopathology and family functioning, school climate, and peer victimization, largely derived from cross-sectional studies. Functional assessment is supported as clinically useful, while standardized instruments such as the SRAS-R require cautious interpretation in autism spectrum disorder. Regarding management, cognitive-behavioral and psychosocial interventions show the strongest, though tentative, support for improving school attendance, with less consistent effects on anxiety symptoms; pharmacological and digital interventions remain limited by small, dated, or preliminary evidence. Long-term outcomes are heterogeneous, ranging from favorable adjustment to persistent psychiatric difficulties, and should not be generalized from small samples. Overall, the reviewed evidence supports an individualized, function-based approach to assessment and management, while highlighting substantial methodological limitations predominantly cross-sectional designs, small samples, and heterogeneous geographic contexts that constrain firm causal or generalizable conclusions.

Keywords: school refusal; anxiety disorders; child and adolescent psychiatry; school attendance problems; autism spectrum disorder; cognitive-behavioral therapy.

1. INTRODUCTION

School refusal refers to a significant and persistent difficulty attending or remaining at school, associated with emotional distress, without concealment of the absence from parents and without prominent antisocial behavior [5,8]. It is not recognized as an independent diagnostic category in DSM-5, but rather represents a heterogeneous clinical phenomenon that can occur across several psychiatric and developmental conditions. Anxiety separation-related, social, generalized, or specifically tied to school situations constitutes its most frequently reported dimension, without on its own accounting for the full clinical picture [3,7,18,23].

The clinical relevance of this topic in child and adolescent psychiatry lies in the diversity of presentations and of the individual, family, school, and social factors associated with it, as well as in the potential consequences of prolonged school refusal for a child's development. Assessment and management raise specific challenges, notably because an outwardly similar pattern of absenteeism may reflect very different underlying mechanisms from one young person to another.

This review aims to synthesize the available evidence on anxiety-based school refusal in children and adolescents, drawing on a corpus of 27 articles, addressing in turn its conceptualization, epidemiology and clinical characteristics, associated factors, assessment, management, and prognosis and prevention.

2. METHODS

2.1 Search strategy

This synthesis is based on a corpus of 27 articles selected for their relevance to anxiety-based school refusal in children and adolescents. The databases, search terms, search period, and date of last search used to assemble this corpus are not systematically documented and cannot therefore be reported here. This review does not claim to reproduce a systematic search in the strict sense (e.g., PRISMA-based); it should instead be understood as a structured narrative synthesis of a defined set of articles.

2.2 Selection criteria

The inclusion and exclusion criteria applied when the corpus was initially assembled are not documented beyond the general criterion of thematic relevance to anxiety-based school refusal in children and adolescents. No formal criteria regarding precise age range, language, publication period, or study design were established; the corpus accordingly includes systematic reviews, scoping reviews, community-based studies, clinical studies, psychometric studies, retrospective studies, longitudinal studies, and non-empirical conceptual articles.

2.3 Data extraction and synthesis

For each of the 27 articles, relevant information (objectives, population, methodology, main findings, limitations) was extracted and organized around several thematic axes: definition and conceptualization; epidemiology; clinical profiles and comorbidities; individual, family, school, and environmental factors; assessment; interventions; and prognosis and prevention. The synthesis presented here is narrative and thematic; it does not include any meta-analysis conducted by the authors of this review the effect sizes reported originate from meta-analyses already published in the source articles.

2.4 Quality appraisal and methodological limitations

The corpus brings together heterogeneous levels of evidence: systematic reviews and scoping reviews [1,2,6,8,12,21,22,23,27]; one large community-based study [18]; cross-sectional clinical studies of varying sample sizes [3,7,9,10,11,19,20,25]; retrospective long-term follow-up studies with small samples [4,16,24]; psychometric studies [9,10,20]; and one non-empirical clinical commentary [5]. No formal risk-of-bias assessment using a standardized tool was conducted by the authors of this review; appraisal of evidence quality relies on the assessments reported within the source articles themselves, where available.

Several cross-cutting limitations of the corpus should be noted: a large majority of the available studies rely on cross-sectional designs, which limits inference about the direction of associations; some samples, particularly in long-term follow-up studies, are very small; definitions and measurement instruments for school refusal vary considerably across studies; the geographic and cultural context of the studies is heterogeneous (notably North America, Europe, Chile, and Japan), which limits the generalizability of some findings; and the literature on pharmacological treatment of school refusal remains dated and based on small trials.

3. Definitions and Conceptualization

3.1 From “school phobia” to school refusal

The term “school phobia,” originally used to describe absenteeism associated with marked fear of school, was progressively judged too narrow: the emotional difficulties associated with school nonattendance can include anxiety but also depressive symptoms, sleep difficulties, or broader social difficulties. The term school refusal is now preferred [5,8]. According to Berg's classical definition, school refusal is characterized by marked emotional distress at the prospect of attending school, parental awareness of the child's absence, the absence of severe antisocial behavior beyond possible resistance to parental attempts at enforcing attendance, and reasonable parental efforts to secure attendance [5].

Anxiety disorders are frequently reported among young people with school refusal in clinical samples, although the specific diagnostic distribution varies across studies. In one clinical sample, separation anxiety disorder (22.5%), generalized anxiety disorder (12.6%), and social anxiety disorder (12.7%) were among the most common diagnoses, alongside a substantial proportion of young people (24.3%) meeting no diagnostic criteria at all [7]. A comparable clinical sample similarly found separation anxiety disorder (22.4%) and generalized anxiety disorder (10.5%) to be the most frequent diagnoses, with 32.9% of participants meeting no diagnosis [25]. These findings indicate that anxiety disorders are common among young people with school refusal but do not affect all of them, and do not support equating school refusal with a single diagnostic entity.

3.2 Distinction from truancy, school withdrawal, and school exclusion

Distinguishing school refusal from other forms of nonattendance is clinically useful, as superficially similar patterns of absenteeism may reflect substantially different underlying mechanisms. Heyne *et al.,*proposed differentiating four types of school attendance problems: school refusal itself (emotional distress not concealed from parents), truancy (unauthorized absence, generally

concealed from parents and associated with behavioral difficulties), school withdrawal (absence actively organized by parents for family- or education-related reasons), and school exclusion (absence resulting from a decision made by the school) [8]. This distinction is not absolute, however: mixed presentations combining school refusal and truancy-like behavior are reported in the literature and appear to be associated with a more severe clinical profile [18].

3.3 Kearney's functional model

The functional model developed by Kearney proposes understanding school refusal not merely through its clinical form but through the function that school avoidance serves for the child. Four principal functions are described: avoidance of school-related stimuli that provoke negative affect; escape from social or evaluative situations perceived as threatening; pursuit of attention from or proximity to parental figures; and access to tangible reinforcement outside school [7,9,10]. The four-function structure has been supported by confirmatory factor analysis, including in a Chilean adolescent sample [10,20], and has been shown to predict the severity of absenteeism more robustly than dimensional measures of clinical form (anxiety, depression) considered in isolation [7]. Specific diagnosis-function associations have also been identified: separation anxiety disorder is particularly associated with the attention-seeking function, whereas oppositional defiant disorder and conduct disorder are more strongly associated with the tangible-reinforcement function [25].

This model also proposes a mechanism by which school refusal behavior is maintained: anticipation or experience of school-related distress leads to avoidance, which produces immediate relief, thereby negatively reinforcing the likelihood of further avoidance in similar situations. This avoidance–relief–reinforcement cycle provides a behavioral explanation for the persistence of school refusal once avoidance has been established.

4. Epidemiology and Clinical Profiles

4.1 Prevalence and demographic characteristics

In the reference community study by Egger, Costello, and Angold, drawn from the Great Smoky Mountains Study, the 3-month prevalence of pure anxious school refusal was 2.0%, that of pure truancy was 6.2%, and that of mixed presentations was 0.5% [18]. Sex distribution differs by presentation: pure anxious school refusal affects girls and boys at near-equal rates (52.1% vs. 47.9%), whereas pure truancy is significantly more frequent among boys [18]. Pure anxious school refusal is also significantly more common among younger children, whereas pure truancy is more prevalent among older children [18]. These findings, derived from a large North American community sample, should not be directly extrapolated to other geographic or cultural contexts.

4.2 Clinical presentation and somatic symptoms

In the community study by Egger et al., somatic complaints were reported in approximately one quarter of children with pure anxious school refusal and in 42% of those with a mixed presentation, but were rare among children with pure truancy [18]. This distribution suggests that somatic symptoms are more closely tied to the anxious dimension of school nonattendance than to truancy-related absenteeism, though the corpus does not provide data on their diagnostic or predictive value in clinical settings beyond this community sample.

4.3 Psychiatric comorbidity

In the study by Egger et al., approximately one quarter of children with pure anxious school refusal or pure truancy had at least one psychiatric disorder, compared with 6.8% of children without school attendance problems; this proportion rose to nearly 90% among children with a mixed presentation [18]. After statistical adjustment for comorbidity, only separation anxiety disorder and depression remained significantly associated with pure anxious school refusal, with the apparent associations with social phobia and specific phobia being largely explained by comorbid depression [18]. This finding argues against conceptualizing anxious school refusal as a simple manifestation of an isolated anxiety disorder.

4.4 Neurodevelopmental characteristics, notably ASD and ADHD

School refusal has also been examined in relation to autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD), although the available evidence differs considerably depending on the specific question addressed.

A Norwegian study reported school refusal in 42.6% of children with ASD, compared with 7.1% of neurotypical children [21]. In a Japanese case-control study of children already presenting with school refusal, age at onset was significantly earlier among those with ASD than among those without (12.6 vs. 13.8 years) [19].

Regarding bullying-related school refusal specifically, a study comparing children with ASD, ADHD, combined ASD+ADHD, other diagnoses, and no diagnosis found that parent-reported lifetime bullying-related school refusal was most frequent among children with combined ASD+ADHD (68%), followed by children with ASD alone (28%), and least frequent among children without a diagnosis (18%); after accounting for co-occurring behavioral difficulties, diagnosis itself no longer predicted the frequency of bullying-related school refusal, and ASD alone did not predict a higher frequency than having no diagnosis [11]. In the Japanese case-control study, bullying was associated with school refusal among boys with ASD specifically, whereas maladjustment to school transitions

was more strongly associated among girls with ASD [19].

The corpus does not include data allowing an estimate of the prevalence of ASD or ADHD among the broader population of young people presenting with school refusal; the available studies instead document the frequency and correlates of school refusal within samples already diagnosed with these conditions. No comparative prevalence data specific to ADHD, independent of ASD, were identified in the corpus.

5. Associated Factors and the Ecological Model

A systematic review organized according to Bronfenbrenner's ecological model identified 44 individual, social, and contextual factors that significantly differentiated young people with school refusal from their peers, drawing on 15 studies with varying sample sizes (from 11 to over 3,600 participants) [22]. The authors note that nearly all available studies address the individual and family levels, that factors at the meso- and macrosystem level (family–school collaboration, cultural factors, education systems) remain very sparsely studied, and that the significance of some associations age in particular varies depending on whether the sample was clinical or community-based and on whether univariate or multivariate analyses were used [22]. The methodological quality of these studies remains generally moderate, and all are cross-sectional in design [22].

Individual and psychological factors. Anxiety state, trait, social, school-related, and separation anxiety is the individual factor most consistently associated with school refusal across the available studies [22,23]. Diverse learning needs (learning difficulties, verbal comprehension, language) are also among the most frequently identified factors [22].

Family factors. A systematic review focused specifically on modifiable parental factors associated with child school refusal found significant associations with overall parental psychopathology, parental depressive and anxiety symptoms, and poorer overall family functioning [12]. Regarding maternal overprotection, only the “communication” component (a tendency of mothers to excessively encourage communication with the child) showed a significant association; the other components (affection, assistance, restriction of activities) showed no significant difference, cautioning against generalizing a uniform association between parental overprotection and school refusal [12]. The direction of these associations remains uncertain, as parental difficulties may contribute to a child's school refusal while themselves being amplified by the burden of managing it [12].

School factors. Insufficient teacher support, poor teacher–student relationships, difficult school transitions, and a negative perceived school climate are associated with school refusal in the available literature, although the largely cross-sectional nature of these studies precludes establishing causality [15,22].

Peer relationships and bullying. Bullying and peer rejection are reported as factors associated with school refusal across several populations, notably among children with ASD or ADHD, among whom the presence of a behavioral support plan and associated behavioral difficulties predicted the frequency of bullying-related school refusal more strongly than diagnosis itself; conversely, individualized 1:1 support was associated with a lower frequency of bullying-related school refusal, suggesting a possible protective role [11].

Contextual factors. Available data on broader contextual factors (poverty, school violence, minority status) are drawn largely from a North American context and should not be assumed to generalize directly to other education systems [15].

6. Clinical Assessment

Assessment of school refusal should extend beyond simply quantifying absenteeism to identify the mechanism underlying it. Interviewing the child or adolescent and the parents helps clarify the onset, course, and circumstances of the refusal, the emotional and somatic response associated with school attendance, and what occurs when the child remains at home. The literature supports attention to psychiatric comorbidity (anxiety disorders, depression, oppositional defiant disorder) as well as to neurodevelopmental conditions (ASD, ADHD, learning disorders), which may contribute to absenteeism through mechanisms distinct from anxiety [19,21].

Distinguishing school refusal from truancy is a central consideration in clinical assessment, with the presence or absence of emotional distress associated with school being the most discriminating feature reported in the literature [5,8,18]. Clinical assessment should also consider family and school factors that may sustain the behavior, including parental responses that may unintentionally reinforce avoidance.

Functional assessment, drawing on the four-function model described above, is supported in the literature as clinically useful for guiding intervention choice [7,9,25]. The School Refusal Assessment Scale–Revised (SRAS-R) is the most widely used standardized instrument operationalizing this functional assessment, with a four-factor structure replicated across several samples, including cross-cultural ones [9,10,20]. Its validity has not, however, been established in children with ASD, one study having concluded it was not valid in this population according to a recent scoping review [21]; its authors also caution against relying on the SRAS alone, given that it captures only four youth-centered functions and does not address broader contextual factors [8]. In children with ASD, its results should therefore be

interpreted with caution and considered alongside a broader clinical assessment rather than as a stand-alone instrument [8,21].

7. Management

7.1 Psychosocial interventions and cognitive-behavioral therapy

Psychosocial interventions, particularly cognitive-behavioral approaches, constitute the most extensively studied component of school refusal management. A systematic review with meta-analysis of 8 studies involving 435 school-age participants published both as a Campbell Collaboration report and as a journal article, the two publications corresponding to the same study rather than to two independent bodies of work [14,26] reports a significant effect of psychosocial interventions on school attendance (g=0.54), but a non-significant effect on anxiety symptoms (g=0.06) [14,26]. The authors conclude that the evidence provides only "tentative" support for cognitive-behavioral therapy, given the limited number of available studies and their uneven methodological quality, including the frequent absence of assessor blinding [14,26].

This caution is reinforced by an earlier finding of no significant difference between cognitive-behavioral therapy and structured educational support on attendance, anxiety, or depression, suggesting that non-specific treatment elements (support, psychoeducation, expectancy) may contribute substantially to observed improvement [17]. Taken together, these findings suggest that the effectiveness of cognitive-behavioral therapy is better established for school attendance than for anxiety symptoms specifically.

7.2 Family- and school-based interventions

Because school refusal occurs within a family and school context, collaboration among the young person, family, school, and healthcare professionals is generally considered an important component of management. Parent-directed interventions may include psychoeducation and guidance on responding to avoidance behavior, informed by the modifiable parental factors identified in the literature (parental psychopathology, family functioning) [12]. Evidence specifically concerning school–clinician partnership approaches remains limited: a systematic review identified only a small number of eligible studies, with mixed and methodologically constrained findings that did not permit firm conclusions about effectiveness [6]. Qualitative evidence gathered from parents of children with emotionally based school avoidance describes a range of experiences in parent–school interactions, spanning from feeling unheard or blamed to more collaborative relationships with school staff, underscoring the clinical relevance of this relationship [27]. Consideration of school-related and broader contextual factors in management is supported by the literature [8,22], though accommodations and individualized attendance plans should be regarded as clinically relevant considerations rather than as interventions with demonstrated effectiveness in the current corpus.

7.3 Pharmacological treatment

Data on the pharmacological treatment of school refusal remain limited. A systematic review of 7 trials involving 306 young people reports heterogeneous findings across the medications studied (imipramine, clomipramine, fluoxetine, alprazolam), with most available trials being dated, small, and underpowered to demonstrate robust and consistent superiority over placebo [13]. These findings do not support a conclusion of established pharmacological efficacy for school refusal as such; when medication is considered, it should be directed primarily toward a clearly identified psychiatric comorbidity and integrated into a broader psychosocial treatment plan rather than substituting for it [13].

7.4 Digital and emerging interventions

A recent scoping review of 31 intervention studies for school refusal found that only 6 (19%) incorporated a digital component (tele-hypnosis, online coaching, virtual reality, among others), with feasibility and acceptability generally demonstrated but evidence of a direct effect on school attendance still limited; one of these studies found no measurable reduction in days of school refusal [2]. These digital approaches most often target the child or family and rarely engage the school environment, and at this stage remain an emerging avenue rather than a validated mode of management [2].

8. Prognosis and Prevention

8.1 Long-term outcome

Available long-term follow-up data derive from studies of uneven methodology and statistical power, which should not be treated as equivalent. The study by Berg and Jackson, following 168 subjects an average of 10 years after hospitalization for school refusal, reports that nearly half of those interviewed remained well or greatly improved throughout the follow-up period, while approximately 30% presented with a clinically significant psychiatric disorder at follow-up a rate judged higher than expected in the general population [4]. A Swedish study with a much longer follow-up period (20 to 29 years), comparing former school refusers with a group of non-refusing child psychiatric patients and with a general-population sample, nuances this picture: overall adult adjustment among those who had experienced school refusal in childhood was not significantly different from that of the general population, whereas the comparison group of child psychiatric patients showed significantly poorer outcomes on several indicators (criminal record, prolonged sick leave) [16]. The school-refusal group nonetheless showed more frequent outpatient psychiatric consultation in adulthood than the general population, along with a lower number of children [16]. An Irish 10-

year follow-up study, based on a very small sample of 10 analyzable subjects, reports broadly convergent findings, with a poorer outcome among young people who had initially presented with separation anxiety disorder compared with those with a phobic anxiety presentation; given the sample size, this finding should be regarded as exploratory and should not be given the same weight as the studies above [24].

Taken together, these studies indicate a heterogeneous prognosis: a substantial proportion of young people who experienced school refusal have a favorable outcome, while a minority retain psychiatric or functional difficulties into adulthood, without school refusal in childhood appearing consistently associated with poorer overall adjustment relative to the general population [4,16,24].

8.2 Factors associated with prognosis

Among the factors associated with a poorer outcome in the available follow-up studies are lower intellectual level and older age at initial treatment [4], as well as an initial presentation of separation anxiety disorder relative to a more phobic presentation in one low-powered study [24]. Conversely, good-quality family, school, and social relationships are more broadly associated with better functioning in the literature on factors associated with school refusal, although evidence specifically addressing protective factors remains considerably less developed than that concerning risk factors [1,22].

8.3 Prevention and early identification

The potentially self-sustaining nature of school refusal through the avoidance–relief–reinforcement cycle described above supports early identification and intervention, before absenteeism becomes prolonged and associated academic and social difficulties accumulate. A multilevel preventive approach, combining early recognition of emotional difficulties at the individual level, guidance on parental responses to avoidance, and collaboration between families and schools, is consistent with the ecological model of factors associated with school refusal [12,22].

9. CONCLUSION

Anxiety-based school refusal is a heterogeneous clinical phenomenon whose understanding requires linking its anxious dimension to the function that school avoidance serves for the child, as well as to the individual, family, and school factors associated with it [7,18,22]. The available literature remains marked by predominantly cross-sectional designs, often limited sample sizes, and substantial methodological heterogeneity, particularly with respect to prognostic and pharmacological data [4,13,16,22,24]. Psychosocial interventions, and cognitive-behavioral therapy in particular, have the strongest evidence for improving school attendance, with a less consistent effect on anxiety symptoms themselves [14,17,26]. Individualized assessment, attentive to the function of the refusal behavior and to psychiatric and neurodevelopmental comorbidities, together with management that engages the child, the family, and the school, appear to be the approaches best supported by currently available evidence.

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