ORIGINAL RESEARCH

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Prevalence of psychiatric comorbidity and associated sociodemographic factors in children and adolescents with school refusal

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Abstract

Objective: To examine the sociodemographic and clinical characteristics of children with school refusal, identify accompanying psychopathologies, and investigate the relationship between comorbid psychopathologies and the severity of school refusal and demographic features.

Method: The study included 52 children and adolescents aged 7-16 who presented to a child and adolescent psychiatry clinic between November 2023 and November 2024 with reluctance to attend school and a diagnosis of school refusal. The researcher administered a questionnaire to participants that included sociodemographic data and questions related to school refusal. Children were asked to complete a school refusal rating scale. Semi-structured psychiatric interviews were conducted with children and their families to identify psychopathologies accompanying school refusal in children.

Results: Of the cases, 48.1% were male, and 51.9% were female. The mean age was 12.31±2.73 years. At the time of referral to the outpatient clinic, more than two-thirds of the children had never attended school. More than two-thirds of the cases were accompanied by at least one psychopathology, and this rate was significantly higher in males. The most common comorbid psychopathologies were generalized anxiety disorder, major depression, and separation anxiety disorder. In the younger age group, somatic complaints were statistically significantly more frequent, and separation anxiety disorder was more commonly comorbid. No significant relationships were found between school refusal rating scale scores and demographic data, clinical characteristics, or comorbid psychopathology.

Conclusion: School refusal is one of the child psychiatric emergencies that causes serious academic, social, and psychological problems in children and adolescents in the short and long term. Furthermore, the presence of accompanying psychopathology further worsens the prognosis. Therefore, understanding the demographic and clinical factors in these children, examining their relationship with comorbidity, and addressing these factors in clinical practice will positively influence intervention processes and prognosis.

Keywords: School refusal, children, adolescence, psychopathology

INTRODUCTION

School refusal is a school attendance problem characterized by avoidance of going to school or difficulty staying at school all day and participating in lessons, usually associated with anxiety or stemming from emotional difficulties (1). It is important to distinguish school refusal behavior from other

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reasons for non-attendance at school. School refusal is a child's reluctance or refusal to attend school, often accompanied by emotional distress. Parents are aware of their child's non-attendance and make efforts to ensure their child attends school regularly. Although they resist their parents' efforts to send them to school, they do not exhibit antisocial behavior. Emotional distress related to going to school may manifest as excessive fear, unhappiness, or unexplained physical symptoms (such as stomach ache, headache, dizziness, and nausea) (2).

School refusal is not classified as an independent clinical disorder in international classification systems such as the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) or ICD-10 (International Statistical Classification of Diseases and Related Health Problems). Findings regarding its prevalence also vary due to differences in the criteria used to define it (3). It occurs at equal rates in both genders. Although earlier studies indicated that school refusal affected 1 to 5% of school-aged children (4), a more recent study discovered that it was present in 1-7% of the youth population and 5-16% of adolescents attending the clinic (5). School refusal can occur at any time. It is often observed during transitional periods, such as starting primary school, moving from primary to secondary school, or transitioning from secondary to high school. These periods involve academic challenges and more complex social relationships (6). Studies show it is more common at the beginning of primary school (ages 5-7) and in early adolescence (ages 10-13) (7).

Refusing to attend school has several detrimental effects, both short-term and long-term. Short-term consequences include failure to complete school, poor academic performance, social isolation, alienation from school and peers, increased conflict with family and school, and hindered social and emotional development. Long-term consequences include school dropout, unemployment, criminal activity, substance use, increased suicide risk, occupational and marital problems, and an increase in psychiatric disorders such as major depression in adulthood (8,9).

Several studies indicate that school refusal is strongly associated with anxiety disorders, particularly separation anxiety disorder, generalized anxiety disorder, social anxiety disorder, specific phobias, and panic disorder. Furthermore, school refusal can be a core symptom of other psychiatric disorders, such as major depression, post-traumatic stress disorder, and adjustment disorder (10). Moreover, compared to their typically developing peers, children with neurodevelopmental disorders like Learning Difficulties and Attention Deficit Hyperactivity Disorder (ADHD), leading to academic challenges, as well as Language and Speech Disorders, which cause communication problems, are more likely to refuse to attend school (11).

A study has shown that accompanying mental disorders, particularly learning difficulties and social phobia, worsen the prognosis in children with school refusal (12). Without accounting for comorbid conditions, they may negatively impact both academic and psychosocial functioning in these children. We believe that understanding the clinical and demographic factors associated with comorbidity is crucial in clinical practice, as it helps address these risk factors and thereby lowers the likelihood of future comorbidity. Therefore, in this study, it was aimed to determine the sociodemographic characteristics of children with school refusal, the severity and clinical features of school refusal, identify the psychopathologies accompanying school refusal, and examine the relationships among these parameters. Our main goal was to investigate whether the comorbid psychopathologies affect the severity of school refusal symptoms and to demonstrate whether there is a relationship between them, thereby contributing to the literature.

METHOD

Participants

68 children and adolescents aged 7-16 who presented to the child and adolescent mental health clinic of a university hospital between November 2023 and November 2024 with complaints of reluctance to attend school[w113.1]. Since children were asked to complete self-report scales in our study, they needed to be able to read and write, so only children in at least second grade were included. For this reason, 9 first-grade children who had just started school and those who refused to attend school were excluded from the study. the children and adolescents with intellectual disabilities and psychiatric disorders (mania and psychosis) that impaired their ability to assess reality, those who were unable to attend school due to an organic disease (e.g., cancer) were not includedin the study. Furthermore, because this study only investigated children and adolescents who were unable to attend school or refused to attend school due to emotional distress, 7 truant adolescents who arbitrarily refused to go to school, and those who wanted to drop out of school were excluded. The remaining 52 children and adolescents who had anxiety-related school refusal were included in the study. This number constituted 76.5% of the cases.

Procedure

A semi-structured psychiatric interview was conducted with all children and adolescents included in the study to assess the presence of comorbid psychiatric disorders associated with school refusal. The Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children-Present and

Lifetime Version (KSADS-PL) was used for this interview. All participating children were also administered a researcher-developed questionnaire assessing their sociodemographic characteristics and school refusal behavior. Furthermore, children were asked to complete the School Refusal Assessment Scale to determine the severity of the school refusal.Permission for this study was obtained from the Non-Interventional Clinical Research Ethics Committee of Sivas Cumhuriyet University Faculty of Medicine with the decision number 2023-10/26 dated October 19, 2023, and the criteria of the Helsinki Declaration were taken into consideration. Written consent was obtained from all children and families included in the study.

Data Collection Tools

Questionnaire Form

This form, prepared and administered by the researcher, consists of two sections: one collecting sociodemographic data on the children and their families, and the other containing questions related to school refusal. The first part, regarding sociodemographic data, asks about the child's age, gender, grade level, academic achievement, number of siblings, parents' education and employment status, place of residence, family structure, family income, and the presence of known psychiatric disorders in the child and mother.

The second section concerning school refusal examines the child's nursery education history, past school attendance difficulties, accompanying somatic complaints, past school refusal experience, past psychiatric treatment received for school refusal, and the extent of the school refusal*. (*To understand the extent of school refusal, children were divided into five subcategories: those never leave home never attend to school; those who could leave home to go to school but could not enter the school gates; those who could enter the classroom but could not stay and cried; those who could stay for a few lessons but wanted to leave early; and those who could stay at school all day but had difficulty separating from their parents in the morning).

School Refusal Assessment Scale (SRAS)

It is a self-report scale developed by Haight, Kearney, & Schafer (13) to assess school refusal in children and adolescents. It was adapted to Turkish culture by Seçer (14). It is a measurement tool consisting of 24 items and a five-point Likert scale, comprising four sub-dimensions: avoidance of negative situations related to school, difficulty in establishing social relationships, resistance to separation from family, and interest in extracurricular activities. The minimum score on the scale is 24, and the maximum is 96. High scores on the sub-dimensions and the scale total indicate a high severity of school refusal.

Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children-Present and Lifetime Version (KSADS-PL)

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (15), the KSADS-PL is a semi-structured diagnostic interview designed to assess past and present psychopathologies in children aged 6 to 18. Numerous psychiatric disorders, including major depression, separation anxiety disorder, severe anxiety/generalized anxiety disorder, obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), conduct disorder, oppositional defiant disorder, enuresis, encopresis, eating disorders, post-traumatic stress disorder, and more, are diagnosed with KSADS-PL. Each interview was conducted by a child and adolescent psychiatrist with the parents and their children separately. Gokler et al. conducted a validity and reliability evaluation of the schedule in a Turkish sample (16).

Statistical Analysis

All statistical analyses were performed using IBM SPSS Statistics version 23. In this study, descriptive statistics, such as the mean and standard deviation, were used for continuous variables, while frequency and percentage were used for categorical variables. To measure the normality of the continuous data, the Shapiro-Wilk test was used. The Mann-Whitney U test was used for data that were not normally distributed. The chi-square test and Fisher's Exact Test were used for categorical variables, and when comparing group means. The value of $p<0.05$ was considered statistically significant in all analyses.

RESULTS

The study included 52 children and adolescents aged 8–16 who refused to attend school due to emotional distress. Of the cases, 48.1% were male, and 51.9% were female. The mean age was 12.31±2.73 years. Detailed sociodemographic and socioeconomic features of the children with school refusal and their families, including information on the children's grades, academic achievement, and the presence of psychopathology in the mother, are provided in Table 1.

Psychopathology was present in approximately 85% of cases, a significant proportion, alongside school refusal. In total, two-thirds of cases had at least one psychiatric disorder accompanying school refusal, which was significantly higher in males than in females ($p=0.047$). At least two psychiatric disorders were present in 18% of cases, and although no significant difference was found between genders, this rate was higher in females than in males ($p>0.05$).

Table 1. Socio-demographic and familial characteristics of participants

Variables	Number (%) or mean±SD
Age (mean-years±SD)	12.31±2.73
Gender (n,%) Male Female	 25 (48.1) 27 (51.9)
Education Status-Class (mean-years±SD)	6.73±2.84
Academic performance status (n,%) High (Grade Point Average ≥70) Medium (Grade Points Average=50-69) Low (Grade Point Average ≤49)	 16 (30.8) 27 (51.9) 9 (17.3)
Accompanying medical illness (n,%)	6 (11.5)
Presence of known psychiatric disorder in the child (n,%)	9 (17.3)
Sibling order (n, %) 1 2 3+	 18 (34.6) 18 (34.6) 16 (30.8)
Maternal education level (n,%) Illiterate Primary education and lower High school level University level	 4 (7.7) 22 (42.3) 20 (38.5) 6 (11.5)
Regular job of the mother (n,%)	13 (25.0)
Paternal education level (n,%) Illiterate Primary education and lower High school level University level	 3 (5.8) 15 (28.8) 25 (48.1) 9 (17.3)
Regular job of the father (n,%)	42 (80.8)
Presence of known psychiatric disorder in the mother (n,%)	5 (9.6)
Place of residence (n,%) Urban Rural	 39 (75.0) 13 (25.0)
Family income level (n,%) Minimum wage or below Above the minimum wage	 17 (32.7) 35 (67.3)
Family type Nuclear Single-parent Extended	 41 (78.8) 7 (13.5) 4 (7.7)

SD: Standard deviation

Table 2 provides detailed clinical features of school refusal, comparing them by gender. According to this, the vast majority of children (82.7%) in the study had attended preschool. Nearly half had struggled to attend school in previous years.

Table 2. Clinical characteristics of school refusal

Variables	Total (n=52)	Males (n=25)	Females (n=27)	p-value*
Age (mean-years±SD)	12.31±2.73	12.52±2.83	12.11±2.68	0.595
Preschool education history (n,%)	43 (82.7)	21 (84.0)	22 (81.5)	0.810
Past struggles adjusting to school (n,%)	25 (48.1)	10 (40.0)	15 (55.6)	0.262
Presence of somatic symptoms (n,%)	36 (69.2)	16 (64.0)	20 (74.1)	0.432
The extent of school refusal Not attending school/Never going to school (n,%)* at least two weeks	35 (67.3)	17 (68.0)	18 (66.7)	0.918
Returning from the school gate (n,%)	5 (9.6)	2 (8.0)	3 (11.1)	0.704
Returning from class (n,%)	3 (5.8)	2 (8.0)	1 (3.7)	0.603
Returning after stopping for a few lessons (n,%)	6 (11.5)	2 (8.0)	4 (14.8)	0.670
Difficulty separating from mother in the morning, even after being at school all day (n,%)	9 (17.3)	5 (20.0)	4 (14.8)	0.722
History of previous school refusal (n,%)	33 (63.5)	19 (76.0)	14 (51.9)	0.071
Past psychiatric treatment for school refusal (n, %)	15 (28.8)	11 (44.0)	4 (14.8)	**0.020**
Psychotropic drug preferences (n,%)**				
SSRIs	6 (40.0)	5 (45.5)	1 (25.0)	0.068
SSRIs + Benzodiazepines	2 (13.3)	0 (0.0)	2 (50.0)	
SSRIs + Antipsychotics	7 (46.7)	6 (54.5)	1 (25.0)	
Subscales and Total score of SRAS				
SRAS—Avoidance of general negative affectivity (mean±SD)	15.96±4.73	15.36±4.62	16.52±4.85	0.363
SRAS—Escape from aversive social/evaluative situations (mean±SD)	12.00±4.86	11.64±4.24	12.33±5.42	0.890
SRAS—Attention seeking (resistance to separation from family) (mean±SD)	15.90±5.33	15.04±5.97	16.70±4.63	0.317
SRAS—Pursuit of tangible reinforcement (mean±SD)	14.15±3.46	13.84±2.81	14.44±3.99	0.606
SRAS—Total scores (mean±SD)	57.65±13.48	55.88±13.23	59.30±13.75	0.425

*The chi-square test and Fisher's Exact Test for categorical variables and the Mann–Whitney U test for continuous variables were used to test group differences. Bold font indicates statistical significance: $p < 0.05$.**Patients who did not begin psychiatric medication were excluded.Abbreviations: SD: Standard Deviation, SRAS: School Refusal Assessment Scale, SSRI: Selective serotonin reuptake inhibitors.

Somatic complaints were present in more than two-thirds of cases; although not statistically significant, they were more common in girls (p>0.05). More than two-thirds of the children presenting to the clinic had not attended school for at least two weeks at the time of presentation and had also experienced school refusal in previous grades. Only one-third of the cases had previously received psychiatric treatment for school refusal, and this rate was statistically significantly higher in boys than in girls (p=0.020).

The scores across all four SRAS subtypes were similar. Although the subtypes avoidance of negative situations related to school and resistance to separation from family scored higher than the other two subtypes in both genders, there was no statistically significant difference between the subscale scores (p>0.05). The total scores obtained by girls on the SRAS scale and its subscales were minimally higher than those of boys, but the difference was not statistically significant.

The most common comorbid disorders associated with school refusal were generalized anxiety disorder, major depression, and separation anxiety disorder, respectively. While there was no significant difference between genders in terms of comorbid psychiatric disorders, generalized anxiety disorder was the most common comorbidity in males, and separation anxiety disorder and generalized anxiety disorder were the most common comorbidities in females. The distribution of comorbid psychiatric disorders by gender is given in Table 3.

The children included in the study were divided into two groups: those aged 7-10 years and those aged 11 years and older. The clinical parameters related to school refusal according to age groups were compared. It was found that children in the younger age group had significantly more somatic complaints than those in the older age group (p=0.016). When comparing the two age groups on the SRAS subscale scores, we found that the third subscale (resistance to separation from family) in the younger age group was statistically significantly higher than in the older age group (p=0.006). No statistically significant difference was found between the two age groups for the other parameters. Table 4 presents the clinical characteristics of school refusal by age group.

When comparing age groups in terms of comorbid psychopathologies, separation anxiety disorder was found to be significantly higher in the younger group than in the older group (p=0.001). The relationship between SRAS scores (total and subscale scores) and somatic complaints, previous psychiatric treatment, previous school refusal, and school refusal dimensions was examined. No statistically significant difference was found between the SRAS scores and any of these parameters (Table 5).

Table 3. Psychiatric comorbidity in the sample

Variables	Total (n=52)	Males (n=25)	Females (n=27)	p-value*
Presence of psychopathology (n,%)	44 (84.6)	23 (92.0)	21 (77.8)	0.252
Current psychopathology status (n, %)				**0.047**
No psychopathology	8 (15.4)	2 (8.0)	6 (22.2)	
One comorbid diagnosis, only	35 (67.3)	21 (84.0)	14 (51.9)	
At least two comorbid diagnoses	9 (17.3)	2 (8.0)	7 (25.9)	
Psychopathology types (n,%)				
Separation anxiety disorder (n,%)	10 (19.2)	4 (16.0)	6 (22.2)	0.729
Social anxiety disorder (n,%)	8 (15.4)	3 (12.0)	5 (18.5)	0.705
Generalized anxiety disorder (n,%)	14 (26.9)	8 (32.0)	6 (22.0)	0.427
Major depressive disorder (n,%)	10 (19.2)	5 (20.0)	5 (18.5)	0.892
Attention deficit hyperactivity disorder (n,%)	6 (11.5)	4 (16.0)	2 (7.4)	0.411
Oppositional defiant disorder (n,%)	3 (5.8)	2 (8.0)	1 (3.7)	0.603
Specific learning disorders (n,%)	4 (7.7)	1 (4.0)	3 (11.1)	0.611

*The chi-square test and Fisher's Exact Test were used to test group differences. Bold font indicates statistical significance: $p < 0.05$.

Table 6 examines the relationship between the presence of comorbid psychopathology accompanying school refusal and SRAS scores. Accordingly, no significant relationship was found between the total scale score and the presence of psychopathology. Similarly, when examining the relationship between psychopathology and scores on each subscale, we found no significant difference. In other words, the presence of comorbid psychopathology did not affect the severity or subtype of school refusal.

DISCUSSION

In the present study, it was aimed to identify the underlying psychopathologies in children and adolescents with school refusal and to examine the relationship between these comorbid conditions and the severity of school refusal and demographic variables.

Most studies show that school refusal occurs at equal rates in both genders (17-19). In this study, the ratio of girls to boys was similar to that reported in the literature. Studies indicate that school refusal can occur at any age, but it is most commonly reported at the time of starting elementary and middle school (10, 18). In this study, the average age of children with school refusal was 12. A study, based on age groups, found that the prevalence of school refusal among 10- to 12-year-olds was 21.6%, making it the second most common age group, after 7- to 9-year-olds (20). The higher average age in our study than in the literature may be because we used a self-report scale that requires children to read and

write. Therefore, the children who had just started elementary school were not included in the study.

Table 4. Clinical characteristics of school refusal according to age groups

Variables	Total (n=52)	7-10 years (n=19)	≥11 years (n=33)	p-value*
Preschool education history (n,%)	43 (82.7)	17 (89.5)	26 (78.8)	0.327
Past struggles adjusting to school (n,%)	25 (48.1)	12 (63.2)	13 (39.4)	0.089
Presence of somatic symptoms (n,%)	36 (69.2)	17 (89.5)	19 (57.6)	0.016
The extent of school refusal				
Not attending school/Never going to school at least two weeks (n, %)	35 (67.3)	11 (57.9)	24 (72.7)	0.272
Returning from the school gate (n,%)	5 (9.6)	4 (21.1)	1 (3.0)	0.034
Returning from class (n,%)	3 (5.8)	3 (15.8)	0 (0)	0.019
Returning after stopping for a few lessons (n,%)	6 (11.5)	2 (10.5)	4 (12.1)	0.862
Difficulty separating from mother in the morning, even after being at school all day (n,%)	9 (17.3)	5 (26.3)	4 (12.1)	0.193
History of previous school refusal (n,%)	33 (63.5)	12 (63.2)	21 (63.6)	0.972
Past psychiatric treatment for school refusal (n, %)	15 (28.8)	3 (15.8)	12 (36.4)	0.115
Psychotropic drug preferences (n,%)**				
SSRIs	6 (40.0)	2 (66.7)	4 (33.3)	0.520
SSRIs + Benzodiazepines	2 (13.3)	0 (0)	2 (16.7)	
SSRIs + Antipsychotics	7 (46.7)	1 (33.3)	6 (50.0)	
Subscales and Total score of SRAS				
SRAS—Avoidance of general negative affectivity (mean±SD)	15.96±4.73	15.79±5.22	16.06±4.50	0.834
SRAS—Escape from aversive social/evaluative situations (mean±SD)	12.00±4.86	11.47±5.62	12.30±4.41	0.335
SRAS—Attention seeking (mean±SD)	15.90±5.33	18.58±4.4	14.36±5.23	0.006
SRAS—Pursuit of tangible reinforcement (mean±SD)	14.15±3.46	15.00±4.38	13.67±2.75	0.383
SRAS—Total scores (mean±SD)	57.65±13.48	59.84±15.06	56.39±12.55	0.447

*The chi-square test and Fisher's Exact Test for categorical variables and the Mann–Whitney U test for continuous variables were used to test group differences. Bold font indicates statistical significance ($p < 0.05$). **Patients who did not begin psychiatric medication were excluded.Abbreviations: SD: Standard Deviation, SRAS: School Refusal Assessment Scale, SSRI: Selective serotonin reuptake inhibitors

School refusal can present with a wide variety of somatic symptoms in clinical practice (18). Abdominal pain, headache, nausea, vomiting, and palpitations are the most commonly observed somatic symptoms and are usually the first signs of school refusal (21-23). These somatic symptoms, which occur in 26.5% to 79.4% of cases and reflect emotional distress, are more common in children than in adolescents and typically present in the morning before school (19, 21, 23). When the study children were divided into two age groups, 7-10 and 11 and older, those in the younger group had significantly more somatic complaints, consistent with the literature.

Table 5. Comparison of psychopathologies accompanying school refusal according to age groups

Variables	Total (n=52)	7-10 years (n=19)	≥11 years (n=33)	p-value*
Presence of psychopathology (n,%)	44 (84.6)	17 (94.4)	27 (79.4)	0.153
Current psychopathology status (n,%)				
No psychopathology	8 (15.4)	1 (5.6)	7 (20.6)	
One comorbid diagnosis, only	35 (67.3)	14 (77.8)	21 (61.8)	0.336
At least two comorbid diagnoses	9 (17.3)	3 (16.6)	6 (17.6)	
Psychopathology types (n,%)				
Separation anxiety disorder (n,%)	10 (19.2)	8 (44.4)	2 (5.9)	0.001
Social anxiety disorder (n,%)	8 (15.4)	2 (11.1)	6 (17.6)	0.534
Generalized anxiety disorder (n,%)	14 (26.9)	5 (27.8)	9 (26.5)	0.919
Major depressive disorder (n,%)	10 (19.2)	2 (11.1)	8 (23.5)	0.280
Attention deficit hyperactivity disorder (n,%)	6 (11.5)	2 (11.1)	4 (11.8)	0.944
Oppositional defiant disorder (n,%)	3 (5.8)	0 (0)	3 (8.8)	0.194
Specific learning disorders (n,%)	4 (7.7)	1 (5.6)	3 (8.8)	0.674

*The chi-square test and Fisher's Exact Test were used to test group differences. Bold font indicates statistical significance: $p < 0.05$.

Table 6. Comparison of School Refusal Assessment Scale scores according to the presence of psychiatric comorbidity

	Psychiatric Comorbidity		
	Yes (n=44)	No (n=8)	p-value*
SRAS—Avoidance of general negative affectivity (mean±SD)	16.43±4.75	13.38±3.93	0.063
SRAS—Escape from aversive social/evaluative situations (mean±SD)	12.18±5.11	11.00±3.12	0.731
SRAS—Attention seeking (mean±SD)	15.91±5.58	15.88±3.94	0.869
SRAS—Pursuit of tangible reinforcement (mean±SD)	14.27±3.55	13.50±3.02	0.674
SRAS—Total scores (mean±SD)	58.36±13.98	53.75±10.12	0.381

*The Mann–Whitney U test was used to test group differences. Abbreviations: SD: Standard Deviation, SRAS: School Refusal Assessment Scale.

Studies on school refusal have shown that the vast majority of children have difficulty adjusting to school (24,25). In the present study, nearly half of the cases had difficulty starting school. Approximately two-thirds of the cases had experienced school refusal in previous grades, but only 28% had received treatment for this reason. The psychiatric treatment received was primarily a combination of Selective Serotonin Reuptake Inhibitors (SSRIs) and antipsychotics. Males re-

ceived therapy for school refusal at a significantly higher rate than females. Our study reveals a significant gender disparity in the treatment of school refusal. It was found that families seek treatment for boys more often than for girls. This pattern might stem from social norms in patriarchal societies, where girls are not expected to receive as much education as boys, leading to a higher incidence of school refusal among boys.

In previous studies, it was mentioned that school refusal was observed at similar rates among girls and boys. Some studies have also shown that there are no significant differences between genders in scores on the SRAS scale used to assess school refusal (26,27). In this study, consistent with the literature, the total and subscale scores from the school refusal scale were similar across genders. Although there was no statistically significant difference in subscale scores, the highest scores were for avoidance of negative school-related situations and resistance to separation from family. Unlike this study, Aslan's study examining school refusal in the 8-14 age group found that the SRAS subscale with the highest score was the pursuit of tangible reinforcement (interest in activities outside of school) (27). In the present study, it was found that scores on the resistance to separation from family (attention-seeking) subscale were significantly higher in the younger age group than in the older age group. As noted in the literature, this was considered an indicator of separation anxiety disorder, which is the most common disorder accompanying school refusal in the younger age group (18,28,29).

School refusal may present in clinical practice as a symptom of various psychiatric disorders. Studies have shown that the vast majority of children with school refusal met the diagnostic criteria for at least one psychiatric disorder at the time of their clinical presentation (25). This rate was reported as 87.9% in the study by Prabhuswamy and colleagues (30) and 88.2% in the population studied by Egger and colleagues (31). In this study, which involved semi-structured psychiatric interviews, we identified psychopathology in 85% of the cases.

In the literature, school refusal is generally associated with anxiety disorders (18,32-34). Separation anxiety disorder is more common in younger children, while generalized anxiety disorder, social anxiety disorder, and depressive disorder are more common in the older age group (35,36). Prabhuswamy and colleagues found that depressive disorder most frequently accompanied school refusal in their studies (30). In this research, the most common psychopathologies accompanying school refusal were generalized anxiety disorder and depressive disorder, similar to other studies. When the data were separated by age groups, it was found that separation anxiety disorder was significantly higher in the younger age group with school refusal compared to the older age group, consistent with the literature (18,28,29,36). Studies have indicated that mothers of children who refuse to attend school exhibit higher rates of psychopathology, and that mothers of children with separation anxiety disorder generally have higher rates of anxiety disorders and depression compared to the general population (18,24,29). In this study, the rate of known psychiatric disorders in the mothers was very low. This result may be due to the small sample size or to the smaller number of younger children in this study.

Limitations of the Study

The small sample size and lack of a control group are significant limitations of this study. Furthermore, having children complete a self-report scale for school refusal and using a semi-structured psychiatric interview to identify comorbid psychopathologies are strengths of the study. Furthermore, given the scarcity of studies on school refusal, this study is considered a positive contribution to the field.

CONCLUSION

In the present study, the demographic and clinical data of children with school refusal were collected, the severity of school refusal was assessed, and the presence of comorbid psychopathology was investigated. The study results showed a significantly higher incidence of comorbid psychopathology in boys. Consistent with the literature, the most common comorbid disorder in our study was generalized anxiety disorder, and in younger children, somatic complaints and separation anxiety disorder were more frequently observed. It was also measured the severity of school refusal using the self-report scale as our primary objective and investigated whether school refusal severity was associated with comorbid psychopathology. Unfortunately, no significant relationship was found.

School refusal is a condition that requires urgent intervention, as delaying action can have serious negative effects on the individual's emotional and educational life. Therefore, the underlying causes of the behavior and comorbid conditions should be identified as soon as possible, and the extent to which they impair the child's functioning should be determined. Although no significant relationship was found between comorbid psychopathologies and the severity of school refusal in our study, it is known that the presence of accompanying psychopathology can lead to negative consequences, including dropping out of school. Considering that the primary and ultimate goal of treatment is to ensure that the child returns to school as soon as possible, identify-

ing and resolving comorbid psychopathologies is of vital importance.

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