1983

An investigation of the phenomenon of school phobia

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Abstract

School phobia is a perennial problem but very little has been written about it in recent years. The problem of school phobia seemed to have gained more attention in the 1950's and 1960's, with greatest concern for the adolescents' affliction in the 1970's. The purpose of this paper is to revive the reader's consciousness to this problem and to encourage understanding and empathy for children exhibiting a pathological fear of attending school.

AN INVESTIGATION OF THE PHENOMENON OF SCHOOL PHOBIA

A Research Paper

Submitted

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Education

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May 1983

This Research Paper by: Juliet Ocenar Ruiz

Entitled: An Investigation of the Phenomenon of School Phobia

has been approved as meeting the research paper requirement for the Degree of Master of Arts in Education

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CHAPTER 1

INTRODUCTION

School phobia is a perennial problem but very little has been written about it in recent years. The problem of school phobia seemed to have gained more attention in the 1950's and 1960's, with greatest concern for the adolescents' affliction in the 1970's. The purpose of this paper is to revive the reader's consciousness to this problem and to encourage understanding and empathy for children exhibiting a pathological fear of attending school.

Refusal to go to school, in all likelihood, has been evident since education was formalized centuries ago. There is no doubt that there are children who would rather skip school for something more enjoyable to do, such as chasing squirrels or just playing hooky. Other youngsters are anti-social, preferring to perform their destructible behaviors someplace else during class time. Older youths may find it more fruitful to get a job to earn a little money. Others may even find it more rewarding to help with the household chores than struggle with school work. Of course, there are occasions when the parents themselves withdraw their children from school because they are dissatisfied or in disagreement with the policies of the school system. Several court cases regarding this action have been quite popular in recent years.

In cases of school phobia, the child has a morbid fear or dread of school, and literally panics at the sight of that building or even the thought of going to school. Such difficulty presents serious problems in the management of the child and will interfere with school learning and performance.

Fear is a word describing a person's reaction to a specific outside danger (Johnson, 1979). It is a normal adaptive response. Synonymous to fear is anxiety. Anxiety denotes a fear that is not focused on any special object or situation (Tyerman, 1968). Anxiety is also used to denote the fear which comes from within a person, because of wishes which he or she feels are dangerous to him or her, or because of inadequately repressed thoughts and feelings which he or she dare not face. Everyone experiences anxiety at one time or another. Trying to avoid the situations that stimulate this experience is a normal reaction. If anxiety is overpowering or persistent, the person may require special help.

Another term related to fear is neurosis. Neurosis is the expression of anxiety resulting from some object, situation, or event. It is of phobic type (McDonald & Sheperd, 1976) when the anxiety becomes intense and the behavior is socially embarrassing and destructive. A phobia is a compulsive fear, unreasonable and greatly exaggerated (Sawry & Telford, 1968). The individual recognizes it for what it is but is not able to overcome it. Once the individual loses complete control with

reality and retreats into a world of make-believe delusions and hallucinations (Clarke, 1968), he or she is suffering from a major mental derangement called psychosis.

Among children, one or more specific fears is experienced during the course of their development (Johnson, 1979), the contents of which change as the child grows older. Infants show fear of noises, depth, and strangers; two and three year olds are afraid of animals; four and five year olds are afraid of darkness, nightmares, and imaginary creatures; at about 10 or 11, youngsters fear physical danger or bodily injury.

A factor analytic study by Miller, Barrett, Hampe, and Noble (Johnson, 1979) described three classes or categories of children's fears:

> (1) fears of physical injury or personal loss (e.g., being kidnapped, having an operation, divorce of parents, parental death); (2) fears of natural or supernatural danger (e.g., storms, ghosts, the dark); (3) fears related to "psychic stress" such as taking exams, making mistakes, attending social events, going to a doctor or dentist. This last group of fears seem to be focused on interpersonal relationships. Fears seen in the classroom setting (e.g., school phobia, social withdrawal, test anxiety) all fall in this category. (p. 382)

Children in school admittedly have certain fears and anxieties which can be considered normal and appropriate responses to specific situations. This paper will focus mainly on an abnormal fear, that is, school phobia, which can either be a neurotic or psychotic reaction to the same situation.

CHAPTER 2

WHAT IS SCHOOL PHOBIA?

For years psychiatrists have recognized that there is a type of emotional disturbance in children that is associated with great anxiety and that leads to serious absence from school. This is a deep-seated psychoneurotic disorder (Johnson, Falstein, Szurek, & Svendsen, 1941) clearly differentiated from the more frequent and common delinquent variety of school truancy. The syndrome, referred to as "school phobia," is recognizable by the intense terror associated with being at school. The mere mention of the word "school" causes the child to experience uncontrollable trembling, loss of speech, wobbling legs, pallor, and increased perspiration, respiration, and heart rate. The child may be absent for weeks, or months, or years, unless treatment is instituted. The children, upon fleeing from school, usually go straight home to join the mother. Eventually they refuse to leave the house.

The term "school phobia" was used in London shortly after the First World War to describe the reactions of children who showed signs of violent terror when being brought to school (Tyerman, 1968). It was revealed that this occurred because these children were brought by their parents, during the war, to the school's ground floor which was used as an air raid shelter. The mothers had been scared and the children had come to associate the building with fear.

The study of children suffering from school phobia began in September, 1953, supported by a grant from the United States Public Health Service (Coolidge, Hahn, & Peck, 1957).

Kennedy (1965) reported a yearly rate of 17 cases of school phobics per thousand in the general school population age. School phobia is equally distributed in both sexes (Harris, 1980; Johnson, 1979; Leventhal & Sills, 1964; McDonald & Sheperd, 1976) although other studies claim that girls are commonly affected (Clarke, 1968; Morris, Finkelstein, & Fisher, 1976). Intelligence tends to be average to above-average with school achievements varying from retarded to at least satisfactory (Boyd, 1980; Hampe, Lovick, Miller, Barrett, & Noble, 1973; Leventhal & Sills, 1964; Lindgren, 1976; Nichols & Berg, 1970). McDonald and Sheperd (1976) believed that school phobics come most frequently from middle- to upper-class homes in the United States. Incidence of school phobia shows a greater peak at the 10- to 13-year-old group (Baker & Wills, 1978; Greshan & Nagle, 1981; Waldfogel, Coolidge, & Hahn, 1956).

The school phobic child is characterized as one who refuses to attend school and who displays physical distress and disruptive behavior when approaching school and when in school (Doleys & Williams, 1977). The symptoms may be induced by fear-arousing aspects in the school setting such as the gym, a teacher, the behavior of other children, school work, or the fear of separation from the parent, particularly the mother. Somatic symptoms such

as stomachaches, nausea, vomiting, diarrhea, headaches, earaches, dizziness, sore throats, cough, fever, asthma, spasms of the neck, back and legs, or general body malaise usually accompany the phobia. These symptoms are used as a device to remain at home and often disappear once the child is assured that he or she does not have to attend school. McDonald and Sheperd (1976) wrote that school phobia manifests itself in different ways and in varying degrees of severity:

> The child may cry and cling desperately to his mother when he first enters nursery school, kindergarten, or first grade; or he may experience acute panic with accompanying painful and distressing somatic symptoms that render him unable to attend school; or he may experience a slow and incipient feeling of apprehension and discomfort at school, or at the mere mention of school. (p. 291)

A typical picture (Waldfogel et al., 1956) is that of a child nauseated and vomiting at breakfast or complaining of abdominal pain. No amount of reassurance, reasoning, or coercion can get the child to school.

School phobic children may express their anxiety affectively in so many ways (McDonald & Sheperd, 1976). They may become depressed, cry a lot, withdraw, and lose interest in social and recreational activities with other children. They may also become irritable and aggressive toward their brothers and sisters, parents, peers, and teachers. They may become restless, apprehensive, anorexic, and insomniac. Often, other phobic symptoms (Waldfogel et al., 1956) may accompany the fear of school, such as fear of animals, fear of noises, night terrors, etc.

CHAPTER 3

TYPES OF SCHOOL PHOBIA

Several researchers investigating school phobia have developed their own classification system for differentiating discrete types of school phobia. In 1955, at the School Phobia Workshop in the Judge Baker Guidance Center, Coolidge, Hahn, and Peck (1957) distinguished their cases into two groups--the "neurotic" and the "characterological."

The "neurotic" type of school phobia is characterized by refusal to attend school with some physical distress and disruptive behavior when approaching school or when in school, but its expression is within a generally sound personality.

The second type of school phobia is "characterological" because the phobic symptom is one of the many symptoms indicating a chronic, pervasive, and complex personality disorder.

The parents of the "neurotic" group reported that their children may have had separation difficulties before, such as persistent or less persistent clinging behavior, but the onset of school phobia was acute and dramatic. The children who had been generally cooperative, pleasant, and happy before the acute symptom arose became wretched, tense, and whinny. The children no longer responded to reasoning or to disciplinary measures that had been effective in the past. In spite of the personality change, the children continued to function well in other areas.

They did not lose ground intellectually nor socially. They remained active in friendship and peer group. The group of the school phobia workshop wrote:

> Clinic observations confirmed the parents' reports. The children's overall personality has seemed basically intact. They express affect and fantasy freely, and derive genuine satisfaction from their inner experiences. The symptom represents an accute regressive reaction in the face of an exacerbation of a conflict typical for the group. This conflict grows out of the need to establish autonomy in relation to mother; but, on the other hand, implicit in this maturing is the threatening necessity for the child to attempt to resolve his bisexual conflicts. The child wishes to avoid the anxiety-laden oedipal conflict by remaining the dependent, asexual baby. Although undertones of pre-genital conflicts--oral or anal in nature--may persist, these children have attained a primarily phallic orientation; it is at this level of psychosexual development that they become blocked.
>
> This group of children handles conflict by the displacement of its focus from mother to school, by the phobic mechanism, and by a regressive clinging to mother. They recognize, nonetheless, the undesirability of their new mode of adjustment and wish to master their fears and return to school. (Coolidge et al., 1957, p. 297)

The second group of cases labeled "characterological" were more deeply disturbed and severely crippled than the neurotic group. The character disturbance existed at an early age, thus, for this type, there is a less acute onset and less sudden regressive shift in the overall personality. The onset of the school phobia was the result of relentless process rather than any marked change. Regarding this type, the workshop trio explained:

> The children in this group appear to be fixated at a pregenital stage, and never to have attained even the conflictive level of genital primacy seen for the

neurotic group; this defect becomes increasingly prominent as the child grows older and is subjected on the one hand to increasing pressure for autonomy from without, and on the other hand becomes increasingly aware of his own inadequacies. The fear of school, then, is an integral part of a more diffuse picture of a generalized fear of the outside world; it is accepted because they see no other alternative. The children are forced to rely increasingly on the defense mechanisms of projection and externalization, appear basically mistrusting and hypersensitive, and refuse to take the responsibility for their own inner feelings and actions.

The central conflict revolves around the symbiotic tie to mother. The increasing external pressure and the consequent sense of inadequacy produce feelings of helplessness which, in turn, increases the yearning for dependence and protection from mother, strengthening the regressive tendencies. The fears of helplessness are partly counteracted by a pervasive and all-consuming need for control.

As a result of his absorption with his inner struggle, the child shows a rather impoverished and constricted personality. Affective display is limited. Tensions are difficult to relieve and remain submerged. Fantasies are frightening, uncommunicated if admitted to awareness or totally suppressed from consciousness. With the incessant need to cling to mother and the safety of the home, there is little energy left for satisfactory relationships with peers. Consequently, social adjustment is generally poor and friendships are hard to make. What few friendships there are tend to be highly ambivalent.

Even though the dependent ties are intense, the child continues to struggle for cleavage from mother and desires to establish his own individuality. In part this is indicated in the child's active or passive negativism and refusal to surrender to mother, and in part in the quality of his relationship to his few friends. He tends to clutch them parasitically, using the friend as a model with whom to compare and contrast his own experiences. He tries to glean laboriously from the friend how to act, how to behave, and how to feel and thereby to establish a sense of inner identity. But the relationship to the friend has much of the quality of the relationship to his mother. The friend easily becomes an alternate, obligatory companion, and he develops the same highly ambivalent dependency upon him. (Coolidge, et al., 1957, pp. 297-298)

Kennedy (1965, 1971) gave new terms for the above types of school phobia. For the neurotic type, he called it Type I school phobia or the neurotic crisis, and for the characterological type, he referred to it as Type II school phobia or the way-of-life phobia.

Type I school phobia appears to be a true phobic reaction. It is a conditioned emotional response to the separation that occurs when attending school; that is, being left by the mother and forced to function autonomously in a school setting. Its expression is within a generally sound personality. This type has an obvious and acute onset. For example, the child missed school legitimately the previous week. Being aware of missing a lot of school work, apprehension occurs and that leads to refusal to go back to school. This incident usually happens in the lower grades--nursery school, kindergarten, first and second grade.

Also, a concern about death is expressed in Type I school phobia. The families are usually closely knit, with a great deal of contact between grandparents, aunts, uncles, and relatives of all description. The likelihood then of the child encountering death is much greater than in a detached family unit which rarely sees older members of the clan. A larger percentage of these children reveal a sudden preoccupation with death, an awareness that death does strike one's own family. Type I school phobic children are found to have been recently thinking about the

nature of death and have suddenly realized that they could lose one or both parents.

In Type I school phobia, family relationships and emotional stability are good. Communication between the parents is good. The father and mother are well adjusted in most areas and the father is quite involved in the family.

Type II school phobia is an extremely complex lifetime pattern of fearful responses to almost any situation. The school separation appears to be only one aspect of a complex series of maladaptive behavior. This is a chronic condition which is repeated quite often and no onset can be readily identified. It is hard to say when the child first refused to go to school. His attendance has usually been irregular over a long period of time. The onset is incipient, slow, and gradual. It increases in severity year after year. There is no identifiable progression. The phobics are referred to the clinics when they are in the upper grades. This is when the parents, who previously were not committed to education, finally seek help. Fathers of Type II school phobics have character disorder personalities. They are frequently out of the home, showing little interest in the household and the children, or their own responsibility as a parent. A character disorder personality indicates irresponsibility, a lack of involvement with other people, aloofness, distantness, and lack of commitment.

The two types of school phobia have overlapping symptoms such as (Kennedy, 1965): (a) Morbid fears associated with school

attendance; a vague dread of disaster; (b) Frequent somatic complaints: headaches, nausea, drowsiness; (c) Symbiotic relationship with mother, fear of separation; anxiety about many things: darkness, crowds, noises; (d) Conflict between parents and the school administration (p. 258).

The Human Development Clinic at Florida State University developed 10 differential symptoms between Type I and Type II school phobias. A differential diagnosis can be made logically and empirically on the basis of any seven of the 10.

Type I	Type II
1. The present illness is the first episode.	1. Second, third, or fourth episode.
2. Monday onset, following an illness the previous Thursday or Friday.	2. Monday onset following minor illness, not a prevalent antecedent.
3. An acute onset.	3. Incipient onset.
4. Lower grades most prevalent.	4. Upper grades most prevalent.
5. Expressed concern about death.	5. Death theme not present.
6. Mother's physical health in question; actually ill or child thinks so.	6. Mother's health not an issue.
7. Good communication between parents.	7. Poor communication.
8. Parents well adjusted in most areas.	8. Mother shows neurotic behavior; father, a character disorder.
9. Father competitive with mother in household management.	9. Father shows little interest in mother or children.
10. Parents achieve understanding of dynamics easily.	10. Parents very difficult to work with.

(Kennedy, 1965, pp. 285-286; 1971, p. 273)

Although different authors have their own labels for school phobic types, there seems to be a substantial agreement that one is a more acute (Type I) and the other is a more chronic (Type II) form of the disorder. A third syndrome was suggested (Johnson, 1979) which is best described as separation anxiety in the very young child who is faced with leaving his mother to attend school. This could be construed as an example of the acute form of school phobia.

Baker and Wills (1978) published a study comparing acute and chronic school phobic children. Precipitating factors and a normal premorbid personality were common among youngsters with the acute onset. They were brought for treatment prior to three months of symptom-onset. The chronic phobics showed signs of mental illness as well. Chronic school phobics were found to be more dependent and poorly adjusted than their acute-onset counterparts.

CHAPTER 4

SCHOOL PHOBIA AS DISTINGUISHED FROM TRUANCY

Sandra, aged nine, was happy at school until she had to move from one school to another. Since then, she had made various scenes about going to school; screaming and throwing herself on the floor. She made no clear indication of her dislike for school but verbalized that she did not like being shouted at, it made her feel "funny" (Kahn & Nursten, 1968).

Roy was a dull boy in junior high. He found schoolwork too hard. He had lost interest and had given up trying when friends of his same age and his younger brother had passed him in grade level. His parents had separated. His mother told him that he was expected to be the man of the house in the absence of his father, that it was his duty to protect her and his brother. His mother was surprised that he did not accept this suggestion as a "challenge." His behavior deteriorated; he began to skip school and later to steal (Kahn & Nursten, 1968).

The girl was school phobic, while the boy was a truant. The inability or refusal to attend school results in delayed learning, retarded academic performance, an inability to establish meaningful peer relationships, negative attitudes toward learning and school, and the possibility of subsequent adult phobic reactions. There is also a confrontation with the legal implications of compulsory education.

The phobics' avoidance of school is distinguishable from that of delinquency and the common variety of school truancy. Four diagnostic features of school phobia are as follows (Johnson, 1979): (a) severe difficulty attending school often resulting in prolonged absence; (b) severe emotional upset including excessive fearfulness, temper outburst, or complaints of feeling ill when faced with the prospect of going to school; (c) staying at home with the knowledge of the parent when the youngster should be at school; (d) absence of antisocial characteristics such as stealing, lying, destructiveness (p. 382). In short, school phobia is only one type of school refusal.

The other type of school refusal is truancy. A truant's motives in not attending school may be many and complex but rarely resemble the fear, anxiety, and somatic distress of the school phobic. The truant pretends to set off for school, then roams the streets and enjoys his or her freedom. Some studies (Harris, 1980) noted that truancy indicates a conduct disorder that often involves other delinquent behavior. Truant children tended to come from large families of lower socioeconomic level, have little respect for social regulations, have changed schools frequently, and often have a poor standard of schoolwork. Yet, they seem to have few neurotic symptoms such as anxiety or guilt. Truants are usually unhappy children coming from homes of emotional or material poverty. Truancy by a child is a warning of some emotional problem and developing delinquent tendency. Truancy is "the kindergarten of crime" (Kahn & Nursten, 1968).

School phobics come from homes where education is valued. Parents cannot get their children to go to school no matter how anxious they are that they should go. The children are miserable and anxious in school but seem happy and carefree when at home. These youngsters refused to go to camps, would not stay overnight with friends, would not go shopping alone, would not stay home alone, and cannot tolerate the mother's absence. Parents are more strict; mothers being more protective, and fathers, passive and uninterested. Nervous disorders are more common in these homes:

> At least 3/4 of otherwise well-adjusted children who developed school phobia are suffering from endogenous depression--a disorder that arises from constitutional influences rather than home or school condition. Anxiety reactions are found in more than half of the school phobics. They are unreasonably worried about problems that other children deal with adequately. The symptoms are recurring with no apparent cause. (Tyerman, 1968, p. 30)

The most distinguishing feature of the school phobic is the element of emotional disturbance, anxiety, or guilt feeling involved in going to school. Truancy is more a misbehavior with social implications.

CHAPTER 5

CAUSATIVE FACTORS OF SCHOOL PHOBIA

There is no single psychological explanation as to the causation of school phobia, although the mechanics of the onset of this problem relate back to such factors as the personalities of the child's or adolescent's parents and the interpersonal relations which exist within the family unit (Clarke, 1968). Theorists from the different schools of thought have their own interpretations as to the cause of school phobia.

1. The psychoanalytic school views school phobia as a consequence of a close symbiotic mother-child relationship. The mother is overly protective and the child is excessively dependent. The emotional relationship of possession, dominance, and dependence creates underlying fears in the mother. In the child, it produces hostility, guilt, ambivalence, and anxiety. The child's impulses, anxiety, and resentment become separated from the mother-child relationship and are projected to the school. To relieve the discomfort, the child attempts to avoid school and remain at home (McDonald & Sheperd, 1976).

Freud presented convincing evidence that the child's phobia was derived not from the fearfulness of the object itself, but from his own frightening impulses that had been externalized and displaced onto the phobic object (Waldfogel et al., 1956).

2. The psychodynamic theorists question the explanations based on separation anxiety. They claim that since separation anxiety is not probable among young children, why does the peak incidence of school phobia occur at 10-11 years of age? Why are the same mother-child relationships seen in families without a school phobia problem? Why is only one child affected within the same family? Why do these children not experience problems separating from their mothers in other dimensions of their lives? These theorists believe that school phobia becomes apparent because of the child's omnipotent fantasies and self-image within the context of everyday relationships and achievements. These children overvalue themselves and their accomplishments and then try to hold onto their unrealistic self-image. When the school, teachers, peers, or classroom activities threaten the child's self-image, the child gets anxious and attempts to escape by staying at home. At home the child is reinforced by an indulging and permissive mother (McDonald & Sheperd, 1976).

3. The learning theorists are less concerned with etiology than treatment, although in general they believe that school phobia is a learned maladaptive pattern of behavior (McDonald & Sheperd, 1976).

Garvey and Hegrenes (1966) proposed the learning theory explanation of school phobia:

> The child fears loss of his mother as a result of comments about leaving by the mother, who is usually disturbed. This fear becomes verbally conditioned

to ideas about going to school, where he would "lose" his mother. As the fear of school becomes intense, he finally refuses to go. Staying at home has reinforcing properties in that it reduces fear and usually offers other rewards, such as toys and affection. (p. 36)

CHAPTER 6

FAMILIAL CHARACTERISTICS AND PATTERNS OF SCHOOL PHOBIA

The characteristics of the families of the school phobic children are important in characterizing the children themselves.

In studying the mothers of the school phobic children (Coolidge et al., 1955), the group of mothers tended to encourage dependency. They teach the child that they are indispensable although they did not indulge their children excessively. They are plagued by unresolved dependency by their own mothers. They have deep feelings of doubt and inadequacy but they are able to provide the child a fairly adequate infancy, being able to gratify the physical and emotional needs to a satisfactory degree. It is only later when the child moves toward independence that the mother's problems interfere seriously. To cover up their anxiety and feelings of inadequacy, the mothers appear strong and protective to their children. They become the child's indispensable companion and involve themselves in all aspects of the child's life. The mothers of the chronic school phobics showed a more marked degree in these tendencies than the mothers of the acute school phobics. The chronic school phobics' mothers are also far more dependent upon the child for their own emotional gratification during his/her early years. This is because of the mothers' fewer significant outlets for their own feelings in other relationships or activities. Therefore, they had greater

need for exclusive possession of the child. If this possession was threatened, they tended to withdraw support from the child and give the child up to mother-surrogates. Then they expressed greater feelings of inadequacy in their own role as a mother. They tended to show signs of real self-esteem damage by having anxiety attacks and depression. The possessiveness and withdrawal make it difficult for the child to develop autonomy and to establish an identity separate from the mother.

The fathers form an integral part of the family patterns. Waldfogel et al. (1956) claimed that the father also plays a significant role in the pathological constellation. The central fact emerges that the father has his own uncertain sexual identification, thus, he is able to define clearly his paternal position. He shares the mother's anxious concern for the child and vies with her for the maternal role. It is as though the child had two anxious mothers to contend with instead of one. The father usually involves himself in the problems of child care and rearing. He tries to prove that he can handle the children better than the wife. This undermines the shaky foundation of the mother's own feelings of maternal inadequacy. The father and the mother are actually looking to each other for gratification of their dependency needs.

In relation to the child, the father's search for dependent gratification takes the form of overidentification with the child but is observed as a competitor like a sibling for mother's affection.

The lack of clear differentiation between the paternal roles (Waldfogel et al., 1956) makes it difficult for the children to establish their own sexual identity. Case after case, the phobic child has bisexual conflicts. With this kind of relationship the growing child develops certain character structure deficiencies. Autonomy of ego-development is hampered by the oppressive closeness of the parents. The children cannot master a difficult situation because the parents are always there to protect them from the pains of an emotional crisis. Added to the children's deficiency of ego-functioning is the inflated need for narcissistic gratification. They achieve this mainly through the continuous exploitation of their subservient parents. The inability of the parents to limit the children's unreasonable demands nurtures their omnipotent fantasies and finally, to them, they are real.

Another consequence of the prolongation of the child's infantile position in regard to parental gratification is the impairment of the repressive process. Although the school phobic children were observed during the latency period, the conscious expression of oedipal and even preoedipal tendencies is ordinarily repressed. This is because the children are unable to successfully inhibit their regressive dependent tendencies.

To understand the relationship between the deficiencies in character and the school phobic symptom, Waldfogel et al. (1956) described the dynamics of the school phobic process:

> There are at least three mechanisms involved in the development of a phobia. One is the displacement of

> the anxiety from its original source to a substitute object; e.g., fear of mother may be displaced to a fear of teacher. Second, there is projection of infantile impulses. Thus, oral aggressive fantasies may be transformed into fear of being bitten by dangerous animals. Finally, there is the mechanism of externalization of punishment, the process by which guilt is transformed into fear of being injured or annihilated by some dangerous object in the environment. This process is perhaps best exemplified by the ubiquitous bogeyman of childhood. (p. 760)

In a more recent study of school phobic children (McDonald & Sheperd, 1976), the following is another description of the intrafamilial dynamics and patterns found in their families:

> In most instances, the family constellation is deeply inbred and a high degree of interdependence characterizes the relationships between the parents, child and grandparents. There is a marked lack of interest in things outside the immediate family. Parents, children, and grandparents live an insular existence in close physical proximity to each other. Mothers and fathers are neurotically involved with their own families. Marital adjustments tend to be on an immature level, each partner feeling neglected and resentful of the attention paid to the child by the other. There is a high incidence of preoccupation and concern with death on the part of both parents and children, with a seeming inability to differentiate between fact and fantasy. "Death" and "going away" are equated in their minds and fears express that their evil thoughts and wishes might be carried out during their absence. Finally, there is an intensely neurotic involvement of mother and child, each clinging to the other both physically and psychologically. (p. 294)

CHAPTER 7

MANAGEMENT AND TREATMENT OF SCHOOL PHOBIA

The treatment method for school phobia depends on the nature and severity of the problems and the theoretical orientation of the therapist. However, regardless of the clinician's orientation, everyone agrees that it is necessary to return the child to school as soon as possible. The faster the treatment begins, the shorter in duration the treatment will be. When the child is allowed to convalesce at home, the treatment becomes more complex and lengthy. The prognosis also becomes more guarded (McDonald & Sheperd, 1976). A good rule is never to make the illness a pleasant experience. The child who complains of a headache when it is time to go to school should be allowed to stay home but should be put to bed for the day--no comics, no television (Mouly, 1968). Educators, psychologists, social workers, physicians, and parents have the responsibility of identifying these children, and to correct the problem or alert others with expertise to eliminate the phobia (McDonald & Sheperd, 1976).

1. The psychoanalytically-oriented approach places great importance on the role of analysis and insight, the improvement of ego-strength, and family equilibrium. An individual therapy is included for the mother since she often exhibits resentment, hostility, unresolved dependency, and conflict. Intensive family therapy is prescribed to restore equilibrium and constructive

interaction among its members. The primary objective of the therapist is to achieve early symptom relief. Later sessions are directed at resolving the underlying neurosis (McDonald & Sheperd, 1976). If the school phobia is a masked, bonafide neurosis, treatment must be more prolonged. Probing into whatever previous maladjustment has produced this state must be done (Adams, 1976). If the phobia is severe, the child may be hospitalized and receive individual and group therapy focused on separation anxiety and social adjustment (McDonald & Sheperd, 1976). Psychoanalytic procedures often become very complicated and time-consuming. A considerable amount of time is usually spent seeking the etiology of the behavior. It often involves the collaboration of many people, such as the phobic child, the therapist, the parents or the entire family, the school, and the teacher. Also, a considerable monetary expenditure may be involved (Brown, Copeland, & Hall, 1974). According to Ayllon, Smith, and Rogers (1970), the most widely accepted approach to neurosis is the psychoanalytic one. The phobic object is said to serve as a symbol of some danger that is extremely real to the patient and whose origins are attributed to early childhood.

2. The psychodynamic approach aims to bring to consciousness the repressed fears focusing on the mother-child relationship and to improve family relations. This method tends to be long-term and expensive. It de-emphasizes the role of the school. This approach may be considered beyond the scope of the counselors'

role (Harris, 1980). Leventhal and Sills (1964) recommend that the complicity of all family members needs to be determined. Assessment of the contributing influence of school personnel, school authorities, and classmates should also be done. After obtaining this information, the therapist can attend to the child's fantasies and unrealistic self-image, and to the power issue in regard to school attendance. Confrontation and graduated pressure is applied to the child to ensure his early return to school, and to prevent intimidation of parents and teachers. Radin (1968) argues that the cyclical dynamics producing the school phobia must be interrupted; that is, attitudes of parents, the self-image of the child, and the expression of reality. Insight therapy is recommended to change parental attitudes, influence the child's self-image, and to restore realism and reduce fears associated with school.

3. Representatives of the learning approach criticize the traditional analytic and dynamic therapies as ill-defined and as providing few specific guidelines for correcting school phobic behavior. The maladaptive behaviors exhibited by the child are learned, therefore, they can be eliminated by directing treatment to them specifically (McDonald & Sheperd, 1976). The behavioral approaches are used to work with children in the school. There, the counselor or child therapist can offer direct support in the feared situation. The supportive relationship makes the child feel more comfortable in the school setting. It is important for

the child therapist to be familiar with learning theory and to have an understanding of the psychological principles involved. Counselors may also want to use other helping professionals, such as the psychologist, to help with dysfunctional family relationship. The behaviorists working on the operant aspects of school phobia focus on consequences of the behavior that reinforce the problem such as parents supporting negative behavior. They also attempt to change environmental contingencies. Reinforcement is dependent on the occurrence of a specific adaptive response. Some of the procedures they use are shaping, desensitization, counter-conditioning, and implosion. The behaviorists on the respondent aspect of school phobia center on the emotional reactions that motivate avoidance of school. For example (Harris, 1980), separation from mother may function as an eliciting stimulus for an anxiety reaction that results in avoidance of school. Those focusing on respondent aspects use counter-conditioning and/or desensitization methods to eliminate the negative response.

CHAPTER 8

SOME BEHAVIORAL INTERVENTION PROCEDURES USED IN SCHOOL PHOBIA

The different techniques used by counselors and other experts in combating the problem of school phobia will be discussed in detail in this section. Their specific advantages and disadvantages are cited. It must be remembered that each technique that worked with a particular child will not have the same effect on another child because of a variety of factors involved.

Classical and Operant Conditioning Approach

The strategy of "behavior therapy" is to introduce reinforcement contingencies that encourage the emergence of nondeviant response patterns. This is achieved by pairing the reinforcer with a stimulus (classical conditioning) and/or by making the reinforcer contingent upon a response (operant conditioning) (Lazarus, Davison, & Polefka, 1965).

Lazarus et al. (1965) used these two theoretical models in the treatment of a neurotic case of school phobia. When the avoidance behavior was motivated by high levels of anxiety, they used the classical counter-conditioning techniques. When the anxiety was minimal and avoidance behavior was seemingly maintained by various secondary reinforcers, operant strategies were applied.

It is crucial for the therapist to use the appropriate procedure by being aware of the patient's degree of anxiety. If

the operant model is used when the degree of anxiety is very high, the premature re-exposure to the feared situation will probably lead to increased sensitivity. If the high level of anxiety leads to another escape response, the resultant anxiety-reduction will strengthen the avoidance responses, in this case, the classroom-leaving behavior.

An inappropriate use of the classical model would also impede therapeutic process. The very acts of inducing relaxation, employing "emotive imagery," and giving reassurance may provide positive reinforcement for dependent behavior. The benefits of decreasing the high levels of anxiety, however, temporarily outweigh the disadvantage of increased dependency (Lazarus et al., 1965).

Another drawback of the application of classical conditioning techniques (Brown, Copeland, & Hall, 1974) is that they can involve extended time in terms of someone qualified to administer the procedure. It can also involve considerable monetary expenditure.

Reciprocal Inhibition and Desensitization Approach

The principle of reciprocal inhibition (Woody, 1969) involves making a non-anxiety-provoking stimulus. There will be a reciprocal effect, that is, the anxiety will be counteracted. Systematic desensitization happens when the person is progressively helped through anxiety-provoking situations, staying at each degree of

anxiety until the effects of reciprocal inhibition have successfully diminished the level of anxiety. The person will eventually be able to experience, with little or no anxiety, the situations that provoked extreme anxiety previously. He then has become desensitized.

Relaxation, either alone or in conjunction with other behavioral modification techniques, such as desensitization, can serve to lower anxiety that may be causing undesired behaviors. It was demonstrated that the effectiveness of systematic desensitization seems to be due to muscular relaxation in the presence of the anxiety stimulus.

School phobic children may be treated by behavioral modification procedures in many ways. The basic goal is to remove the child from the unrealistic haven--the home and the stimuli that tend to draw the child away from the school, which may or may not be related to the child's feelings about the mother or insecurity. Steps then will be taken to take the child to school with regular attendance and participation in class activities. With this objective, and the following desensitization model, the procedure would be to establish a relationship and acceptance which may be called a counseling relationship; to develop a series of anxiety-provoking situations related to the school phobia--the hierarchy would come from the discussions, the questioning, and the probing between the therapist and the child; and finally, to start the actual desensitization therapy.

In a pilot project, Lazovik and Lang (1967) demonstrated that desensitization could be successfully carried out under controlled laboratory conditions. The result paved the way not only to a more precise evaluation of treatment outcomes, but also made it possible to test conflicting theories of the treatment process.

According to Woody (1969), the process of desensitization therapy is to maintain the child's acceptance of the therapist, thereby giving the child a supportive, understanding, and helping relationship, and to gradually progress through the various anxiety-provoking situations. The "progressing through" could be done by having the child actually experience the situations, which is called "in vivo desensitization" or by vicarious (simulated) means.

Below is an example of the hierarchy of fear-provoking situations of school phobics in 10 steps (Woody, 1969, p. 184):

1. Watching children pass his house on their way to school
2. Walking out of his house with school books
3. Walking the route to school
4. Seeing the school in the distance
5. Standing in front of the school
6. Standing alone on the playground
7. Standing on the playground with other children
8. Standing at the doorway of the school
9. Standing in the hallway of the school
10. Standing in the classroom

Step 1 would be the least anxiety-provoking. The steps increase in anxiety-provoking power on to step 10. If the mode of treatment was "in vivo" or actual experiencing, the therapist would stand with the child by the window and watch other children

pass on their way to school. The two could discuss how the child was feeling (counseling). When the child felt comfortable with step 1, the therapist might accompany the child, carrying his books out of the house. Each step could be repeated and discussed until the child no longer felt the anxiety when going out of the house as though he/she was going to school. Then the child could do it alone while the therapist watched through the window. Step 3 might include a gradual walk toward the school, one block the first time or for several trials until step 4 is reached without the child experiencing anxiety. The treatment would continue until the child is able to enter the school alone and eventually remain in the classroom.

The child could also experience the same steps by simulated means. In fact, it is advisable to try this before having the child experience the actual situations. The simulated means can be done by having the child visualize himself or herself in each of the respective situations. As soon as anxiety is felt as a result of the visualization, the child should be told to forget the anxiety-provoking situation, think of something pleasant, and relax. When comfortable, the child can be asked again to visualize the same anxiety-provoking situation until it no longer provokes anxiety. Another simulated technique is showing a picture of another child undergoing the same steps. The anxiety-provoking stimuli could also be written on cards. The child could read them until anxiety starts, then relaxation would be suggested.

Systematic Desensitization
with Medication

Gittleman (1976) reported a controlled experimental study of the use of medication ("imipramine") with school phobic children at Hillside Medical Center in Long Island, New York. The Federal Food and Drug Administration has approved the marketing of "imipramine" for the treatment of depression in adults and enuresis in children. The experimental study was hoping to eventually cause the FDA to approve the marketing of the medication for the treatment of school phobia.

In this study, "imipramine" was found to be effective in the alleviation of separation-anxiety but not of anticipatory anxiety. Once in school, the treated children remained anxiety-free although they would still initially refuse to enter situations which they expected to be uncomfortable. If the medication can alter the child's adaptation, it is probably because it affects the deviant psychological state.

Clinicians dislike using a drug for a disorder that so often responds to a simple manuever, such as forcing the child back to school. In this study, "imipramine" was only used with those who had been completely unresponsive to intensive efforts to force them back to school, sustained for at least two weeks.

The treatment of severe school phobia is best carried out under the supervision of a therapist, usually a mental health specialist in a local clinic. The teacher refers the youngster to the guidance counselor or school psychologist. The parents

are then provided with the name of a nearby clinic. Sometimes, the pediatricians are the ones who refer the parents to the specialist.

Once the therapist is engaged, the treatment will consist of a joint effort by the child, the teacher, the parents, and the therapist as the coordinator. This is a form of contact therapy. The child knows ahead of time what to anticipate, what responsibilities to meet, and what the consequences are for meeting and for failing to meet them.

The immediate goal is to return the school phobic child to the classroom. In some cases, this cannot be done right away so the child is led through incremental steps, each one bringing the child closer to complete school return. Below is a description of how one boy was treated with this tactic combined with medication (Gittleman, 1976, p. 42):

> Week 1: Imipramine treatment initiated. Child stayed in guidance counselor's office with mother for one hour a day.
>
> Week 2, Days 1-2: Child and mother visited class, then child returned to guidance counselor's office and stayed there alone. Mother picked him up after one hour.
>
> Days 3-4: Child and mother stayed in class for one hour.
>
> Day 5: Child stayed alone in class for 30 minutes while mother was in counselor's office.
>
> Week 3, Days 1-2: Mother accompanied child to class. He stayed alone in class for 45 minutes. Mother waited outside the school.
>
> Days 3-4: Same as above, but for two hours.
>
> Day 5: Same as Day 4, but for the whole day. Mother returned home. (Child was upset when mother left him, but fine after she was gone.)

Week 4, Days 1-2: Father took child to class; mother picked him up. Child stayed in class all day. (Mother was replaced by father, for whom child's attachment is less marked.)

Days 3, 4, and 5: Father brought child to class. After school, child took the bus home.

Week 5: Child went to school and returned by himself.

The above is an example of a smooth, easy progression. In most cases, however, fluctuations occur.

Rapid Treatment Program

Kennedy (1965) reported the successful treatment of 50 Type I (neurotic) school phobic children. For Type II (chronic) school phobia, the program was somewhat less successful. The treatment involves six essential components as follows:

1. Good professional public relations. Good communication with schools, clinics, physicians, and parents ensures rapid referral and follow-up.

2. Avoidance of emphasis on somatic complaints. Every effort is made to avoid encouraging the children in their complaints of headaches, stomachaches, drowsiness, etc. Such complaints should be handled matter-of-factly by a pediatrician who will see the child either on the way to school or after school. He will also reassure the parents that the medical complaints are not critical.

3. Forced school attendance. It is essential to be able to require the child to go to school. Parents should be willing to use any force, if necessary. If the child can be placed back in

the feared environment with the school, parents, physicians, and psychologists guaranteeing that the situation is not dangerous, then the child's fear will gradually be desensitized.

4. Structured interview with the parents. This is designed to give the parents confidence to carry out the therapeutic program even in the face of considerable resistance from the child. Being optimistic by stressing the nature of the problem tends to lighten the depression of the parents regarding their child's unwillingness to go to school. Emphasize success and present the formula simply and directly.

5. Brief interview with the child. The therapist should see the child briefly and only after school hours. Content of the interview could be conversations regarding the advantage of going on in the face of fear. The transitory nature of the phobia should also be stressed.

6. Follow-up. Phone calls can be encouraging but not over-solicitous. For long range follow-up, talk with the parents about further school phobic symptoms, incidence of other phobias, school attendance records, academic progress, and the occurrence of other emotional problems in the child.

Assertive training (Kennedy, 1971) is a fundamental part of the rapid-treatment program. The children are forced to act as though they and their parents believe that they are able to survive in school and that they are expected to go. The very act of attending school is, then, anxiety-reductive. The children in

this case are trained to assert themselves in the face of the anxiety and to go to school. The word "forced" means they are coerced, encouraged, convinced, brainwashed to the point where they undertake an activity that normally produces anxiety and which tends to produce increased anxiety the longer it is postponed.

Behavioral Consultation with Time-out

Greshan and Nagle (1981) did a study to illustrate how behavioral consultation can be integrated by the school psychologist using a modification and expansion of Kennedy's "rapid treatment procedure" for eliminating school phobia. Kennedy's procedure has been effective but it does not address the role of the school psychologist as a qualified behavior consultant to teachers, parents, and administrators. Kennedy's method provides parents with some information and suggestions for dealing with their school phobic child, but it does not attend to the role of the teacher in dealing with the child's aversive behavior in the classroom setting.

The following case study demonstrates the importance of including teachers, as well as parents and administrators, as consultees and participants in the decision process. A mild time-out procedure was used on Sally. Every time she whined or cried, she was placed in the corner of the classroom. She returned to the group when she stopped crying or whinning. Her

behavior (except crying or whinning) was reinforced by the teacher through praise, attention, and access to desired classroom activities. All somatic complaints were ignored by the teacher and the parents.

The combinations of time-out, extinction, and reinforcement were effective in eliminating Sally's fear of the school situation. The mild time-out procedure was used only to suppress undesirable behavior (crying or whinning) so that appropriate responses could be reinforced. They emphasized that reinforcement-based procedures should almost always be attempted first to increase desirable behaviors.

Implosive Therapy

This approach is based on a classical extinction model and basically consists of presenting the patient with imaginative scenes involving stimuli which evoke strong anxiety responses. The anxiety response is assumed to be the result of previous classical traumatic conditioning, and the high intensity presentation of the anxiety-evoking stimuli (CS) in the basence of a primary aversive stimuli (UCS) will result in extinction of the anxiety responses. While the technique has reportedly been employed with considerable success in the treatment of anxiety in both neurotic and psychotic adults, to the author's knowledge, there are no reports in the literature of the use of implosive therapy on children (Smith & Sharpe, 1970). The present study

concerns the use of this approach in the treatment of a severe school phobia of relatively long duration in an adolescent.

Billy, a 13-year-old boy with severe school phobic symptoms of 60-days duration, was the subject of Smith and Sharpe's (1970) study. His symptoms had developed following a three-week absence from school due to illness. Physical examination proved negative. Tranquilizers did not help. Force, bribes, punishments were to no avail.

Assessment procedures were achieved by interviewing the patient to identify the relevant anxiety-evoking cues. Consultations were held with the parents to obtain the case history and to explain to them the procedures and rationale of the treatment. This is also a way of gaining their cooperation. School authorities were notified and arrangement was made for a preplanned schedule.

The boy was seen for six consecutive daily sessions of implosive therapy. During each session, he was asked to imagine scenes involving the hypothesized anxiety-arousing cues. To help him in focusing on the scenes, he was asked to describe the scenes and his feelings at the moment. Each of the scenes listed below was presented in more than one session. During each session, the scenes to be presented were patterned in a smooth flowing sequence of imagery. Each scene was presented until a visible reduction in anxiety was observed.

1. The patient is awakened and ordered to dress and come to breakfast. During breakfast his parents neither speak to nor look at him.

2. Billy is ordered into the car by a cold and rejecting mother. It is emphasized how "different" she seems. The suspense increases as the car moves toward town and the patient both wonders and fears what will happen to him. Presently, he sees the school looming in the distance.

3. Step by step, the patient slowly approaches the school, being half dragged by his grim and silent mother. His eyes are glued to the building and many thoughts and ideas flash through his mind. Evil, laughing faces appear in the windows and then disappear from view.

4. After walking through the halls of the school, which are deserted and strangely silent, Billy finds himself at the stage door of the auditorium. The door opens and the patient is confronted by the leering school principal, who says in a sadistic tone of voice, "We have all been waiting for you." He can hear many voices from inside the auditorium chanting, "We want Billy." Billy looks to his mother for assistance, but she coldly says, "I'm through taking care of you. You're on your own from now on." She turns and leaves.

5. The patient is half dragged by the principal onto the stage. The auditorium is filled with students and teachers, all of whom are laughing at and jeering him. The parents of all the pupils, including his own parents, file into the auditorium. Billy's parents are described as behaving in a cold and rejecting manner.

6. While on stage, Billy, with spotlights in his face, is examined by each of his teachers, who ask him questions which he cannot begin to answer. He is being examined "to find out what he has learned on his vacation." The gym teacher removes Billy's shirt from his frail body and demands 30 push-ups, which he is unable to complete. The audience jeers, chants, and stares at him with hate-filled, menacing eyes while he is on stage.

7. The patient is ordered to his literature classroom by the principal. The room is dark and strange, and the chairs have been pushed to the sides of the room. Students begin silently filing into the room. It is too dark to identify them. Tension grows as Billy wonders what will happen. The students encircle him, pressing ever closer, and begin to murmur, "Crazy Billy" and "stupid, stupid, stupid." They then begin to jostle and strike him.

8. Billy enters the deserted library where he expects to take make-up tests. Fellow students enter the room and jeer while each teacher asks impossible questions in a rapid-fire manner.

> 9. The patient boards his school bus for the first time since his absence began. The bus driver is described as thick-skinned, ape-like, sinister, and evil looking. (At this point, Billy, through tears, sobbed, "But that's what our driver looks like!) The students on the bus stare silently and malignantly at the patient as the bus veers from its normal route and enters a forest. When the bus stops, the silent students slowly move toward the patient and begin to jostle him.
>
> At the conclusion of the first implosive therapy session, Billy was directed to attend his anxiety-provoking mathematics class the next day. Following the second and third sessions, he was told to attend half-day sessions of school and, following the fourth session, he was directed to school on a full-time basis. This procedure was followed in order to systematically expose Billy directly to portions of the anxiety-arousing stimulus complex. In addition, Billy was instructed to identify situations in school which evoked anxiety, and his reports resulted in several of the scenes described above. (Smith & Sharpe, 1970, p. 241)

The first session was disturbing and exhausting for the patient but, oddly enough, he was able to eat breakfast the following morning. The rest of the sessions went on fairly well.

Suggestibility is assumed to be a factor in the magnitude by which the anxiety-evoking imaginative scenes are experienced realistically by the patient. Thus, the speed with which extinction of the anxiety response occurs is faster among children between the ages of 8-14, when suggestibility appears to reach its peak. The author supported the considerable utility of implosive therapy on such an age group. Also, children would seem less likely to have developed sophisticated cognitive avoidance responses which could interfere with the ability to vividly imagine and respond to the anxiety-arousing cues provided by the therapist.

The advantage of implosive therapy is that the child's anxiety responses occur in the therapist's office. The child will then receive no negative social feedback from peers which is likely to accrue if that child exhibits strong anxiety responses within the school setting.

Emotive Imagery

Emotive imagery is another technique based on the reciprocal inhibition principle. It is a deliberate picturing of subjectively pleasant images such as Christmas and a visit to Disneyland while relating them to the school situation (Lazarus et al., 1965).

Boyd (1980) used emotive imagery in the treatment of a 16-year-old retarded boy with acute school phobia. The behavioral contract was that he would be deprived of television and radio if he would not attend school. For no more than two absences in two weeks, he will be rewarded by a trip to the circus. The behavioral contract required Ricky to go to the school psychologist's office every morning for relaxation training and exercises in emotive imagery. The following hierarchy of behaviors was established with him designating his anxiety level for each (p. 188):

1. Alarm clock rings at 7:00 a.m.
2. Ricky gets up and gets ready for breakfast
3. Breakfast at 7:30
4. Ricky is completely dressed and ready for school
5. Ricky walks to the corner to wait for the school bus to ride to school at 7:45
6. Ricky boards the bus to ride to school at 8:00 a.m.
7. Ricky gets off the bus at the high school at about 8:20

8. Ricky goes to homeroom at 8:30
9. Ricky attends first period class
10. Ricky attends all other classes
11. Ricky goes home on the bus at 3:45
12. Ricky relaxes with T.V. and snacks

Ricky was taught to relax after each level that produced anxiety. Then that level is repeated until it no longer bothers him. He made his trip to the circus and began full-day classes on schedule.

The case of Ricky strongly supported the contention that emotive imagery appears to have a great deal of potential in its application to the treatment of school phobia. The advantage of this approach is that the student can be desensitized to the school setting in the security and safety of the home. In this particular case, the boy verbalized a strong desire to go back to school and to rid himself of the fear and anxiety evoked by the school. Further application of such procedures should recognize the relationship between the initial motivation and success of such behavioral treatment procedures.

Shaping

Requiring a school phobic child to return immediately to school and therefore to a feared stimulus frequently produces unwanted avoidance behavior. To reduce this problem and the risk of intensifying the phobia, differential reinforcement is used to gradually introduce the child to the feared stimulus situations. This is called shaping because the child is reinforced for each

behavior that leads him a step closer to the desired goal of returning to school.

Neisworth, Madle, and Goeke (1975) provided an example of how to treat a preschooler with severe separation anxiety. The subject of this study screamed, sobbed, and withdrew from the time her mother left her at a preschool program until her mother returned. This behavior did not abate with time. Using a shaping procedure, the child was reinforced for progressively longer periods of non-anxious behavior in the school setting. Initially, the mother left the child for only a few seconds. The separation period was gradually increased until the child exhibited no anxiety-related behavior during the three-hour preschool session. This was accomplished quickly and with almost no display of anxiety by the child.

CHAPTER 9

PROGNOSIS AND TREATMENT OUTCOMES

Gelfand (1978) believed that the prognosis for improvement was good if the child received attention before absentism became a chronic problem. Most authors are in agreement that younger children seem to have a better prognosis. Treatment literature on school phobia ranges from promises of complete success to predictions of continued psychological disturbance for many of these youngsters (Johnson, 1979). Various brief intervention strategies which focused on rapid return to school consistently report good results. Kennedy (1965), for example, suggested that the brief intervention approach, or the so called "rapid treatment procedure," was 100% effective in eliminating acute-onset school phobia. Psychotherapy, he claimed, may be more appropriate for the chronic types. Baker and Wills (1978) suggested just the reverse. Rodriguez, Rodriguez, and Eisenberg (1959) used an approach similar to Kennedy's rapid treatment, in which each child was forced to attend school; parents were told to refrain from attending to "sick" behavior, to minimize any secondary gains for non-attendance, and to reinforce the child for going to school without complaints. He reported success in children 11 years or younger. However, only 36% of older youngsters were successfully treated with this method. Perhaps more adolescents suffer from the chronic form of this disorder

which is less amenable to therapeutic intervention. Ayllon, Smith, and Rogers (1970); Brown, Copeland, and Hall (1974); Tahmisian and McReynolds (1971); Hersen (1970); and several other authors confirm the utility of brief intervention in which the child is rewarded for school attendance and inappropriate behaviors are ignored. One hundred percent school attendance was achieved in less than two months with subjects in a study. Youngsters successfully treated in this manner range from 7 to 13 years of age. Neisworth, Madle, and Goeke (1975) had success with a preschooler. The procedure was accomplished in a total of 17 hours, during which only 10 minutes of anxious behavior was observed. The problem was completely eliminated and showed no signs of recurrence over the subsequent six months.

Other learning theorists, using a variety of behavioral techniques, reported further successful results. Miller (1972), for instance, successfully eliminated the school phobia of a 10-year-old boy by combining imaginal and in-vivo desensitization. Social praise and consumable reinforcers were awarded. A follow-up at three months and again at 18 months revealed maintenance of all behavior changes with no evidence of new problem behaviors.

Tahmisian and McReynolds (1971) were first in reporting the use of parents as primary change agents in the successful treatment of a 13-year-old school phobic girl. Parental praise and encouragement were contingent upon appropriate adaptive behavior. Hersen (1970) involved the mother and the school counselor in the

treatment of a 12-year-old school phobic boy. The mother was instructed to be firm, consistent, and resolute in having the boy attend school. She was asked to reinforce progressive responses with attention, to be alert to substitute behaviors, and to ignore all physical complaints and criticisms about school. The boy's school avoidant reactions were eliminated within 15 weeks. A six-month follow-up indicated that not only was the boy able to successfully complete the school year without recurrence of symptoms, but he was doing equally well the following year.

Garvey and Hegrenes (1966) devised the in-vivo desensitization procedures with full cooperation of school officials on a 10-year-old school phobic boy. A 12-step hierarchy was completed over 20 consecutive days and involved 10 to 12 hours of therapist time. A two-year follow-up has indicated that there has been no subsequent manifestation of the school phobia.

Patterson (1965) applied the principle of interference and reinforcement to the treatment of a 7-year-old school phobic boy. During the first of each session, doll play, which closely matched situational cues from the child's environment, was structured to shape behavior. When the child showed greater independence, primary and secondary reinforcers were administered. The mother became familiar with the techniques and, at a cost of 20 bags of M & M's and 10 hours of staff time, the boy was returned to school. No further problem was reported three months after the treatment.

Hillyer's study in 1978 (Johnson, 1979) reported the successful treatment of 12 cases using a variety of brief, operant, and counter-conditioning procedures.

Lazarus, Davison, and Polefka (1965) used a combination of classical and operant conditioning methods on a 9-year-old school phobic boy. In this case, although treatment was not expedient, it was successful 10 months after termination. The boy had not only maintained his gains, but had made further progress.

Favorable results were also reported by the psychoanalytically oriented therapists. Quick symptom relief was accomplished 80% (Tyerman, 1968) of the time.

A 10-year follow-up conducted by Coolidge, Brodie, and Feeney (1964) reported substantially lower success rates. Only 28% of the treated youngsters were functioning adequately. Another 43% had moderate limitations and 30% were severely limited.

Weiss and Burke (1970) noted in a 5- to 10-year follow-up study of school phobic children and adolescents, that little difficulty resuming school after hospitalization was experienced. On the whole, they were earnest school workers, but the social adjustment in school reflected some degree of social isolation and discomfort with peers and some teachers.

Baker and Wills (1978) found 70% of their youngsters on psychotherapy and/or supportive therapy had good outcomes. There were no differences between the acute and chronic forms of this disorder.

Smith in 1970 (Johnson, 1979) reported a 90% success rate, although it may be an inflated estimate because the results of treatment for 22% of the total sample were unknown. Smith noted poor results with the older children, though.

Berg (1970) and Berg and Fielding (1978) distinguished between young and adolescent school phobics. The distinction seemed warranted because of their differential responsiveness to treatment methods. The authors claimed that young school phobics responded better to traditional therapy and to the urgency of early school return. The adolescents, on the other hand, responded better to psychiatric in-patient units, special educative programs, and social rehabilitation. In a follow-up study of hospitalized school phobic adolescents, Berg reported that about 1/3 of the cases are found to be well adjusted on review. Another third are discovered to have some limitations in functioning. The remaining third are found to be severely handicapped by neurotic problems and inter-personal difficulties. It appears, then, that about 40-60% of hospitalized school phobic adolescents return to school following treatment.

CHAPTER 10

CONCLUSION

McDonald and Sheperd (1976) stated:

> There is no question that school phobia is a painful and frightening experience for children, or that it is a baffling and frustrating problem for parents and school personnel. Teachers, counselors, psychologists, physicians, and parents must be alerted to the first signs of school phobia so quick recognition, correction, and/or referral is prompt and effective. School phobic children are not malingering and are not truants--they are, however, children in need of professional help. (p. 304)

To relieve the anguish of school phobia, thus making a normal childhood possible and hopefully prepare the child for, as Radin (1968, p. 193) worded it, "emotional growth" and ability "to cope more realistically with life's challenges," is a task that requires teamwork. Anyone who undertakes the responsibility of treating a school phobic child without involving the school personnel (Gittleman, 1976) is doing the child a serious disservice. The role of the teacher is very important. "Teachers must understand the child as an individual if they are to provide educative experiences maximally conducive to his growth" (Mouly, 1968, p. 506).

Teachers should show a sensitivity and a sympathetic understanding of the child's situation, never attaching blame or punishment. The teacher's behavior can be preventative and remedial if given the right way and the right time (Concannon, 1980). For the teacher to identify the school phobic children,

Hampe, Miller, Barrett, and Noble (1973) gave a tip for unexplained or unjustified absence. If the child has good intelligence and performs well academically, an assessment of the child is likely to result in the diagnosis of school phobia. Then, planning the earliest possible intervention is imperative for "although fearful avoidance of school is a complex and serious problem among school-age children, there are techniques available to professionals for assisting children to overcome school related anxiety" (Harris, 1980, p. 268).

After reviewing several schools of thought on school phobia, it is quite difficult to subscribe to only one particular approach. The divergent orientations have their own special merits. Different behavioral techniques in the learning theory impressed me though, because they are practical, economical, and more direct in the sense that the treatment is school-based and everybody involved with the child, namely the parents, educators, psychologists, administrators, and physicians are in close cooperation and in an active interaction with each other. This team approach ensures a more effective treatment, avoiding vague translations and misunderstandings. However, there are cases involving deeper psychological disturbance--as, for instance, in the characterological or chronic types of school phobia--which respond better with the psychoanalytic approach. This orientation, though, should not exclude or de-emphasize the school, school-related events, and its personnel.

From the literature, the author has accumulated a smorgasbord of pointers when dealing with school phobia. First of all, a good rule is never to make illness a pleasant experience. If the child has too much of a headache to go to school, he or she should stay in bed for the day. Television, comics, cardgames, etc. should not be allowed. If the child is sick, the rest will be beneficial. If the child is faking, any repetition will be discouraged. Naturally, a physician's check-up is a must if indicated.

Probing for pressures in the school causing the illness should not be overlooked. Incidentally, do not suggest a change in the school or class. Trying to make school easier or less demanding does not help. School phobic children have great difficulty adjusting to a new situation. Introducing a new environment is more likely to aggravate the problem. Home instruction should not be arranged for it will communicate to the parents and the child that school attendance is not necessary. But then, it is not also advisable to literally force the child back to school. If the school situation is worse than expected, then the child will be more frightened. Do not suggest that the child stay longer or try to do something other than what has been previously arranged. School staff members are understandably eager to see the child get well as quickly as possible, so they try to encourage the child to do more than what has been agreed upon with the parents and the therapist. The school phobic child

who is confronted with unexpected, new demands will perceive the classroom as an unknown situation, where unpredictable demands may arise at any time. The child may become mistrustful and may refuse to take a chance by going to school.

Recognition of the school phobic child should pave the way for proper professional help which consists mainly of a team effort by the parents, educators, and psychologists or physicians. Early return to school is the prime ingredient in various treatment approaches, reserving psychoanalytic methods for deeper psychologic disturbances. The results of such treatments have been met with significant success.

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