SCHOOL PHOBIA: PSYCHODYNAMIC AND DEVELOPMENTAL CONSIDERATIONS

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School Phobia: Psychodynamic and Developmental Considerations

A dissertation submitted to the Institute for Clinical Social Work in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Social Work

by

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Developmental Considerations

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PREFACE

The psychosocial problem and treatment of school phobia has always held wide interest for me as a clinician. This project embodies my experiences in a number of therapeutic settings, including child guidance clinics, in-patient units, and private practice. I hope to convey the findings of my investigation into the problem of school phobia in an effort to compare, substantiate, or otherwise incorporate the views of many other workers in this field of interest.

This project does not represent new or original knowledge but rather is a survey and summation of existing theory with the purpose of integrating this theory into practice.

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CHAPTER I

Introduction and Background: An overview of the Problem of School Refusal

The condition of school refusal is sufficiently widespread and severe to warrant a continuing examination of its nature. School phobia is a disturbance of the individual, but social problems arise where symptoms are expressed in an educational setting and in a form which challenges community obligations and resources. Thus, school phobia is a clinical problem of the individual; it is also a problem of inter-personal relationships for the family, an educational problem of the school, and a social problem of the community.

In this country, over forty years ago, an atypical group of children with psychoneurotic elements in their character structures was noticed; a similar observation was made a few years later in England. Despite these observations, the term "school phobia" itself did not appear in the literature until 1941.

The term "school phobia" is used, as it now has wide acceptance but "school refusal" is a more inclusive term, since it covers all cases where there is a psychosocial component.

The term "playing hookey" came into use after education had been made compulsory towards the end of the nineteenth century. At that time, the term probably covered all forms

of absence from school without leave, and it is only recently that the different forms that absence may take have begun to be studied.

The difference between truancy and school phobia needs clarifying. A truant is usually thought of as a child who is absent from school without his parents' or the school's permission, although there is another type of truant who is kept at home by his parents because the child can be of some direct help by his presence within the family. Either the child or the parents can initiate absence from school. If it is the child who starts it, unknown to the parent, it is called truancy; if it is the parent who openly encourages the child to stay away, it can be called school withdrawal. Both are significant social problems.

By contrast, the child with school phobia may want to go to school, but finds that he cannot. He is suffering from an emotional problem, based on acute anxiety at the thought of leaving home. It is because he fears leaving home that he cannot go to school. In fact, school phobia is a misleading term as it is only the result of another problem, the source of which is the tie between parent and child and its ensuing conflicts. School phobia can be considered a neurotic state which tends to express itself mainly around the recurring need to pass from home to the socially more structured and more demanding atmosphere of school.

These brief definitions indicate that the social problem of truancy and the emotional and pathological problem of school phobia are very different. Absence from school is the factor common to both, but they are not just different degrees of the same difficulty. They have different causes and are as different as any two syndromes.

The first planned studies which compared the differences between truants and children refusing to go to school for irrational reasons, were made by Warren (1960) and Hersov (1960). Both writers confirmed that truants were showing indications of conduct disorders which often included delinquent trends, while those who failed to attend school for irrational reasons were showing one aspect of a neurosis which often involved the entire family.

Hersov's statistical study of fifty cases of school refusal was an examination of the clinical features, type, outcome and follow up of children seen in the children's department at the Maudsley Hospital. He further investigated the hypothesis that children referred for persistent nonattendance at school fell into one of two groups: those whose behavior is one facet of a psychoneurotic syndrome; and those whose attitude and behavior indicates a conduct disorder. From this hypothesis predictions were made of significant differences in respect to environmental circumstances, parent/child relationships, and personality and intellectual level of the child. The

results of Hersov's study confirm, to a large extent, the hypothesis and predictions made. Children referred for neurotic refusal to go to school came from families with a higher incidence of neurosis and had less experience of parental absence in infancy and childhood; they seemed passive, dependent, and over-protected but exhibited a high standard of both work and behavior at school. Children referred for truancy came instead from large families, where home discipline was inconsistent. They have more experience of mother's absence during infancy and father's absence during later childhood. Schools have been changed often and the standard of work which the child produces is poor.

Just as the word "truancy" covers different forms, so does the term "school phobia". It is a comprehensive, umbrella term. The basis of most conditions is the fear of leaving home, and, if the child is pressed to do so, his anxiety can amount to panic. School represents the outside world and is a different type of reality from the one which the child has experienced at home. Some children find it too much to face, and they retreat to something more familiar. School is often the first place where a child has to get along without his mother's support.

In the development of a school phobia a conflict in the child is sometimes displaced, or transferred, to the school situation. Some aspects can fill the child with fear, but if it is treated in an apparently logical manner, by, for instance, changing the school or excusing the child from an

abhorred lesson, another focus is soon chosen. For instance, Ann, a 10 year old sixth grader, was absent from school for several weeks due to severe allergies. When her physical symptoms subsided, she refused to return as she said she feared she had fallen behind in her lessons. The pediatrician arranged for a home teacher to work with Ann until she was caught up with her school work. However, when it was time for her to return to school, Ann developed a fear of the dark, could not sleep at night and instead slept in the morning as she was "too tired" to attend school. In this instance Ann chose as her second focus, something that the adults in the situation were either unwilling or unable to alter.

Looking at the focus of fears and into the precipitating factors does not identify the actual causes. The precipitating factor is likely to be just the most recent, disturbing event that has upset an already predisposed child and made his fears the easier to focus. The cause lies within the child and within the family relationships, as the symptom of school phobia can frequently cover a deep disturbance. It may be the beginning of a more complete withdrawal from life. School may be just one activity of many from which the child withdraws.

In many cases the child is susceptible to some emotional disturbance and school phobia is just one expression of many that the breakdown can take. Often the

symptom of school phobia, although only one of the modes of pathological expression, points to a disorder of the parent-child relationship. This is particularly true if acute anxiety is aroused in the child due to some previously unresolved conflict and if, simultaneously, the mother is threatened in her security by such things as illness, marital unhappiness, economic hardship, or demands that she resents. In her frustrating situation the mother partly needs the presence of the child at home. Mother and child both revert to a former stage of mutual satisfaction, but at this stage their relationship may get out of step and the child's hostility and demands can become distressing to the mother. There is, therefore, always some wish for the situation to be cured, even though the symtom partly fulfills a need.

Adelaide Johnson (1957) stated that her ideas, formulated in 1941 could now be accepted as a scientific principle. It was felt that given (a) a poorly resolved dependency situation between the mother and child and (b) coincidence of precipitating factors causing acute anxiety to the child, with a threat to the mother's security (e.g., economic or marital) school refusal would become overt. The child's anxiety and need for dependence maintained an attachment which the mother could not afford to forgo. This principle has been shown to be particularly relevant to those cases occurring in adolescence. When dependency in the child has been unduly prolonged, the urges that arise

during adolescence from within begin to conflict with the external pressures that already exist. The stability of the personality becomes precarious, and any change in the balance of forces in this conflict can lead to a state of panic and of regression to levels more appropriate to early childhood.

Separation anxiety as a basic component of school phobia is fully discussed in other papers. Eisenberg (1958) graphically describes the protective domination that some mothers show. This reinforces the existing anxiety within the child. The mother's apprehension brings on a quavering voice and trembling gestures and yet, accompanying these modes of behavior, are empty verbal reassurances. It is as if the child is told by nonverbal means of communication of the dangers that lie ahead--the unknown becomes even more frightening than he had dared suppose. When the mother of Barbara, a 9 year old school phobic girl, telephoned and stated in the child's presence, "What do I do when this plan doesn't work?" the child's symptoms appeared comprehensible as a response to the more hidden needs of the mother. In this instance, the mother was voicing the goal of getting Barbara to school but was simultaneously sabotaging the chances of doing so.

From an overview of the recording of clinical obsevation, it is possible to see revealed the wide range of underlying psychopathology in these cases. It can sometimes

be considered to be a specific phobia, and it appears that anxiety can become detached from a certain situation in early life, and be displaced on to the school as a neurotic fear. Anxiety may be controlled, to some extent, by an avoidance of the feared situation; the anxiety is then recognized and an escape is sought from the people or the places on to which the intense fear has been displaced. Another group of papers show the range of conditions within the term "school phobia." It has been observed that cases of school refusal can occur in neuotic and psychotic children as well as those who while actually present at school absent themselves from the learning process. Coolidge (1962) stresses the severity of the problem when it occurs in adolescence, although it can be associated "with widely varying degrees of emotional disturbances ranging all the way from transient anxiety states--reflecting a developmental or external crisis--to severe character disorders bordering on psychosis . . . we have observed a definite and direct relationship between the age of the child and the severity of the disturbance."

In another study by Coolidge (1962) two separate groups of school phobic children were identified, although it was acknowledged that one could shade into the other. Out of twenty-seven cases, eighteen were considered to have their basic personality intact, but nine were found to be much more deeply distrubed. The former group comprised mostly

girls. They functioned well intellectually and socially, in areas apart from attending school. The conflict between the child and the mother was thought to be displaced on to school, and the problem was considered to be an anxiety reaction similar to other childhood phobias. The children were still tied to their mothers, and hesitated to take a step forward into the triangular patterns of relationships which included the pattern.

The latter group comprised mostly boys in an older age range, who had experienced a less acute onset of their school phobia. Their school refusal seemed to be the culmination of a gradual but relentless process rather than an acute, marked change. They had a diffuse fear of the outside world and were mistrusting and hypersensitive. They had no energy for relationships with their own age group, and social adjustment was poor. However, there was sometimes a struggle to attain some individuality, and there could be a refusal to surrender totally to the domination of the mother.

The author of this study is impressed with the presence of disturbed family dynamics in families where there is a school phobic child. This is particularly true in the mother-daughter relationship with school phobic girls and is often expressed in intergenerational proportions. In this author's clinical experience with these cases, the following family pattern has been familiar: mothers and daughters had

emotional needs which they felt to be unfulfilled. They longed for gratification and found it difficult to separate, but they were confused in their idea of nearness in space meaning closeness in spirit. The mothers were often still dependent on the maternal grandmothers, but also resentful of their need of them. This tie continued despite marriage, and the situation was reenacted with their own daughters. The strong (and opposite) feelings, of their need and their resentment of it continued to pull in different directions. The mothers were anxious on some counts, not to repeat mistakes that they felt they could view objectively, when they examined their own upbringing. For instance, they frequently had felt over-protected in relation to sexual information and, in their eagerness not to repeat this mistake, were inclined to push their young daughters from childhood into adulthood by over-confiding in them. Here, closeness seemed also to be equated with intimate, cosy chats. In fact, the maternal grandmother was often living with the family and, as a group, they showed little interest in events outside the home. The parents were not happily married, but stayed together out of a sense of duty; they seemed to behave as they would have expected good children to act. It was noticed, too, in these parents that fact and fantasy often blurred one into each other. They were involved with their fears of death, and even a simple act which involved absence would stir up their fantasies. Going

away was equated with death, which in their eyes was taken as meaning abandonment, and being left with no one on whom to depend.

The wide range of pathology, and the severity of some of the conditions behind the manifest symptoms, can be seen in the fact that school phobic children have been included in studies of various problem areas. For instance, anxiety was taken to be a factor in a survey of absence among 10,000 children, and it seemed likely that other such absence might be cloaked under somatic disorders. School phobia is mentioned as a problem in a paper on preschizophrenic symptoms, in a Rorschach study of twins, in a study of depression in girls during latency, and in a classification of psychotic disorders in childhood (where reference is made to a psychotic boy who was also school phobic).

Although the term school phobia is a comprehensive, umbrella term, the author feels that the study of the condition frequently reveals a wide range of underlying psychopathology. School phobia is often a misleading term in that it is a manifestation or result of another problem, the source of which is the dependent tie between parent and child and the conflicts that occur when this tie is threatened. Thus, separation anxiety is a basic component of school phobia.

In order to examine the nature of school phobia and its ramifications, the author's perspective must be explained in

terms of his own theoretical frame of reference so that the reader may understand the context in which the author is conducting this study. Chapter II describes psychoanalytic developmental psychology as the author's theoretical frame of reference.

CHAPTER II

Psychoanalytic Developmental Psychology as a Theoretical Frame of Reference

The complexity of school phobia requires a thorough examination of personality determinants and behavior and necessitates a theoretical orientation which can encompass physical, intellectual, and emotional components. Psychoanalytic developmental psychology, as a theoretical framework, lends itself to the kind of in-depth examination of pertinent factors that is essential for a comprehensive understanding of the condition and its ramifications.

Psychoanalytical Psychology may be viewed as developmental psychology in that it accounts for the structuralization of the personality from birth onward. While the most rapid and fundamental features of structuralization take place in the early years of life, development is a process which continues throughout life. Thus, psychoanalytic developmental psychology takes into account diagnostic and psychodynamic formulations in addition to the advances in developmental theory.

There has been a recent flourishing of interest in potentially innovative directions deriving from developmental perspectives (Settlage, 1977). The developmental point of view can be seen as one of several orienting perspectives in psychoanalytic thinking.

Psychoanalysis has long been accepted as a genetic, dynamic, and structural psychology. Within psychoanalytic circles, its tenets have rested on generally established assumptions. The inclusion of a developmental perspective, however, will also require generally accepted explanatory hypotheses which rely on assumptions of a developmental point of view.

In order to adequately examine the etiology,treatment, and prognosis of school phobia in children and adolescents, the influence of hereditary factors, the impact of familial and other environmental influences, the significance of developmental capacities and vulnerabilities, the fluidity and plasticity of the young child's personality characteristics, and other pertinent considerations must be taken into account. Therefore, a traditional medical somatic model is insufficient in dealing with the psychopathological disorder of school phobia. Descriptive clinical, genetic, and dynamic dimensions must be viewed in a manner appropriate to the developmental nature of childhood.

The term development is used to designate the increasing differentiation, complexity, and ultimate integration of structure, function, or behavior. Development can thus be said to encompass the interaction of maturational patterns and of experience or learning.

In regard to personality development, certain principles can be fairly readily discerned, having some

parallels with physical patterns. These include continuity and consistency, with each stage of development related to and influenced by preceding stages as the personality gradually becomes more organized and consistent in its patterns of response. The individiality of these patterns is maintained, however, despite the tendency of certain common clusters of personality traits to emerge in older childhood and adult life. Personality development tends in general to follow a certain sequence; nevertheless, the rate of development, while often showing consistency, may vary considerably from individual to individual and from stage to stage within individuals. Phases of development can be identified. Transitional periods occur between these phases and involve developmental crises that must be resolved before the child can move forward to the next phase.

Although gradual progression is the rule, with a tendency toward the crystallization of an inner psychic structure, development is ordinarily uneven in childhood. Spurts, plateaus, and lags are characteristic, as in physical growth. Noxious stimuli of various sorts can induce temporary behavioral regression to more safely established levels of adaptation, or they may result in arrest or fixation in different dimensions of psychological development. Either intrinsic or experiential factors can produce a developmental lag, a serious retardation, or a blunting or distortion in one or another aspect of personality development.

Some interrelationship appears to exist among the several aspects of personality development. These embrance intellectual, emotional, physical and social dimensions in all their capacities and relate to the psychological, physiological, and social levels of organization. Parallel progress may occur among dimensions; widely divergent paths may be followed, however, and much unevenness may appear. It can be said that a basic ground plan of personality development exists for the individual child. Within this overall framework, founded on maturational underpinnings, each part of function is seen as having its own special time of ascendancy, based on previous steps and responding to a particular configuration of environmental stimuli. The basic progresssion appears to move from global and undifferentiated responses in early infancy toward increasing differentiation of function within the different dimensions. Ultimate integration of differentiated functional parts of the personality appears to take place in the constant interplay between the developing organism and its environment, resulting in a functioning whole that is more than the sum of it parts .

In the first several months of life, prior to the development of true object relations with a parent figure, the infant apparently has a limited capacity to screen out or to monitor stimuli from without or within. At this stage he appears to respond in an immediate and global fashion to

overstimulation or to a lack of gratification of his needs ranging from nutritional to stimulus hunger, with a number of organ systems diffusely involved in the particular response.

As object relations and primitive ego functions develop, the older infant or young preschool child is able to react in a more differentiated fashion to emotional conflicts. These take place originally between himself and his environment, represented initially by the parents, and occur in the context of the young child's struggle to master himself and his environment. Such reactions at this stage are often transient and reversible, generally responding to the resolution of conflict involved in environmental shifts or supportive influences from the parents.

The further development of the mental apparatus in the late preschool and early school-age child, including the formation of the conscience or superego, together with the appearance of more effective repression of affects and of other ego mechanisms, makes it possible for him unconsciously to internalize emotional conflicts of the nature described, when these remain unresolved. At times of developmental crisis involving conflict situations the child at this level may be able to resolve the conflict and move forward to a higher level of adaptation and personality development. Or he may be unable to accomplish such a successful resolution, depending upon his adaptive capacity

and the current family situations, so that repression and internalization of the conflicting emotions may take place. Conflict may thus become self-perpetuating in nature, leading to repetitive and often maladaptive attempts by the child to employ various inappropriate defensive or coping maneuvers. Thus, unconscious conflict, together with the associated defenses, may become an integral part of the personality structure. The potentiality for future modification may be limited under such circumstances; this represents the model of neurosis. Or there may be a different--perhaps a temporary retrogression, more long-term arrest or fixation in function or development, or decompensation and adaptive breakdown, the latter leading to a more serious level of psychopathology.

In its broadest sense, psychoanalytic developmental psychology underlines the importance of the interaction between innate and experiential factors in the child's development as his burgeoning mental apparatus integrates external environmental forces with intrapsychic perceptions and adaptive operations. As Anna Freud (1965) has pointed out in her "developmental profile," defensive or adaptive maneuvers utilized by the child will depend upon his inherent characteristics and upon his developmental level, with its available capacities. The attitudes of the parents or other persons in the social milieu will support or interfere with the use of particular mechanisms. The

balance of internal and external forces is thus the vital factor in the diagnosis and treatment planning for both the child and the family.

Psychoanalytic developmental psychology draws heavily upon psychoanalytic theory involving structural, dynamic, genetic, and adaptive aspects of the functioning of the mental apparatus. Indeed, the concepts of emotional conflict, conscious and unconscious levels of thought and feeling, the phenomenon of repression and the operation of other psychological defense mechanisms in response to anxiety, and the importance of object relations, with their vicissitudes, have become cardinal features of modern dynamic psychology and clinical practice.

In more recent years there has been an emphasis by workers in the psychoanalytic field upon ego psychology. These workers have elaborated on earlier concepts of ego functioning, stressing the importance of such aspects as perception, discrimination, integration, thought, affect, motility, tension regulation, speech, individuation, self-perception, and reality testing. These ego functions appear to subserve coping mechanisms directed toward the solution of psychosocial tasks in development along with the additional influences of family, peer group, social class, ethnic, and other sociocultural and historical forces.

While Freud's own writings and those of his "pupils" provide an ample literature for the student of Freudian

theory before 1940 or so, there is little in the way of a comparable unified literature on contemporary Freudian ego psychology, usually referred to simply as ego psychology or, lately, as psychoanalytic developmental psychology. This may be accounted for by the fact that, after Freud's death, there was no longer a single mind evolving theory. Rather, a number of investigators whose works to some extent build one upon the other, but to a much greater extent are complementary, contribute to the totality of modern Freudian theory. The writings of these theorists constitute primary sources. However, unification of the theory is attained only by reading each of these authors separately. In Ego Psychology: Theory and Practice, Blanck and Blanck (1974) attempt such a unification in their study of the evolution of psychoanalytic developmental psychology.

The Blancks summarize the works of Heinz Hartmann as well as his collaborators, Ernst Kris and Rudolph Lowenstein whose contributions are believed to constitute the foundation stones of contemporary ego psychology. In addition, the theories of Edith Jacobson, Margaret S. Mahler, Rene A. Spitz, Otto F. Kernberg, and Heinz Kohut are included.

A comprehensive study of psychoanalytic developmental psychology would also entail the contributions of Anna Freud, John Bowlby, and Erik Erikson as well as the object relations theorists Klein, Fairbairn, Masterson, and Guntrip.

Theoreticians Greenacre (1960,1967,1971), Jacobson (1964), Kernberg (1966,1974,1975), Kohut (1971), and Mahler (Mahler and Furer, 1968; Mahler et al., 1975)--have over the past decade provided us with a still expanding theory of earliest psychic development. New efforts at defining the pathogenesis and pathologic formations of psychological conditions rest upon the precise correlation of traumatic experience during the first years of life with the newly delineated phases of primary psychic development and the specific emerging developmental attainments these comprehend: self-object differentiation; core identity and the sense of self; autonomous and experientially shaped basic ego functions; early defensive and adaptive mechanisms and modes; initial control and modulation of drive and affect expressions; libidinal object constancy; initial capacity for one-to-one relationship.

In the past, psychoanalytic knowledge, for the most part, was based primarily upon the process of reconstruction. However, direct observational studies of the development of children during the first years of life is proving to be increasingly valuable.

Settlage (1977) states that each of the study approaches, the reconstructive and the direct observational, has its merits and limitations. The reconstructive or retrospective view from the clinical situation provides an understanding of the vicissitudes of development over time

and of the eventual outcome of the impact of traumatic experiences. This understanding cannot be equalled through attempting to predict the future results of currently known trauma in the developing child. On the other hand, the reconstructive formulation of the precise nature and timing of trauma and of the details of the normal developmental progression is, although impressive, unable to approximate these delineations as gained in statu nascendi from direct observation. It seems evident that the approaches are complementary to rather than in conflict with each other, and that both of them are valuable and essential to a full psychoanalytic understanding. Indeed, Freud observed as much in 1905: "Psychoanalytic investigation, reaching back into childhood from a later time, and contemporary observation of children combine to indicate to us still other regularly active sources of sexual excitation. The direct observation of children has the disadvantage of working upon data which are easily misunderstandable; psycho-analysis is made difficult by the fact that it can only reach its data, as well as its conclusions, after long detours. But by cooperation the two methods can attain a satisfactory degree of certainty in their findings" (p. 201). Ernst Kris (1950) stated that the data furnished by direct observation has attained the dignity of an analytic study proper and has become increasingly capable of integration with material derived from reconstruction in the analysis of adults and children.

Kohut (1971) has expressed himself on this issue in a comparison of his and Mahler's conceptual frameworks. He characterizes his formulations as being in conformance with psychoanalytic metapsychology, requiring the empathic reconstruction of childhood experiences through their revival in the transference. He sees Mahler's formulations as belonging to the realm of "psychoanalytic interactionalism," having their basis in the sociobiologic framework of the child in interaction with the environment. "Mahler observes the behavior of small children; I reconstruct their inner life on the basis of transference reactivations" (p. 219).

Invaluable as it is, the genetic, reconstructive approach has limitations with regard to those aspects of development, particularly infantile development, that are subsequently condensed, telescoped, integrated, synthesized, or transformed so as to be difficult to perceive in the analysis of the older child or adult. The lack of capacity during the preverbal and preoedipal phases for conscious memory and full verbal symbolization tends to preclude the clear representation of earliest psychic experience in the analytic situation, thus seriously handicapping reconstruction of those phases. Psychoanalytically based emphatic observation of interpersonal behavior during this developmental period, along with a study of its determinants, is thus essential to a complete and accurate

psychoanalytic understanding of the initial development of object relations and of psychic structure, and to the process of reconstruction in the treatment of disorders whose psychopathology involves these areas of development.

As mentioned earlier, psychoanalytic developmental psychology sometimes utilizes explanatory hypotheses which rest on assumptions of a developmental point of view. Abrams (1978) lists 5 hypotheses fundamental to psychoanalytic developmental psychology:

"1. Maturational emergence: there is an expected sequence of emerging functions in the psychic apparatus leading to progressively differentiated structures of hierarchical organization; the sequences, the functions, and the structures are rooted in biological sources.

2. Mileiu: to materialize and flourish, each require environmental stimulation. The range of stimulation and the timing are important variables influencing outcome.

3. Experiential interface: the experiential products of the "outer" and "inner" interaction also codetermine what is to follow.

4. Transformations: each step in the sequence involves transformations as well as sequences.

5. Progression-regression processes: development is also effected by intrinsic regressive and

progressive processes which influence intensity, duration, and cadence" (pp. 388-89).

The developmental hypotheses arrived early on the psychoanalytic scene. By 1905, in the course of outlining the psychosexual phases, Freud had found use for all of the listed five. Maturational emergence: oral, anal, and phallic drives were a sequence guaranteed by biology. Milieu: the Anlagen materialized within settings. Experiential interface: severe frustration or excessive gratification were believed to have critical impact on what would follow. Transformations: transformations were explicit in the concept of sublimation of sexual aims and implicit in the appeaance of hierarchical levels of organization. Progression-regression processes: shifts, arrests, and fixations were critical in appreciating the range of implications of the new discovery.

Despite the centrality of these propositions, it was not the developmental aspects of Freud's thesis that attracted the attention of clinicians. Rather, what stood in the foreground was the convincing demonstration of the existence of infantile sexuality and the far-reaching theory of instinctual drives which Freud conceived to account for its existence. The clinician's goal became access: access to the drive-derived sexual expressions of childhood which had gone awry. A topographical model of the mind was created to concretize the quest for earlier determinants of behavior.

What followed was a couple of decades of depth psychology, an important period of confirmation and new challenges. In 1926, in his monograph on anxiety, Freud summed up much of what had been discovered in the preceding generation and mounted a new plateau. He reexamined anxiety and used the frame of reference of his developmental psychology to do so. Steps in the ontogeny of danger was a maturational given; each step involved a climate of interaction; the resultant product of the innate and of the milieu cast its influence on what followed; new signals of danger were correlated with the establishment of new mental structures; and, naturally, there was the inevitable ebb and flow to it all. Anxiety wasn't simply a result of repression; it was a biological guarantee, both a signal of danger and a stimulus for growth.

However, once again, it was not the developmental features of Freud's monograph that moved the clinician. Instead, attention to this critical ego function had the effect of accelerating the shift from "topography" to "structure." The clinical focus was no longer the drive-derived infantile sexual components alone. Rather, the orientation turned toward access to the unconscious conflicts which had existed between systems of the mind and had become accessible to recall in the structure of those systems thereafter.

Anna Freud's the Ego and the Mechanism's of Defense (1936) was a pivotal contribution in the thirties. The same developmental concepts were central in this work as well.

The forties began with an interest in the "milieu" postulate. There was an enhanced attention to life's circumstances, either from the viewpoint of their being "average expectable" (Hartmann) or definitively directive (e.g., Erikson). Although Hartmann and Erikson's work remained well within the classical psychoanalytic framework, an accelerated interest in "social" issues and "external" sources of conflict induced many other clinicians to shift their therapeutic perspective from the field of mental representations to the arena of interpersonal reactions.

The past 25 years have seen the pressure to attend to developmental propositions arising primarily from the research observations and the analyses of children. A listing of all the sources of such pressures would produce an impressive bibliography. Piaget from a position outside psychoanalysis and Mahler from inside it would have many citings in such a reference list.

In considering the reconstructive and developmental approaches separately, one can see that the traditional explanary stance of the clinician is inclined to have a reductionistic base. The analyst searches for fundamental elements, for the roots of behavior. He seeks access to the

forgotten past and especially to certain criticial experiences in that past. What people probably think about most when they think about psychoanalysis is this explanatory orientation: "understanding" requires access to the fundamental, to the source elements that determine behavior. That is what "analysis" literally means, i.e., "the resolution of anything complex into its simplest elements."

A reductionistic stance, too rigidly entrenched, however, precludes the recognition of other explanatory possibilities, some of which may be useful in engaging the developmental features of the psychoanalytic situation. Something more than a reductionist stance, something more than atomistic reasoning is necessary to account for the existence of new products and for their influence. For example, Schur (1955) has proposed that a "somatization" may be understood as a transformation of an affected state, not necessarily a consequence of simply some antecedent element of impulse. Similarly, reductionism alone can never account for the presence of special idealistic trends, of object removal, or of affective intensities of the kind that first make their appearance during the phase of adolescence. A good deal of the behavior of teenagers can often be explained on the basis of the impact of these new emergencies rather than earlier determinants.

An additional explanatory stance is necessary to comprehend complexities of this sort. An effort at synthesis is one of the requirements in that addition. Entailed within it is coordinating, integrating, bringing together the old and new in a way that places the same and the different on a new plane of experience. Piaget (1963) calls a stance of this kind a "constructivist" type. He defines a constructivist explanation as one ". . . which while giving a certain place to reductionism (since it is one of the aspects of all explanation), mainly emphasizes construction processes. . . ." He goes on ". . . insofar as one can give a constructive explanation of conduct or mental activity, a certain specifically psychologic explanation is attained which is no longer reducible to social, physiologic or organic properties . . ." (p. 164). Perhaps such attention to the possibility of emerging new levels of integration routinely pervades every good clinician's mind in the course of his treatment efforts. The label, constructivist, if such is the case, merely affixes a name to that process.

This explanatory stance, which involves a readiness to consider the varying synthetic processes at different levels of hierarchic organization--this "constructivist" mode of attending--could be viewed as an addition to the customary reductionist approach. It impels one's attention to move to

transformations and the organizational impact of new structures rather than to linger on past sources alone.

Thus far, the author has attempted to present an overview of the problem of school phobia and has described his theoretical frame of reference in terms of psychoanalytic developmental psychology. The remaining chapters of this study will be concerned with the definition of school phobia (Chapter III), its etiology (Chapter IV), treatment considerations (Chapter V), and follow-up studies (Chapter VI).

CHAPTER III

Definition, Types, and Classification of School Phobia

The diagnosis of neurotic illness in children differs from that in adults, since in normal development the child suffers emotionally unsettling experiences which can be mistaken for neurotic symptoms. In the Oedipus period especially, when the child is establishing his emotional adjustment to his parents, night terrors, fear of the dark, and other sleep disturbances are common, but they disappear when the child reestablishes his equilibrium. The same disturbances may appear during a period of marked sibling rivalry or difficulty with peer relationships.

Neurotic illness, however, can occur during the early years when the ego is severely weakened by repeated traumatic experiences. The emotional disturbance in this case lasts longer and the symptoms are more intense.

Anxiety is the predominant characteristic of neurotic conflict and lies behind neurotic symptomatology. Neurotic anxiety is the signal with which the ego warns the child that a state of danger exists and that action must be taken or he will suffer from some force in the outside world. The anxiety is unconscious and assumes the same forms in the child and the adult.

Neurotic anxiety may appear as a phobia or circumscribed anxiety. The classical example of phobias in

childhood is the horse phobia of five year old Hans, reported by Freud (1909). In this study, he showed that the child's phobia was not derived from the frightfulness of the horse, but from the child's own frightening impulses that were first projected, and then displaced. A phobia starts with repression; the original offensive idea or wish is made unconscious. Hans' repressed wish was to attack his father. The next step is projection: It is not he who wishes to attack the father, but the father who will attack him. The third step is displacement: It is not the father who is dangerous; it is the horse. Fearing the horse instead of the father is a way of solving the conflict. The hatred is displaced onto the horse, and the father, who has been loved and hated simultaneously, can now be loved completely. Freud also points out that a boy associates with his father daily, whereas the threatening horse can be avoided by not going out of doors.

Children forced to meet a feared object or situation suffer intense agony although they do not understand what they fear. Most frequently, childhood phobias are of school, transportation, and animals. It is impossible to obtain a complete list of the incidence of phobias in childhood because casual surveys do not differentiate reported fears from true phobias.

For purposes of classification a school phobia can be conceived of as a partial or total inability to attend

school. It is a phobic state which tends to express itself mainly around the recurring need to proceed from the more familiar home environment to the socially more structured and more demanding atmosphere of school. It may appear in milder forms and only be a transient symptom or it can become a firmly established behavior pattern, highly resistant to treatment, which becomes enormously disabling to the child.

In the general population of child guidance clinics, boys out number girls, but most authors report that school phobias are more common in girls. A number of writers have suggested that the incidence of school phobia is on the rise, but few report an actual percentage of school children who display its symptoms each year. Leton (1962) stated that about 3 per 1,000 primary-grade pupils and approximately 10 per 1,000 high school students have school phobia during any given year. Three years later, Kennedy (1965) reported a higher incidence of 17 cases per thousand school-age children per year. As has been noted by Bonstedt, Worpell, and Lauriat (1961), Kahn and Nurstein (1962), and Prince (1968), this recognized increase in frequency of cases reported may not be a function of an actual increase in incidence but merely a reflection of a growth in awareness of and familiarity with school phobia and its treatment.

A child's reluctance to go to school is often the result of a morbid dread of some aspect of the school situation--the teacher, other children, the journey, eating in the cafeteria, or any other specific of school life. However, it is clearly justifiable in a large number of cases to say that the phobia represents a fear, not of what will happen in school when he is there, but what might happen in the home when he is away from it. Within the school phobic child, forbidden wishes are repressed, projected, and displaced in classical fashion. However, the end-result, and clearly one major purpose, of the school phobia is that the child remains home; since his mother is usually also home, he can be with her. Coolidge et al., describe the psychology of the child as follows: "The central concern in the child is the fear of abandonment by the parents. The child fears that some danger from the outside world will befall the parents, particularly the mother, and that thus abandoned, he will either die of lack of care or because of lack of protection be a victim of violence from the outside world. This underlying fear is considerably intensified at the outbreak of the symptom, bringing with it an increase in the damned-up aggressive fantasies which stem from murderous wishes toward the parents. These are experienced as too dangerous, and the child defends himself by regressing to increased dependence on the mother while displacing the anger associated with his

hostile wishes to the outside world, notably the school" (1962, p. 330).

In the above analysis, the role of aggression is paramount. The child, fearful of aggression, regresses to earlier dependency. And, increasingly dependent upon his mother for protection, he is more than ever in conflict about his feelings of aggression toward her. Without his mother, he will be totally defenseless against the violence he imagines in, or projects into, the outside world. Remaining at home reassures him that his hostile wishes against the mother are not coming true, and that he is still well-protected.

The fact that girls are more prone to school phobias than boys might be related to their greater readiness to admit to dependence or anxiety. Girls are also likely to be more ambivalent toward their mothers, and thus less able to express their aggression openly.

Some form of psychosomatic symptom is usually associated with school phobia. The most frequent complaint is abdominal pain which may be accompanied by vomiting and dizziness. These symptoms usually disappear on days when the child is not required to go to school. School phobia may appear after an acute illness which may not be severe. The regression which is associated with illness is often enough to upset the child's emotional balance. The child who unconsciously needs to be at home with his mother has

found that during the course of his acute illness he has had his mother largely for himself. When he has longed for this, the illness may so condition him that he cannot give it up.

School phobic youngsters do not constitute a homogeneous group and consequently there have been attempts to differentiate different types of school phobia. According to Waldron et al. (1975), a review of the writings on school phobia has permitted the formulation of four types of school phobia that are not mutually exclusive. Type 1 includes those cases in which the school refusal is seen as a consequence of separation anxiety in the context of a mutually hostile-dependent relationship in which the mother (or rarely, the father) and child cling to each other. This kind of phobia can be characterized as the family interaction type.

In Type 2, school refusal is often described as a phobia that involves the defenses of displacement, projection, and externalization and differs from other childhood phobias only in that the presence of the mother is more mandatory. This is often considered the classical phobia type.

Type 3 school phobia includes cases in which the child has a barely concealed, overwhelming conscious concern about what will happen to a parent while the child is away. This felt danger might be stirred by an actual threatened danger,

such as medical illness or acute depression in the mother (Davidson, 1961). For children with Type 3 school phobia, the complaints about school may represent flimsy rationalizations that can easily be abandoned by the child. The child is therefore not suffering from a phobia, but from an acute anxiety reaction. This school phobia is thus called the acute anxiety type.

In Type 4 school phobia, the child may avoid school out of fear of real situations in school that threaten the child with failure, loss of self-esteem, or even bodily harm. The children with this type of school phobia, as described in the literature (Milman, 1961; Leventhal, 1964; Lazarus et al., 1965; and Leventhal et al., 1967), generally appear to be characterologically more vulnerable to such crises due to inadequate development of autonomy and self-esteem. This then can be called the situational-characteriological type of school phobia.

In discussing approaches to the management of school phobias, Sperling (1967) differentiates between acute and chronic school phobia and between common or induced school phobia. In addition, the child's age must be taken into consideration, i.e., whether the onset of the phobia occurs in prelatency, latency, or adolescence.

An example of the family interaction type or chronic induced school phobia is illustrated in the case of Steve.

Steve is a 16 year old 11th grader who was referred by the school psychologist. He is an only child of divorced parents and lives with his mother, maternal grandmother and maternal step-grandfather. His parents divorced when he was 2-1/2 years old. His father was a military man who was an alcoholic and who moved to another part of the country following the divorce. There has been no contact with the father since that time.

When Steve was referred for evaluation he was refusing school daily. He began absenting himself following Christmas recess while he was in 9th grade at a junior high school. He has had asthma and multiple allergies since infancy and he became increasingly symptomatic the remainder of the school year to the point that he was constantly absent and was finally refusing school altogether. The pediatrician had arranged a home teacher for the last 2 months of 9th grade. However, when Steve was to begin 10th grade at a new high school the following fall, he became terrified and panicky at the new, larger school and was unable to attend. By the time Steve presented himself for evaluation, other concerns were his insomnia, multiple somatic complaints, extreme shyness, social isolation and his overreliance upon his mother. Despite Steve's overt passivity and apprehension, his mother described him at home as being extremely demanding, uncooperative and negativistic, with frequent temper outbursts.

In obtaining historical and background information, it was readily clear that Steve's presenting symptom of school phobia was not a manifestation of an acute condition but rather a consequence of chronic separation anxiety induced by a mutually hostile-dependent relationship with his mother.

Steve's mother is also an only child. Her parents also divorced when she was 2 and she saw her natural father but one time, at age 10. She described herself as also being basically introverted, shy, without friends, and having multiple fears, including a brief school phobia in junior high.

When Steve was born, his father was overseas and mother recalled her being exceedingly anxious and fearful of being alone during delivery. She attempted to breast feed but was very anxious and had insufficient milk. Steve developed colic and projectile vomiting and mother felt frightened and inadequate. Mother was fearful of the dark and when Steve would cry at night it was difficult for her to be casual and reassuring. During the time of the parents' divorce, Steve had a great deal of both constipation and diarrhea and he continued to wet the bed until age 7. Mother recalled her being very anxious that Steve "might hurt himself" and so she was quite restrictive and protective regarding his increasing motility. She described Steve as a very clingy, dependent child, however, he would also have temper outbursts over trivial incidents.

In such a case of chronic induced school phobia of the family interaction type, treatment of both the parent and child is not only preferable but imperative.

An example of the common or classical phobia type is illustrated in the case of Diane.

Diane is a 9 year old obese girl who began absenting herself from school in 4th grade. She is bright, articulate and appeared to be somewhat adult-oriented which had the effect of setting her apart from her classmates. She seemed to be constantly seeking approval from adults and appeared unconcerned that she was virtually friendless. Diane has a 7 year old brother who had also experienced some emotional difficulties but who has thus far not been school phobic. Parental attempts to get Diane to school were now totally unsuccessful with Diane becoming violently ill, vomiting, hyperventillating and complaining of excruciating headaches. She had so far not attended school during the new school year and was out of school for 3 weeks when the parents brought Diane for consultation.

The parents are in their middle twenties, the father is employed as a plumber and the mother is a beautician who has a salon in the family home. Evaluation reveals that the parents' marriage has been tenuous throughout and that it was fraught with multiple crises and several separations. At age 17, the mother was pregnant with Diane prior to the parents' marriage. They had gotten married against the

father's parents' wishes. Diane was full term, normal delivery, however, labor was difficult and 21 hours in duration. Mother was exceedingly anxious and frightened during the pregancy and gained some 50 pounds. She apparently had a post-partum depression and a public health nurse came into the home daily to help out over the first several weeks. During Diane's first year, her paternal grandmother died of a brain tumor.

The parents separated for several months on each of 3 occasions when Diane was 4, 6, and age 8. In each instance, the mother left the family, was involved in extramarital affairs, the last time in which she lived in a communal or group living arrangement. Although divorce was threatened repeatedly, the mother would typically return to the family repenting and pleading "for one more chance."

In treatment, Diane was gradually able to express a great deal of ambivalence toward her mother through the medium of play therapy. She seemed conflicted with intense anxiety in the face of her fear that her mother would leave again. At the same time, Diane appeared to have tremendous rage over her mother's repeated abandonment. However, since Diane's aggressive feelings toward her mother were unacceptable consciously, they were repressed, then projected in that she felt she was the cause of her mother's desertion; finally Diane developed school phobia as a displacement of her unacceptable feelings onto the school in

an attempt to resolve her conflictual feelings. She felt that as long as she could stay at home her mother would not leave again.

An example of the acute anxiety type of school phobia, or Type 3 as described previously is illustrated in the case of Glenda.

Glenda is a 10 year old 5th grader who is the youngest of 4 children. Her mother died of kidney failure on the day after Glenda's 8th birthday. The father arranged for Glenda to live with her maternal aunt as the father was involved in several business ventures and was unable to care for Glenda's daily needs. Glenda's older siblings were all married and had their own families and the maternal aunt, who Glenda was quite fond of, agreed to assume physical custody. This maternal aunt is 3 years younger than was Glenda's mother and had never married.

Glenda's school phobia began suddenly one day in school during recess. She became panicky and ran home looking for her aunt. The next day she was reluctant to go to school. In school she became panicky and ran home again. This repeated itself, and after a few days she refused school completely. In treatment, while retracing the circumstances under which Glenda had her first anxiety attack at school, it was learned that she was becoming increasingly anxious over her birthday which was rapidly approaching and which her aunt had reminded her of in asking Glenda what kinds of

presents she was hoping to receive. She apparently associated her birthday with her mother's death 2 years previously which did occur while Glenda was at school. While at school, Glenda expressed an irresistable urge to see her aunt for fear that she too might die. When these underlying fears began to be expressed, Glenda's reluctance to go to school diminished and she was eventually able to resume attendance on a full time basis.

An example of Type 4 school phobia or the situational-characterological type as earlier described, is illustrated in the case of Robert.

Robert is a 12 year old 7th grader who is the youngest of 4 children. His mother is unemployed and admittingly is having difficulty adjusting to the fact that the older children are either married or are attending school away from home. The father is a high school teacher who is dissatisfied in the lack of advancement he has experienced in his job. He had difficulty asserting himself at home and he was particularly distressed that he could influence other peoples' sons, but not his own, as any conversation he tried to hold with Robert ended in an argument.

Robert became pubescent during last summer and then at school was exceedingly self-conscious about undressing for P.E. He was very tall and gangling and his scragginess preyed on his mind. He complained of sore throats and toothaches on Mondays, Wednesdays and Fridays--the days P.E.

was held. He also complained of the horse-play and smoking that went on in the locker room. Although reluctant to attend school regularly, Robert managed to continue until he became increasingly identified as a "sissy" by a clique of bullys who taunted him and roughed him up considerably one day while returning home from school. This incident resulted in Robert's total refusal of school. Apart from this, both parents recognized Robert had significant emotional disturbance which warranted treatment. However, the situation which culminated in Robert's total non-attendance was based on the real threat of ridicule and bodily harm. It was not until school authorities were able to intervene by stopping the harrassment of Robert by this group of boys that Robert eventually felt comfortable enough to return to school. As in other forms of neurotic illness, this type of school phobia may represent a comparatively simple conditioning in which the precipitating factor owes its strength to special conditions. When this is the case, once the precipitating factor is recognized and eliminated, the school phobia may disappear quite promptly. If the ego of the child is relatively strong, as was the case with Robert, the difficult reality situation does not necessarily produce serious, chronic regression.

In other classification studies, Coolidge et at. (1957) and Waldfogel et al. (1957) were the first to differentiate "neurotic" and "characterological" types of school phobia.

The "neurotic" group showed an acute and dramatic onset and more or less persistent clinging behavior, but the children generally continued to function well in non-school areas. The "characterological" group reveal a less acute onset, indications of a deep character distrubance from an earlier age and were uniformly more deeply disturbed and more severely crippled. Subsequent studies have basically agreed that these two categories exist (e.g. Berg et al., 1969; Kennedy, 1965; Weiss and Cain, 1964). The "neurotic" group is comprised mostly of young children in grades kindergarten through fourth, while the "characterological" group is made up mainly of early adolescents. Though the evidence cited with respect to degree of pathology may lack empirical validity at this time, its consistency in reporting suggests that it may be useful to distinguish between at least two types of school phobia--the neuroses and the character disorders--for diagnostic and treatment purposes and to ascertain the eventual utility of having made the distinction.

One other type of school phobia apart from those mentioned above is referred to as "incipient psychosis" by Millar (1961) and as "childhood psychosis" by Kahn and Nurstein (1962). "The refusal to attend school in these cases has been explicable on the basis of the first appearance of psychotic manifestations in the classroom. Experiencing frightening hallucinations and delusions in

that setting, the child avoids attending" (Millar, 1961, p. 399). Kahn and Nurstein (1962) mention that school can increase the strain of severely disturbed individuals and, thus, school is avoided to reduce stress.

In summary, since school phobic youngsters do not constitute a homogeneous group, there have been numerous attempts to differentiate various types of school phobia. For purposes of definition and classification, the partial or total inability to attend school represents a phobic state which expresses itself around the recurring need to proceed from the more familiar home environment to the socially more structured and more demanding atmosphere of school.

Although the literature indicates that the condition of school phobia may represent a broad range of underlying psychopathology, the author has found that the symptom of school phobia more often than not is a consequence of separation anxiety within a mutually hostile-dependent relationship between the child and his mother or primary caretaker.

Chapter IV describes some of the more central etiological factors of school phobia in an effort to arrive at a psychodynamic formulation of the condition.

CHAPTER IV

Etiology

Anxiety has been defined as a fear which is either not justified by external reality, or which is an extreme reaction to a real threat. The younger the child, the more difficult it is to draw the line between inner and outer reality. Some of the common fears of young children illustrate mechanisms which are involved in the complex structure of the full blown neurosis. Such childhood phobias are considered normal because they appear so frequently in young children and are outgrown, but they are structurally similar to the fixed phobias of later childhood.

In some forms of neurosis, there is no feeling of anxiety; in others, the patient is aware of a great deal of anxiety. Since one purpose of a neurotic symptom is to defend against anxiety, it may seem strange that anxiety can itself be a neurotic symptom. If the patient is very anxious, what is he warding off? The answer is that the symptom disguises the source of the anxiety. The place, person, thing, or activity which the child fears is only a substitute for the real object, manifest fear which disguises a latent fear just as the manifest dream hides the latent dream content. This explains why a phobia does not yield to simple reassurance.

Freud's major reformulation of the theory of anxiety in 1926 has been followed by an ever-expanding literature which has not, however, always brought added clarity. Allen Compton's recent surveys of this literature (1972) have underlined many disparities of opinion and controversial formulations.

A developmental view was prominent in Freud's formulations of 1926, and was reflected in his concern with the developmental sequence of danger situations--overwhelming excitation, loss of the object, loss of the object's love, castration, and loss of the superego's love. Subsequently, much attention was also given to developmental factors in the etiology, experience, and mastery of anxiety. Variously interested in some or all of these matters, Spitz (1950, 1965), Benjamin (1961, 1963), Brody and Alexrod (1966, 1970), Schur (1953, 1958, 1966), and many others made valuable observations and contributions. Many writers showed a special interest in the developmental progression from physical to psychic responses.

Anna Freud's "developmental lines" (1963) are concerned not with the development of the id, or the development of the ego, or of any one part of the personality viewed in isolation, but with "the basic interactions between id and ego and their various developmental levels, and also age-related sequences of them, which in importance,

frequency, and regularity are comparable to the maturational sequence of libidinal stages or the gradual unfolding of the ego functions" (p. 246). Examples of such lines include the well-studied one which leads from dependency to emotional self-reliance and adult object relations via various stations on the way; from irresponsibility to responsibility in body management, from wetting and soiling to bladder and bowel control.

The line from egocentricity to companionship, for example, will lead from an early, narcissistic view of the object world, in which other children are seen first as intruders into the mother-child relationship; then as mere objects to be pushed around, adopted, and discarded at will; then as helpmates in constructive play or in mischief; and ultimately, as partners in their own right. It is characteristic of these lines of development that the child may progress along them unevenly, meeting various setbacks on the way, often of a temporary kind; and that progress along different lines may not always be comparable. Advance along one line may be accompanied by delay on another; and movement along some of them may, from time to time, be set in reverse.

The classic analytic model of a general phobia is that the original object of the fear has been replaced by some other object, and the original source of the fear reaction has been repressed. Thus the child's phobia is not derived

from the fearfulness of the object itself but from his own frightening impulses that have been externalized and displaced on the phobic object with the original impulses deeply repressed. From an analytic point of view, school phobia may be dynamically like the other phobias of childhood in that anxiety is shifted from its basic source to the school situation.

School phobia is a condition which often involves more than a simple phobia of school. Hersov (1960a and b) carried out a study on a sample of British children referred to a clinic with school refusal. He concluded that their difficulties resulted from "an affective disorder, with anxiety reactions occurring more frequently than depressive reactions," and that with these children "fear of separation from home was the most common underlying factor." It is common now to find the term school phobia used to denote a syndrome involving both fears of school and of leaving home.

Berg et al (1969) defined school phobia as a disorder affecting children in whom there is severe difficulty in attending school, severe emotional upset at the prospect of going to school plus a tendency to remain at home with the knowledge of the parents, and in whom there is an absence of significant antisocial problems.

Theories on the etiology of school phobia have been advanced by various writers from differing orientations. For example, Johnson (1941) regards school phobia as a

result of poorly resolved dependency relationships between the mother and child leading to separation anxiety and consequent displacement of anxiety on to the school by the child. Eisenberg (1958) suggested similarly that school phobia results from specific child-parent interactions that evoke separation anxiety.

Currently the most prevalent and influential view concerning the etiology of school phobia has been the separation anxiety model. Writers of various persuasions have emphasized different facets of this relationship, but one central factor typically remains: an unresolved dependency relationship between mother and child (Broadwin, 1932; Coolidge, 1957; Davidson, 1960; Eisenberg, 1958a; Estes, et al., 1956; Johnson, 1957; Johnson et al., 1941; Talbot, 1957; Prince, 1968).

In a series of studies Berg (Berg et al., 1969; Berg and McGuire, 1974) has demonstrated empirically that mothers of school phobic children prefer them to be dependent. In this model, the mother is ambivalent but encourages overdependence in the child which fosters satisfaction of her needs rather than those of the child. However, these positive feelings are contrasted with hostility brought about by her feelings of resentment of being trapped with a basically unrewarding husband, marriage, child, etc. Feelings of anger lead to guilt and overprotection which are manifest in the mother's inability to set any limits for the

child's difficult and demanding behaviors and thus gratifies her child's every whim. The basic strivings in the child are directed by the intense dependence on the mother and when these attachments occur at a later age in the child's development, they tend to be inappropriate. It is at this point that guilt arises in the child. The guilt is derived from a number of sources: knowledge that infantile demands are socially unacceptable and even cruel, the resulting death wish of the child directed toward the mother as a result of the child's fears that if his mother denies his desires he will die. The child, thus, recognizes his mother's ambivalence and strikes back, often with hostility, which is thought to be displaced toward the teacher and the school.

If a prevailing theory of school phobia is that the fear is basically a fear of leaving mother rather than that of attending school, then the core problem would seem to be that of separation anxiety. However, according to Johnson et al. (1941), the separation anxiety is a predisposing factor when combined with the following two factors: (a) an acute anxiety in the child developed by an organized disease or by some emotional conflict such as the arrival of a new sibling, promotion in school, change of residence and school, etc., and (b) a corresponding increase in anxiety in the mother due to some threat to her emotional satisfaction (unfulfilled marriage) or security. Thus, the mother

usually derives less than what she considers her due share of gratification at a time when the child may have been home with an illness or a flurry of anxiety. The mother's dependency needs are recognized and appreciated by the child, and the cyclical process is initiated. From this point of view, school phobia is related to some significant precipitating event and not merely a specific form of mother/child interaction.

What, then, do we know of the parents of children who experience school phobia? Most of the characteristics of the mother of the school phobic child are agreed upon by experts in the field. She has generally had an emotionally deprived childhood (Eisenberg, 1958a; Goldberg, 1953; van Houten, 1948) and has not adequately resolved her dependent relationship with her own mother (Buell, 1962; Coolidge et al., 1957; Davidson, 1960; Eisenberg, 1958). The mother tends to be perfectionistic (Davidson, 1960; Jackson, 1964), and when she cannot live up to her own standards, she comes to feel that she is an incompetent mother (Buell, 1962; Talbot, 1957; Waldfogel, et al., 1957).

Often, the mother of the school phobic child did not desire to become pregnant and birth was feared and difficult (Davidson, 1960; Eisenberg, 1958b). Agras (1959) has found that she nearly always displays overt signs of depression, and Berg, Butler, and Jackson (1964), and Suttenfield (1954) have found more neuroticism in her than would be expected in

the mother of a "normal" youngster. And finally, Talbot (1957) reports the mother has a lack of interest in anything outside of the family and usually has no friends.

There is less agreement on what the typical father of a school phobic child is like. Most studies describe the father as being passive, dependent, and ineffectual as the head of the family (Agras, 1959; Davidson, 1960; Goldberg, 1953; Jackson, 1964; Leton, 1962; Levenson, 1961; van Houten 1948). Futhermore, he is reported as being disinterested in, withdrawn from, and peripheral to family affairs (Choi, 1961; Chotiner and Forrest, 1974; van Houten, 1948). An alternative opinion is that "the father is usually very much involved in the problems of child care and rearing, and by trying to prove that he can handle the children better than his wife, undermines the shaky foundations of her own feelings of maternal adequacy" (Waldfogel, et al., 1957, p. 758). Hersov (1960b) found both the ineffective, inactive type father and the firm, active type father in his samples. Thus, it appears that the school phobic child has a father who may be either concerned about or disinterested in family affairs, but regardless, turns out to be ineffective in dealing with family problems. Despite these inadequacies, he usually provides a good material living (Choi, 1961; Hersov, 1960b; Jackson, 1964) and is very conscientious and hard working at his job (Buell, 1962; Chotiner and Forrest, 1974; van Houten, 1948).

Like the mother, the father frequently is involved in unresolved dependency relationships with his own parents (Choi, 1961; Goldberg, 1953; Talbot, 1957). Often he is a heavy drinker (Agras, 1959; Choi, 1961), and he is more likely to display some form of psychiatric disorder than if his child were "normal" (Agras, 1959, Berg et al., 1974; Jackson, 1964; Suttenfield, 1954).

It is generally agreed that there are usually poor marital relations between the two parents of school phobic children (Choi, 1961; Chotiner and Forrest, 1974; Estes et al., 1956; Goldberg, 1953, Talbot, 1957; van Houten, 1948) with poor communication and unsatisfying sexual relationships (Choi, 1961, Talbot, 1957). Despite the difficulties that may be present, these marriages nearly always are enduring and remain intact (Hersov, 1960b; Johnson, 1957; Talbot, 1957).

Inasmuch as it is frequently reported that the husbands are passive and withdrawn from family activities, it is not surprising to find it is usually the mother who is found to be the dominant spouse in the marriage (Davidson, 1960; Jackson, 1964; van Houten, 1948).

Perhaps it is the poor marital relationship or the mother's unresolved dependency relationship with her own parents or her feelings of incompetence or a combination of these that has resulted in Coolidge et al. (1957), Estes et al. (1956), and Johnson (1957) finding that the typical

mother of a school phobic child encourages her child to become excessively dependent upon her. In comparing school phobics with normal controls, Berg and McGuire (1974) found that mothers of school phobic youngsters prefer them to be excessively dependent. "That the over-dependence of the child has positive values for the mother was often pointed up by the disappointment and even resentment shown to the therapist when the child made strides out on his own" (Eisenberg, 1958b, p. 715). Thus, the evident need for, and encouragement of, dependence frequently results in a deep interdependent relationship between the mother and her child.

The parents keep the child immature and, in fact, the child's striving for growth and independence is greeted with alarm by his parents (Choi, 1961, Eisenberg, 1958a; Johnson, 1957). The mother achieves this strong dependency by being overprotective and overindulgent toward her child and by shielding her youngster from experiences that would teach him how to deal with the outside world (Goldman, 1953; Waldfogel et al., 1957). Inconsistent handling of the child by his parents with an inability on their part to set firm limits for the child (Weiss and Cain, 1964; Davidson, 1960) and their vacillating between being restrictive and being permissive (Choi, 1961; Talbot, 1947) occurs frequently in these families. This inconsistent handling, with the will of the child winning out, with the lack of other "real

world" experienes, eventuates in feeding the child's omnipotent fantasies so that he believes that his will is all powerful and that his needs are the only important ones (Choi, 1961; Waldfogel et al., 1957). Thus, the child has become dependent on his mother to meet his needs, to protect him from unpleasant experiences, and to reassure his omnipotence.

Waldron et al.'s (1975) study of children with school phobia demonstrated fairly close links among a mutually hostile-dependent relationship between mother and child, excessive importance of the child to the mother, marked separation anxiety in the child, and faulty development of autonomy and self-esteem leading to the child's having an impaired capacity for autonomous functioning. This impaired capacity would tend to lead to the development of difficulties in school because the school situation requires considerable capacity for independent functioning.

The sequence of events leading to an impaired capacity for independent functioning was described by Waldfogel and associates (1957): "Thus the parents . . . fail to provide the child with any basis for a stable system of inner controls. At the same time he internalizes their rage at his parasitical demands, and is left without any substantial source of narcissistic support except even greater reliance on his parents to bolster his self-esteem" (p. 759).

The findings of Waldron et al. (1975) add to the body of data on the role of parental and family pathology in the genesis of emotional illness in childhood. The probable etiological significance of their finding an almost universal lack of emotional health in the parents and families of neurotic children they studied is supported by other studies that included normal children.

The studies by the Gluecks (1950), Meyers and Goldfarb (1962), Wynne and Singer (1966), Masterson (1967), and Stabenau and Pollin (1968) all show a continuity of increasing family malfunction from normal to neurotic to delinquent to schizophrenic children and adolescents. The findings of Westley (1958) in a study of families of emotionally healthy adolescents provide a striking contrast to Waldron's (1975) findings in families of neurotic children. Thus, there is strong evidence that unhealthy parents and families generate unhealthy children. We will not know to what degree and under what circumstances until we do the systematic epidemiological research into the relationships between family functioning and emotional health of children that these findings call for.

The literature on school phobia abounds with statements to the effect that it never exists in isolation, but is always intimately associated with a complementary neurosis in the mother (Estes et al., 1956), leaving one with the impression that the mother is the cause. This explanation

must be regarded as a partial one, for several reasons. First, the same dynamic conflicts have been observed in mothers of children with different kinds of problems (e.g., psychosomatic disorders and psychoses), so it is questionable that there is a specific cause-and-effect relationship between the mother's problems and the child's. Second, school phobia does not especally run in families. Why is only one child so affected? Third, investigations of parental psychopathology have not involved the use of control groups, so one cannot know how many mothers with the same conflicts are raising children who are free of phobias. Unfortunately, much of the information about parents of disturbed children is gathered only <u>after</u> the children's symptoms are reported; and only after intensive study.

However, whatever the origin of the child's school phobia, there is no doubt that the mother's reaction will affect its duration and intensity. An immature mother will have a difficult time coping with her child's anxiety, and may reinforce rather than alleviate it. Viewing clinical case material, the therapist often wonders what was primary and what was secondary--that is, how much of the mother's anxiety was engendered by the child's obvious distress, and to what extent her anxiety created his distress. Even when the separation anxiety starts with the mother, the psychopathology will, after a time, be internalized, becoming an integral part of the child's personality

structure. The child learns the psychology of the mother and makes it his own. In most of these cases, the therapist sees a continuous cycle, with no clear-cut starting point.

With these different child, mother, and father characteristics, Hersov (1960b) related three main types of parent-school phobic child relationships: "(a) An over-indulgent mother and an inadequate, passive father dominated at home by a willful, stubborn, and demanding child who is most often timid and inhibited in social situations away from home. (b) A severe, controlling and demanding mother who manages her children without any assistance from her passive husband. The child is most often timid and fearful away from home and passive and obedient at home, but may become stubborn and rebellious at puberty. (c) A firm, controlling father who plays a large part in home management and an over-indulgent mother closely bound to and dominated by a willful, stubborn, and demanding child, who is alert, friendly and outgoing away from home" (p. 140).

There appears to be a tendency to simplify the dynamic picture of school phobia and other conditions in the direction of attributing the "energy" for the formation of the symptom to current aspects of family dynamics. Such formulations, although undoubtedly correct in part, tend to miss the intermediate step of formation of psychic structure in the child, which occurs to a great extent before the

child reaches school age and reflects the characteristic family interactions (Tennes and Lampl, 1966).

Turning to an examination of the characteristics of the individual child, one feature of the school phobic's personality that is not agreed upon is whether he is basically shy and timid or assertive and willful. "One of the most striking observations is of the child's need and ability to manipulate and control his parent" (Millar, 1961, p. 399). "These children . . . were adept at using stubborness . . . to avoid anxiety-producing situations" (Suttenfield, 1954, p. 373). On the other hand, the adjectives used by Chazan (1962), van Houten (1948) and Weiss and Cain (1964) to describe school phobic youngsters are timid, submissive, shy, quiet, fearful, and passive. Berg and Collins (1974) specifically studied the subject of willfulness in school-phobic adolescents by comparing 43 school-phobic and 37 non-school-phobic psychiatric in-patients. They found no significant difference in the degree of willfulness between the groups.

Research by Hersov (1960b) and Jacobsen (1948) provides at least a partial solution to this difference of opinion. "The majority of children (37 of 50) were timid, fearful and inhibited away from home, 9 were alert and friendly and 4 domineering and aggressive. The reverse picture of behavior was shown in the home in that the majority (37 of 50) were assessed as willful and demanding, whereas only 13 were

passive and obedient" (Hersov, 1960b, p. 139). Jacobsen (1948) found that in analyzing the descriptions of the children as given by parents and teachers, four types of personality stood out quite clearly. They were: 1) willful toward parents but timid in other relationships; 2) passive and obedient in all relationships, including parental ones; 3) willful in all relationships; and 4) friendly and outgoing generally, but willful toward parents. Most of her cases (77%) were evenly divided between the first two types. So it appears that neither "timid" nor "willful" accurately describes all school phobic children and that many of them behave passively outside the home but act willfully when with their parents. These results indicate the importance of behavioral assessment of the child in more than one environment in order to obtain a clear picture of the child's range of behavior.

Viewing school phobia as an intra-psychic disorder, Sperling (1967) considers a phobia (including school phobia) as a neurosis which is related to the anal phase of instinctual development, and even more specifically to the anal-sadistic phase. A new version of the earlier conflicts about separation appears at and belongs to the anal phase of development (roughly between age one and one half to three). It is during this phase that the motor equipment necessary for active separation--walking away from mother--develops, and when the ambivalence conflict concerning the anal

instincts is at its height. It is the conflict of whether to hold on or to let go of feces (unconsciously equated with objects). During the oral phases there is only passive dependence because the child lacks the equipment for initiating any active separation from mother in reality.

Speaking of the psychodynamics of phobias, Sperling (1967) states: "I would suggest classifying the phobias as being midway between the obsessive-compulsive and the hysterical neuroses, but closer to the first. The main mechanism of defense in phobias and in obsessive-compulsive neuroses are similar--namely, displacement, isolation, and projection. In 1909 Freud described a mechanism characteristic of the phobias, i.e., the externalization of an instinctual internal danger, which then can be avoided as an external danger. The high degree of ambivalence and narcissism, the persistence of the fantasy of omnipotence, and the exaggerated need for control are characteristic pregenital (anal-sadistic) features of this neurosis, and provide the link with other pregenitally fixated disorders (character disorders, certain perversions such as fetishism) and with psychosomatic diseases, especially with asthma and colitis. In all these conditions, separation anxiety is a crucial issue and its persistence interferes with a satisfactory resolution of the Oedipal conflicts" (p. 376).

From this it follows that school phobia has to be considered a psychoneurosis in the true sense; that is, that

it is based on unconscious conflicts and fantasies and that the reasons a phobic child gives for his behavior are rationalizations, while the true reasons are unknown to him.

As mentioned previously, theories on the etiology of school phobia have been advanced by various writers from differing orientations. The author's experience is in accord with those that regard school phobia as a result of poorly resolved dependency relationships between the mother and child which evokes separation anxiety that is displaced on to the school.

The separation anxiety model is currently the most prevalent view of the etiology of school phobia. Clinicians of various persuasions may differ in their emphases of specific facets of the condition of school phobia, however, there is overwhelming concensus on the central factor of the unresolved dependency relationship between mother and child. In addition, the disturbed separation process frequently represents multidimensional dysfunction within the family.

Chapter V will attempt to address some of the complexities of school phobia with respect to management and treatment considerations.

CHAPTER V

Management and Treatment

The management and treatment of school phobia has been examined less intensively in the literature than other aspects. However, the condition of school phobia, regardless of the various types as described in Chapter III, is an indication of a serious personality disturbance and is a difficult disorder to treat effectively, requiring skill, patience, and time. There is the problem of initiating early treatment, and of separating the mother and child even within a clinical setting; there is the constant pressure for advice, and frequently the inability of parents to understand what the discussions of family relationships have to do with getting the child back to school.

The papers on treatment fall broadly into two groups, those which advocate (1) a planned, but eventual, return to school, and (2) an insistence on an early return to school. In the former cases the pressure is removed from the child, and his problems are worked upon, before a joint plan is made concerning his readmission to school. In the latter cases there is sometimes action before insight, as there is an insistence by the therapist on school attendance, however limited. Help is then given, while the child continually faces his problem in the school situation, even if for only a few minutes each day. An admitted drawback to this

approach is that a motive for the continuation of treatment is removed, once the child is back at school.

Clinicians vary on this issue largely along the lines of their differing theoretical orientations and treatment philosophies. The levels of clinical intervention range from case management concerns with the emphasis on pragmatic expediency and symptom removal, to treatment of the total neurosis, of which the school phobia is but one manifestation. This raises the argument whether treatment should be limited to removal of the presenting symptom for which the child and parents "contract" with the therapist, or, whether treatment should be regarded as successful only when it brings about favorable changes in the personality and character disturbances associated with school phobia and not on the basis of whether the child does or does not return to school quickly.

What does appear to be consensually agreed upon, at least among clinicians with a psychodynamic orientation, is that proper diagnostic assessment and treatment plans are essential for a successful outcome. Thus, a psychosocial diagnostic evaluation is the cornerstone in the formulation of an individualized treatment plan.

Diagnosis and classification are a means of stating what an individual child's disorder has <u>in common</u> with other disorders. It identifies the key features of the disorder which enable a grouping of the disorder according to the

denominators which it has in common with other similar disorders. This can be useful because it narrows down the field in terms of causes, treatment and prognosis and because it provides a shorthand language of communication with other professionals. If a therapist says that he has just seen a school phobic child this conveys meaning to other therapists. However, because classification is based on the lowest common denominators, it necessarily provides a crude grouping, which disregards all that is unique about the child. Accordingly a further process is required to bring out these qualities. That consists of the diagnostic formulation which, unlike classification, emphasizes what is different and distinctive about this particular child.

The formulation puts forward ideas and suggestions about what psychological or biological mechanisms might be operative, what the underlying causes and the precipitants of the disorder for this child are, what the factors leading to a continuation of the disorder are and, on the basis of these considerations, what treatment approaches are likely to be most effective. Essentially it is a process of generating and testing hypotheses, which requires all the creativity and rigors of research. The hypotheses about mechanisms and treatments must, of course, be put to the test so far as possible and this means a careful monitoring and evaluation of the treatment process. It is also essential to have some means of determining whether the treatment which is employed is being effective.

Since one of the most common presenting symptoms of school phobia is somatic manifestations, psychotherapeutic intervention should always be preceded by a medical examination. Once the pediatrician establishes that there is no physical malfunction, then psychological treatment can begin.

The therapist must strive to understand the meaning and function of the child's symptoms and behavior, which requires exploring the various factors in the child and in his environment. The study of each case should begin with a careful investigation of whatever complaints the child may bring about the school. Clearly, a sadistic teacher, an organized group of delinquents, or an unreasonable academic load, etc., may precipitate fear of going to school. A fear of school due to these factors should be examined differently from neurotic disorders. Also, the attitudes of the parents to school and teachers, parental reactions to the school refusal, the potential influence of siblings, the influence of school authorities, etc., need to be considered.

Basic to the treatment of school phobia from a dynamic point of view is an eventual working through of the unresolved dependency relationship between mother and child, though some writers (Levensen, 1961; Malmquist, 1965; Skynner 1974) also feel that the relationship with fathers, especially for adolescent males, is critical.

According to many therapists (Coolidge, 1964; Eisenberg, 1958b; Glaser, 1959; Rodriquez et al., 1959; Suttenfield, 1954), the key to a successful treatment resides in an early return to school for the child. This tends to break up the symbiotic mother-child closeness and exerts a pressure to change. It is argued that the phobic state denies the child the experiences necessary for growth and forces him into more intimate contact with the sources of his psychological impasse. Perhaps of less theoretical importance but still of practical consideration, prolonged absence from school may force the child to fall behind in his school work so that he then becomes in danger of failing which would provoke more fear and anxiety. Rodriquez et al. (1959) justify their advocacy of an early return to school for the following three reasons. It brings into sharp focus the primary issue of separation and disassociates the therapist from the family's displacement of the fantasized dangers of the school situation. Second, it emphasizes the core of health in the child which reassures the panicked family, and finally, the return to school restores the child to a growth-promoting environment and removes him from the pathological cycle to which he has succumbed. Both Eisenberg (1958a) and Rodriquez et al. (1959) advocate legal intervention if necessary to convince the parents how necessary it is for the child to return to school.

Many therapists recognize the need to approach the return to school gradually. Berryman (1959) enunciates this concern clearly. She advocates a step-by-step process of returning the child to school which may include such behaviors as having a parent drive the child to school and just sit in the car, looking at the school, walking around the school yard, going into the principal's office, doing errands for the principal, going to school without the parents for a few hours, an entire day, and finally withdrawing the parent altogether. The scope of such programs varies considerably with different therapists. It is worth noting that, though the resolution of the unresolved dependency relationship seems critical from a psychodynamic point of view, the above general statements do not focus on it directly. Even among many analytic writers, an early return to school is an important step for successful treatment. However, this implies "action before insight" and seems somewhat contradictory to the developed etiological factors discussed earlier which logically imply "insight before action."

A few therapists take issue with advocacy of returning the child quickly to school (Talbot, 1957; Hersov, 1960a; Davidson, 1960; Greenbaum, 1964; Radin, 1967). Talbot (1957) states, "The first step is to relieve pressure for attendance, then when the tug of war is over, treatment can begin." He believes that not only must one consider the

psychological framework of the child in this regard but also the readiness of the mother to let the child go. This orientation seems aligned with an "insight precedes action" approach. Most of these authors feel that intensive psychotherapy with the mother and/or child is necessary.

Some additional psychotherapy factors focus on the notion of whom to treat. Only in the case of older children is it believed to be appropriate to treat the child alone (Johnson et al., 1941). A few therapists suggest treating individually the mother who is thought to be suffering from unresolved dependency conflicts (Waldfoget et al., 1957). More typical than either of these approaches is the strategy of including both the mother and child in treatment. The vicious circle of family pathology that so predominates school phobia can only be broken when the critical units are brought together in treatment (Coolidge, 1960; Davidson, 1960; Johnson et al., 1941; Waldfogel et al., 1957; Waldfogel et al., 1959).

Although fathers are ascribed relatively less consideration in the etiology of the disorder, most writers recognize their importance if only as the individual who contributes to the wife's unfulfilled emotional needs. Thus there are references in the literature of the necessity of treating both parents as well as the child. For example, Johnson et al. (1941, 1957), Coolidge (1957), Lippman (1962) advocate family-oriented treatment once the child has been

returned to school. Malmquist (1965), and to a much greater extent, Skynner (1974), demand the inclusion of father for family therapy.

A treatment orientation that differs in theoretical perspective from the more traditional psychotherapies is advocated by those who adhere to a learning model of therapy. Nevertheless, many of the cases (Lazarus, 1960; Kennedy, 1965; Patterson, 1965; Smith and Sharpe, 1970) describe the child as suffering from separation anxiety. Different from the analytical writers, however, these authors do not posit the need to attack this aspect of the clients' history; rather they accept Eysenck's (1960) orienation "Get rid of the symptoms and you have eliminated the neurosis." The importance of this position is also emphasized by a nonlearning theorist such as Eisenberg (1958a) who states: "It is essential that the paralyzing force of the school phobia on the child's whole life be recognized. The symptom itself serves to isolate him from normal experience and makes further psychological growth almost impossible. If we do no more than check this central symptom we have nonetheless done a great deal" (p. 645).

Basic to the treatment paradigm of learning theorists is the changing of the phobic sequence (separation from parents ⟶ anxiety reaction ⟶ escape or avoidance behavior) to some form of new response that is incompatible with anxiety. The necessity for changing this sequence has

been underscored by Garvey and Hegreves (1966). They argue that, since many children are forced to go to school against their wishes, then those people who try to get them there become anxiety-producing cues through a classical conditioning paradigm. This orientation could be helpful in understanding why parents of phobics are typically unsuccessful in getting their children to return to school but seems to overlook the number of children who are forced to go to school but who do not become phobic. However, using this basic model it is theorized that the rewarding of responses that are incompatible with anxiety will result in gradual extinction of the escape and avoidance response and in a diminution of the anxiety response.

Clinicians of a dynamic persuasion generally agree that once the evaluation is completed and the diagnosis of school phobia is confirmed, a psychotherapeutic direction can be established. In this author's experience, treatment as a process directed to the source of the conflict should include therapeutic intervention in an effort to bring about a recession of the acute phobic phase in addition to extended psychotherapy to treat the underlying problem. The specific therapeutic techniques utilized by the clinician involves an understanding of the behavior and play of the child, the nature of his resistances and defenses, and the therapist's awareness of transference and countertransference phenomena as factors influencing treatment.

In the treatment of school phobic children, one of the most troubling problems is the waiting period that ordinarily intervenes between the onset of the symptoms and the beginning of clinical treatment. When treatment is initiated quickly, before the symptom has a chance to crystallize and secondary complications in the child's relationship to mother and school develop, rapid symptomatic improvement often results. In children who have withdrawn completely from school, a quick return, in a matter of four to six weeks, is often accomplished. In children who have not completely withdrawn from school, but whose attendance is erratic, precarious and deteriorating, a complete withdrawal is often forestalled.

The bulk of the therapeutic material in many of these cases consists of reporting of the week's events, elaborations of reality incidents, vivid play productions during the interviews and sometimes telling of dreams and daydreams. When the therapist can work within the child's own framework of expression, fantasy material is often told relatively freely, and despite occasional signs of anxiety, the children take pleasure in talking about these matters. In part, there seems to be a beneficial effect from the therapist's mere understanding acceptance of these fantasies and from his clarification of the child's impulses that shape these ideas.

In some of the short term cases, therapy remains on the plane of simple clarification of the quality of the child's impulses without much focus on the defenses or the conflicts set up as a result of the opposing impulses. In other children, however, it becomes necessary to delve somewhat more deeply into the conflicting nature of their impulses, working simultaneously with the defenses, conscious and some preconscious material. Even preliminary interpretations are appropriately explained to the youngster at the proper time in a manner which the child can accept and with the intent of increasing the child's understanding of himself. By bringing to the surface the conflicts created by such desires as the wish to be both boy and girl, the wish for closeness to one parent without antagonizing the other, or the wish to remain small and dependent versus the desire to grow big and independent, the child is able to choose one alternative and no longer be immobilized by the ambivalent struggles.

In some cases, symptom focus, fantasy focus, and interpretation are all part of the psychotherapy process of overcoming resistances and of gradually analyzing the defenses so that fundamental conflicts are brought to the surface. These are the children in whom fear of being apart from the mother has usually been increasingly specified until it has become verbalized as a fear that harm may befall her. This, in turn, must be translated into the wish

behind the fear, that the child under certain circumstances actively wishes harm or death upon his mother. It then becomes possible to link this wish with the child's conscious fear of being separated from mother. In this process of dealing with the child's ambivalence toward his mother, the therapist can often help the child to become specifically aware of the inner stress that ensues when feelings of anger and resentment against a mother upon whom he is necesarily dependent become strong.

The need for involving the parents in the overall treatment of the school phobic child cannot be overemphasized. Although separation anxiety and ambivalent dependency upon mother have been accentuated, little has been written concerning the psychodynamic significance of performance. Radin (1967) identifies a cycle frequently encountered in school phobic families in which life performance, parent-child transactions and an emerging sense of self participate.

A significant key to the understanding of school phobia is that whatever the parental attitudes happen to be--rejecting, overvaluating, demanding, domineering, submissive, permissive, seductive, overindulgent--the child's security and adequacy systems depend to an inordinate degree upon the quality of his own life performance and the discrepancy between his family and the school in the evaluation of his performance.

As a group, children who develop school phobia are poorly prepared to meet life's challenges when the sanctuary of the home is left. There is a high probability of experiencing failure, real or imagined, with resultant feelings of marked inferiority and insecurity.

The parents of children with school phobia have carefully nurtured their child's omnipotence for a number of years, generally since birth. Overly permissive, submissive and indulgent parents do not promote conformity or excessive obedience; thus, there is less of a need for the child to submit his ego to devaluation and to relinquish his infantile omnipotence. Other children with school phobia are spuriouosly overvalued. This constitutes a deception since it is based upon the parent's unconscious hope for gratification of their own unfulfilled aspirations via the child's attainments and successes. The child's capacities are thereby exaggerated and not based upon his encounters with reality. Parental aggrandizement of the child's doings imparts to him an imperious manner and are viewed by both child and parent as a testimony to his greatness. The child's aspirations, which include parental standards and unfulfilled desires and ambitions, are embodied in the child's ego ideal.

Where the infantile omnipotence unduly persists, as in the overvalued child, the considerable gap between the ego and the ego ideal is narrowed or closed by an illusion

shared by child and parent in which both parties equate the reality ego with the ego ideal. This illusion is cultivated and maintained within the confines of the home. However, more critical peers and adults, such as are encountered in school where the accent is on realistic performance in a highly competitive milieu threaten this illusion. It is shattered by real or imagined failure in performance and the actual gap between ego and ego ideal becomes painfully apparent. A marked loss of self-esteem is experienced. Alexander (1938) and Piers (1953) emphasize that failure, unfavorable exposure or comparison creates a tension between the ego and the ego ideal. Piers stresses that shame arises out of the tension because goals presented by the ego ideal are not reached. The unconscious threat implied in shame anxiety is abandonment. This is in contrast to the castration threat related to guilt over transgressions of the superego. The coexistance of shame and guilt and the use of one to conceal the other are mentioned by Piers (1953).

Failure in performance is blatant in school and results in marked feelings of inferiority with the threat of loss of love and abandonment. The ego ideal is at a low ebb and, as these authors have noted, aggression is used to restore the ego ideal to its previous level. This resurgence of rage carries with it previously repressed prohibited desires of a sexual and aggressive nature which were formerly held in

check by the fear of conscience. The return of repressed rage and prohibited desires reawakens the guilty fear of inescapable punishment, the fear of conscience including rage and prohibited desires are again repressed in order to avoid punishment and to regain loving parental care, but this once more exposes the vulnerable shamed child with a lowered self-esteem and sense of pride. Defiant rage is again required for a reestablishment of an acceptable mental representation of the self. This may become an endless and vicious cycle which helps explain the alternation and coexistence of pervasive anxiety and defiant rage in children with school phobia.

The phobia represents an attempt to regain control and to restore the homeostatic balance by containing and redirecting the overwhelming bouts of guilty fear and defiant rage. Thus shame and guilt, with their unconscious fears of abandonment and castration, are added to the dreaded school situation with its real or imagined fears of failure, humiliation and physical intimidation by peers and teacher.

School phobia develops when the unconscious conflicts begin to emerge as repression weakens, and overflowing emergency emotions (Rado, 1956) are displaced onto the feared object, in this instance usually a teacher. The child, however, typically displays his destructive rages within the secure confines of the home. These are in the

form of arguments, temper tantrums and physical aggression toward the parents, siblings and self. He frequently destroys his own property and possessions. He may react with depression to the rage turned inward, or self-punitively with hypochondriasis. Fear and rage discharged over the autonomic nervous system account for physical symptoms with or without symbolic significance. The teacher, a parent surrogate, is a natural phobic object.

This construct, as formulated by Radin (1967), emphasizes the unequivocal importance of the child-family unit as basic to the understanding of school phobia. Although there are profound and critical intrapsychic phenomena present, to consider these primarily in isolation is to acknowledge only a segment of what appears to be a complex that is capable of being forged and transmitted over successive generations. Hence, the involvement of parents or their surrogates in the treatment process is essential.

One of the most persistent and crucial problems in treating the mother of a school phobic child is dealing with her unresolved dependency conflicts. She may present herself as poised, eager for help, with a demeanor of grown-up sophistication, and, in matters other than child rearing, display considerable independence of thought. However, when talking about her child, she frequently resembles a frightened and frustrated little girl who feels she cannot cope with being a mother. Thus, she presents

both sides of her own personality: the grown-up, mature and rather sophisticated person who has done so well in so many ways; and the helpless little girl with, unresolved dependency yearnings, caught and confused in the relationship to her own child. With the loss of her sense of adequacy and self-esteem, there usually is a rise in both her dependency wishes, and in her defenses against them. She often comes for treatment searching to find what she has done "wrong," yet simultaneously rationalizing and projecting blame to others.

A frequent problem in treatment arises when the mother is reluctant to take a parental stand in situations in which she anticipates that the child will be anxious or resentful. Here, the therapist may work to develop the mother's understanding that the reasonable exercise of her parental authority may actually be in her child's best interests. Thus, the therapist gives the mother "permission" to assert her parental role and supports her efforts to reconcile her conflictual feelings. The therapist encourages the mother to realize that it is possible to be both firm and loving in her relationship to her child. Within the therapeutic relationship, the therapist assists the mother to realize that it is possible for her to express some of her dependency needs without total surrender.

With regard to the issue of termination of treatment with school phobic children, certain considerations are of

prime importance. For these children, termination represents a vitally significant phase of therapy, re-evoking as it does their core problem, that of separation from an intensely and ambivalently loved person. Thus, in a sense, it affords a second opportunity for a therapeutic experience. For this reason, termination should be anticipated with the child well in advance of its actual date, and the feelings about it should be thoroughly explored. The positive feelings derived from the child's wish to grow and be independent should be supported and encouraged. The negative ones deriving from his hostility and fears should be interpreted and allayed. It seems well founded to permit the child a voice in making the decision to terminate and in setting the date, and to give him opportunity to experiment with independence by increasing the interval between treatment appointments before regular contacts have finally been discontinued.

Since school phobia is not merely a family-centered problem, several writers have stressed that successful treatment must include coordination with the school (Davidson, 1960; Eisenberg, 1958a; Waldfogel et al., 1957). The school must help the absent child to maintain his academic progress, preferably through individual help in the school building rather than in the home. Allowing a teacher to work with the child in the home tends to encourage his isolation and withdrawal and prolongs his inability to separate himself from his family.

When the child returns to class, he may need special consideration. This is when it is particularly important for the therapist to communicate with and be available to school personnel. The child's attendance may be irregular at first, but the school must welcome him even if he is absent more than he is present. The teacher may have to seat him close to herself, meet him at the door, modify recess or lunch rules for him and, above all, accept him in his effort, however shaky, to return. From this author's clinical experience, it is obvious that the treatment of school phobia requires the therapist to be accessible to school authorities and to be available for consultation and collaboration with teachers, school counselors, and other significant members in the community.

In conclusion, clinicians seem to vary on the management and treatment of school phobia largely along the lines of their differing theoretical orientations and treatment philosophies. However, among clinicians with a psychodynamic orientation, there is consensual agreement that proper diagnostic assessment and appropriate treatment planning are essential for a successful outcome. The levels of clinical intervention range from case management concerns with the emphasis on pragmatic expediency and symptom removal, to treatment of the total neurosis, of which school phobia is but one manifestation.

The author of this study advocates that treatment should proceed as a process that is directed to the source of the conflict and should include therapeutic intervention in an effort to bring about a recession of the acute phobic phase of the condition in addition to extended psychotherapy to treat the underlying problem.

Chapter VI reviews some of the significant follow-up studies, summaries and conclusions.

CHAPTER VI

Follow-up Studies, Summary, and Conclusions

Although it seems to be theoretically possible to distinguish between the etiology and treatment of school phobia, the majority of the writers fail to do so. They imply that a given understanding of etiology implies a definite treatment orientation. However (Buchwald and Young, 1969) emphasize that there is no logical reason why etiology should be related to treatment techniques.

In a follow-up review of treated school phobics, Eisenberg (1958a) indicated satisfactory results with young children but less satisfactory results among adolescents. Rodriquez et al. (1959) report similar findings. Though these lend some support for differential classification, it should be noted that no mention of criteria for adjustment or initial level of psychological functioning was made. In a semi-controlled study Waldfogel et al. (1959) demonstrated that school phobics who were treated early in their development had a relatively successful outcome, while those children left untreated (basically for uncooperativeness) had a greater number of persisting symptoms. The two groups obviously were not randomly selected and this fact strongly biases the results. Hersov (1960b), Weiss and Cain (1964), and Warren (1965) generally report approximately two-thirds of the treated school phobics return to school following treatment of various durations.

Coolidge et al. (1964) report a 10-year follow-up study of 49 children. The results generally indicate that three classes of adjustment can be distinguished, those with no limitations, those moderately limited, and those severely limited. One of the major difficulties, however, in interpreting adjustment of school phobics concerns the lack of a specified criterion. This study illustrates how adjustment is intimately related to the criteria. For example, if return to school is considered a criterion measure then 47 out of 49 children made successful adjustments, but if one is concerned with the emotional health of the child then a more discouraging picture emerges. The authors note that caution seems to be the theme regarding adjustment as more than half of the children are characterized as leading "colorless, restrictive, unimaginative lives with delayed or absent heterosexual development, excessive dependency, blunted affect and a lack of mood-swings." Difficulty in making adjustment to adolescent life seemed to be more difficult for boys than for girls.

Follow-up studies of school phobia must be examined with caution. Since it has been shown that many different conditions may be included under the term school phobia, the results--whether expressed in terms of percentages, or value judgments--can be related only to the particular sub-group whose later adjustment was examined.

Lazarus et al. (1965) report the successful treatment of school phobia dealing with the child's refusal to go to school but leave unclear whether this symptom removal was a sufficient accomplishment in terms of later emotional adjustment. Kennedy (1965) reports that his rapid treatment program is successful in removing symptoms of school phobia in all 50 cases treated. The follow-up data, conducted over a number of years, however, concerns only those with recurring symptoms flagrant enough to lead the child to be rereferred to the clinic. With this narrow requirement it is not readily apparent how well the children really adjusted following their return. Additionally, the type of cases selected do not appear to be severe school phobic children but rather seem to represent a more transitory disorder.

In a clinical 5 to 10 year follow-up of hospitalized school phobic children and adolescents Weiss and Burke (1970) report that all were successful in returning to school though their social adjustment reflected some degree of isolation and discomfort with peers and teachers. Thus it appears that though school refusal was eliminated, the children's mental health was basically unchanged.

In addition to these studies' lack of systematic data collection, interpretation of the effectiveness of treatment programs is further limited by failure to discuss the child's and parent's initial level of psychological

adjustment at the outset of the phobia, the severity of the disorder, the treatment strategy implemented, or the later coping mechanisms of the parents.

In summary, there is a variety of clinical categories of psychopathology where failure of school attendance is an inevitable consequence. These include psychoneurotic, psychotic, and character disorders. In some cases, the relationship of these conditions with failure to attend school seems to be a direct one. In others the symptom is merely incidental to the underlying disturbance which has other implications in addition.

In this study, the author has proposed that insight into the problem of school phobia can be gained by looking upon it as a failure in one of the developmental stages of the personality of the child, at a point where the child proceeds from life predominantly in the family to life in the outside world.

A review of the literature and the author's own clinical experience, reveals that the boy or girl with school phobia reacts to the prospect of attending school with panicky fear and/or stubborn refusal. He generally fortifies his protestations with a variety of physical complaints. These include nausea, vomiting, cramps, diarrhea, dizziness, and fear of peers, teachers and school failure. Withdrawal, guilt, and extreme sensitivity to the opinions of others are not uncommon. A fear of loss of

control and the feeling of being trapped are often verbalized by older children. Whatever somatic complaints are present usually subside when permission to remain at home is granted. The parents try to reason, persuade, force and bribe the child to return to school with little effect. Although the child suffers, the parents often appear to suffer more and to be at the mercy of their youngster. The onset of the disorder may be sudden or insidious and is frequently preceded by illness, vacation, death in the family or change of school. A history of phobias or counterphobic tendencies is usually present, and the children range in age from nursery school through adolescence.

The complexity of school phobia requires a thorough examination of personality determinants and behavior and necessitates a theoretical framework which can encompass physical, intellectual, and emotional components. The author submits that psychoanalytic developmental psychology is such a theoretical framework and lends itself to the kind of in-depth examination of pertinent factors that is essential for a comprehensive understanding of the condition and its ramifications.

Throughout this project it has been apparent that there does not exist a single comprehensive view to account for the occurence and treatment of school phobia. However, the author has attempted to compare and incorporate the views of

many other writers with respect to psychodynamic and developmental considerations in an effort to increase understanding of the etiology and treatment of school phobia as a clinical entity.

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