ADOLESCENT SCHOOL PHOBIA:
ITS CAUSES, TREATMENTS, AND IMPLICATIONS

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ABSTRACT

Adolescent School Phobia:
Its Causes, Treatments, and Implications

This study examined the causes, characteristics, and treatments of adolescent school phobia. School phobia is the most commonly seen phobia in school age children and adolescents. Students who experience school phobia exhibit an extreme fear of school or some aspect of the school situation. The student exhibits somatic symptoms while preparing to go to school or while in the classroom. These somatic complaints hinder students' abilities to learn and their relationships with peers. While younger children suffer from a form of separation anxiety, the school phobia exhibited by adolescents is characteristic of a deep-seated neurosis which may be linked to a familial pattern of neuroses. Treatment is advised for the entire family. The goal of all treatments is to get the child back to school as soon as possible. Treatment perspectives examined were: psychoanalytical, psychodynamic, behavioral, and learning theory approaches. This study presented suggestions for use by parents, educators, and school psychologists/counselors who deal with school phobic adolescents in the home, classroom, or counseling environment.
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Research has suggested that the majority of children have, at some time or another, shown a great reluctance to go to school. Although most children show anxiety about school at one time or another, this distress is usually short-lived and clears up without treatment. Occasionally, this reluctance culminates in outright refusal which can be a serious problem, sometimes called school phobia. Long-standing cases of school refusal are a more difficult problem (Marks, 1978).

School phobia is a term that has been used to describe situations in which students express unusual fear of school. Traditionally, school phobia has been defined as school refusal or school avoidance characterized by severe somatic complaints (Boyd, 1980). School phobia is a dramatic, puzzling, and serious emotional crisis which occurs frequently and presents a threat to the child's psychological health and educational development (McDonald & Sheperd, 1976). Chotiner and Forrest (1974) defined school phobia as "any condition which prevents a child from attending school because of a morbid fear or dread and is an expression of a serious emotional disorder" (p. 167). Gresham and Nagle (1981) noted that studies conducted by Leary and Wilson in 1975 indicated that school phobia is the most frequent phobia for which children are referred to mental health clinics. While
the frequency of school phobia is unknown, most authors agree with Kennedy's (1965) estimate of 17 per 1000 students per school year. Marks (1978) stated that school phobia peaks at those ages when there are drastic changes of school demands and organization in a given country's school system. In the United States, it is between ages 11 and 12 when the child enters junior high school.

Goldberg (1977) presented a study of five cases of adolescent school phobia and proposed that adolescence is a time particularly vulnerable to the appearance of school phobia. Although school phobia is less common among the adolescent age group, its occurrence presents a serious adjustment problem (Harris, 1980). Ordinarily, the phobic adolescent has a more severe problem than does a younger child. When a teenager's fear of school becomes so powerful that it overrides his need for conformity and independence from his family, it implies a greater degree of illness than it does in the younger child who is normally more dependent (Whiteside, 1974). The onset of school phobia in adolescence could herald a severe generalized phobic state continuing into adult life where it may lead to work phobia in which the adult clings to a familiar setting such as the home and avoids work and the anxiety and somatic discomfort it produces (Kelly, 1973; Chotiner & Forrest, 1974).
School phobia presents parents, educators, and school psychologists with the challenge of helping phobic children overcome irrational fear of the school situation (Gresham & Nagle, 1981). Kelly (1973) stated that most, if not all, schools potentially possess structures, practices, and personnel that may cause, occasion, or aggravate the development of school phobia. The author suggests that teachers who can combine enough firmness to keep a reluctant child in school with patient gentleness to allay the child's anxieties may play an important role in the prevention of simple forms of school phobia. School phobic children are silent sufferers; many of them are left untreated, some are poorly treated. The long-term adverse effects of untreated or poorly treated school phobia are cumulative; they not only increase the resistance of the child, but also render the child further behind in all areas of development (Hsia, 1984).

The purpose of this seminar paper was to review the literature regarding the causes, characteristics, and treatments of adolescent school phobia and to draw implications for parents, educators, and school psychologists/counselors dealing with school phobic adolescents.
CHAPTER II
Review of the Literature

This chapter reviewed the literature regarding adolescent school phobia, its characteristics, correlates, and contributory factors. Information presented described four treatment perspectives: psychoanalytical, psychodynamic, behavioral, and learning theory.

Characteristics, Correlates, and Contributory Factors

School phobia is a term originally used by Johnson, Falstein, Szurek, and Svendsen (1941) to characterize the phenomenon in which a child experiences marked anxiety related to attending school and subsequent refusal or failure to attend (Trueman, 1984b). Throughout the literature there was constant reference to the study by Johnson, her work considered classic in the field.

From 1941, when the label first appeared, through the 1950's, school phobia was often viewed as a symptom of separation anxiety of the child from the mother. In the 1960's and early 1970's several studies appeared that examined the responses of the mother; that is, her overprotectiveness and subtle encouragement for the child's overdependence by not taking a firm stand in enforcing the child's school attendance. In studies examined by Hsia (1984), the mother was described as midly neurotic, with unresolved dependency needs herself.
Literature has suggested that a parent-child schism enters somehow into the formation of an adolescent school phobia. The child might be anxious and timid away from home but willful and controlling within the home. Work with such children by a number of authors led to the impression that while separation anxiety was the primary consideration in the formation of a school phobia in a child entering school, as the child reached his teens, the separation anxiety played a diminished role. (Chotiner & Forrest, 1974).

Chotiner and Forrest (1974) suggested the school phobic adolescent may have had a role in preserving his parent's marriage, a role that his continued maturation and school success leading to college may threaten. The adolescent responds to these pressures in a manner that proves most painful to his parents, often without understanding the family tensions that act upon him. The authors contend it is possible that while frustrating his parent's ambitions for him to excel and redeem them, the adolescent may satisfy their less conscious wish for him to fail and stay with them to protect them from each other and the dissolution of their marriage.

Although there was incomplete agreement on the origins, causes, or dynamics of the problem of adolescent school phobia, authorities agreed that there appeared to be a strong level of anxiety coupled with a determined reluctance to attend school
Regardless of the variations in terminology or perspective, many shared points of agreement could be seen. First, the school is merely a focal point for the high level of anxiety experienced by the phobic youngster. The fear is not so much related to the school as it is to the deficiencies it brings into focus, such as personal and social inadequacies. Secondly, there is typically a notable distortion in the total family relationship. A third point centered around the fact that the phobic child will experience rather predictable symptoms, including nausea or vomiting at the prospect of going to school, good health on weekends and holidays, inadequate social relationships, lack of assertiveness, and mediocre academic performance despite average or better ability (LeUnes & Siemsglusz, 1977).

School phobia manifests itself in different ways and in different degrees of severity. The school phobic child may cry a lot, become depressed, lose interest in social and recreational activities with peers, become irritable and aggressive toward others, become excessively fearful and preoccupied with thoughts of physical harm or desertion by his family, project blame for his problems onto others, and/or experience sleeplessness or anorexia. Somatic symptoms usually occur during the early stages of the disorder, generally emerging after parental pressure has been exerted to return the child to school. These ailments and reactions disappear once the child is assured
that he does not have to participate in school activities or to attend school at all (McDonald & Sheperd, 1976). Other characteristics of the school phobic child have included sheer refusal to attend school, having an overprotective mother and a passive father, shyness and self-consciousness, trembling, inability to move, dizziness, pickiness over food, enuresis, diarrhea, an unwillingness to leave the mother, and/or being the oldest or last child left at home (Nice, 1968; Goldberg, 1977; LeUnes & Siemsglusz, 1977; Lall & Lall, 1979). Somatic complaints are found more frequently in younger children, but are more serious when they occur in adolescents, indicating the youngster's personality resources are so lacking that he must resort to drastic measures in order to feel safe and free of fear (Kelly, 1973; Chotiner & Forrest, 1976). As parents are paralyzed by these complaints, the child becomes increasingly resistive and manages to stay home with or without the original accompanying physical complaints (Hsia, 1984).

Negative correlates of school phobia have included learning gaps and fears concerning missed school work, inadequate peer and teacher relationships, negative attitudes about school and learning in general, acceptance by others of school fears being real, confrontations with legal ramifications of compulsory education, and the possibility of subsequent adult phobic
reactions (Leventhal, Weinberger, Stander, & Stearns, 1967; Goldenberg & Goldenberg, 1970; McDonald & Sheperd, 1976). The child in danger of failure in school rarely becomes phobic. Students with clear-cut learning problems do not express a reluctance to go to school; they want to go even though they have little success (Goldenberg & Goldenberg, 1970).

Johnson and her associates distinguished school phobic disorders from school truancy and identified school phobia as a more complex childhood psychoneurosis. Many authors stressed the need to differentiate between school phobia and truancy. The phobic's avoidance of school is distinguishable from the truant's in that the school phobic, having fled the school in a panic, will run straight home to the mother, while the truant is usually away from home during his absences (McDonald & Sheperd, 1976). Motivations, characteristics, and symptoms differ between truancy and school phobia. In a study conducted by Hersov (1960) it was indicated that in cases of truancy: (a) a conduct disorder was indicated and involved other delinquent behaviors such as lying and stealing, (b) there was a lack of discipline at home, (c) schools were changed frequently, (d) there was a poor standard of school work, and (e) there were few neurotic symptoms. In cases of school phobia: (a) families had a higher incidence of neuroses, (b) children were dependent and overprotected, (c) there was less maternal/paternal absence during
infancy, and (d) there is a high standard set for school work and behavior (Marks, 1978; Haris, 1980). The truants did not refuse to go to school but used many tricks to stay away from school and wander alone or in company with other truants, their whereabouts unknown to their parents who first learned of the truancy from school authorities (Marks, 1978).

Sperling (1968) believed that school phobia has to be considered a psychoneurosis, that it is based on unconscious conflicts and fantasies, and that the reasons the phobic child used for his behavior were rationalizations while the true reasons were unknown to him. Although studies of a large number of school phobic students disclosed that the most frequent explanation for school refusal was the fear that if he went to school some harm would come to his mother, students expressed other fears as well. Fears examined included fears of strict or sarcastic teachers, ridicule, bullying, or harm from other children, academic failure, illness within the family, parental problems, birth of a sibling, anxiety about meeting high standards, and a feeling of depression or withdrawal. Some students could only respond that "something" prevented them from attending school (Lall & Lall, 1979; Concannon, 1980; Harris, 1980; Kennedy, 1984).

From a learning perspective, the school phobic child may view school as a preaversive stimulus; that is, the occasion for the loss of positive reinforcement. The child regarded
separation from a parent as a synonym for the loss of positive reinforcement. In effect, the school signaled the loss of an overabundance of attention and sheltering. Since the school was viewed as aversive, the result was for the child to increase the frequency of avoidance behavior. An overly dependent child could attach anxiety to any aspect of school life, real or imagined. An unusual occurrence in the home could further precipitate the phobia (Long, 1971).

Gittleman (1976) suggested that fear of something happening to the mother may frighten a phobic child and make him feel guilty for thinking such things and afraid of leaving home. His guilt, in turn, may lead to worry that something will happen, if not to the mother, then directly to him. A child's fears also give rise to feelings of anger which further confuse him but which he usually manages to suppress. School phobia then is a complicated tangle of unpleasant feelings which the child neither understands nor knows what to do about other than to try to avoid the anxiety altogether by staying home. However, staying home from school does not cure the anxiety. It will show up elsewhere unless steps are taken to relieve the underlying cause (Wilner, 1966). Most school phobic students were aware their worries were irrational. Most school phobics formerly enjoyed satisfactory adjustment to life and could recall their symptom-free life, recognizing they were different from
their previous selves and from their normal peers (Gittleman, 1976).

Every individual's experiences, personality, and particular situation help to determine what will be stressful situations for him. The upsetting change may be an obvious one such as the first day of school, or it may be somewhat accidental such as an illness. The child who develops school phobia does not necessarily fit into the usual stereotype of a crybaby or sissy. He may seem quite independent and even rebellious (Wilner, 1966).

Since school phobia has appeared less commonly in the adolescent age group, there has been a tendency to neglect it in the literature and focus on the elementary school child. In this older group, chronic, deeply embedded problems are encountered that yield slowly to treatment. In cases studied on preadolescent and adolescent school phobia, there was a noted early history of symptoms which subsided spontaneously only to reappear after several years of regular school attendance (Coolidge, Willer, Tessman, & Waldfogel, 1960).

Treatment perspectives

Various theories have been proposed to explain school phobia dynamics and eliminate its symptoms and consequences (Kelly, 1973). The treatment of school phobia has taken many forms. The psychoanalytic, psychodynamic, behavioral, and learning theory perspectives are four major treatment theories discussed
in the literature. Each of these perspectives will be discussed individually in the following sections.

**Psychoanalytic perspective.** The psychoanalytical school of thought has paid the greatest attention to school phobia and has offered the most comprehensive explanations (Goldenberg & Goldenberg, 1970). Psychoanalysts de-emphasize or exclude the school or school-related events from their accounts of etiology and only rarely implicate the school or its personnel in treatment.

Psychoanalysts have generally viewed school phobia as a consequence of a symbiotic mother-child relationship in which the mother is overly protective and the child is excessively dependent (McDonald & Sheperd, 1976). Psychoanalytic explanations stress the over-dependency fostered by a mother who is often mildly neurotic and whose own dependency needs on her own mother are frequently unresolved. The dependency creates repressed hostility in both the child and the mother, and in the child especially a fear of separation. This repressed hostility grows in the mother because of ceaseless demands by her child and grows in the child as a result of his unconscious resentment of being held in dependence. The father is often in a competing role with the mother and seems to try to outdo her in household tasks. He, too, overidentifies with the child. Waldfogel (1957) stressed the father's inability to clearly define his parental position in the family unit. He believed that these mothers and fathers
look to each other for gratification of their own dependency needs. The dependency, fear, and hostility inhibit the ego-development of the child, and the fear is displaced onto the school as the child anxiously clings to his mother in unresolved dependency (Kelly, 1973). Thus, the climate within the family prevents the child from ever finding out whether he, of his own volition, can solve his problems. This emotionally-laden atmosphere is sooner or later ignited by some apparently simple and transitory situation arousing intense anxiety within the child which is manifested as a school phobic reaction (Nice, 1968).

The child's anxiety is increased by the prospect of going to school. The child's fear and anxiety become detached from the deficient mother-child relationship and are displaced onto the school in the form of a neurotic fear. The child attempts to control his anxiety by avoiding the now-feared school situation (Kennedy, 1965; Kelly, 1973).

The school phobic child was typically seen as a bright, although anxious individual whose ties to his parents, especially his mother, resulted in excessive separation anxiety which was then manifested as a school phobia. This separation anxiety may be part of a familial pattern of dependence fostered by the parents. As a result, treatment for the parents is oriented toward resolving the underlying neurotic
Successful treatment of school phobia in accordance with a traditional psychoanalytical model requires a lengthy process of uncovering unconscious dynamics for both the child and his parents. School phobia is viewed as a symptom of childhood neurosis. Treatment involves the determination of underlying causes, their severity, and a predicted prognosis (Boyd, 1980). Among the psychoanalytical theorists, generally good results have been reported dealing with returning school phobic students to school and resolution of the mother-child conflicts. Quick symptom relief was accomplished about 80% of the time (Kelly, 1973; McDonald & Sheperd, 1976).

The role of analysis, insight, and the improvement of ego-strength and family equilibrium are paramount in a psychoanalytically-oriented treatment. Included is individual therapy for the mother. Intensive family therapy is advocated to restore harmony and constructive interaction among its members. The primary objective of the therapist is to achieve early symptom relief, with later sessions oriented toward resolving the underlying neuroses. If the phobia is severe, the child may receive in-patient residential or hospital care (McDonald & Sheperd, 1976; Contessa & Paccione-Dyszlewski, 1981).

**Psychodynamic perspective.** Psychodynamic explanations state that the school phobic child overvalues himself and his
achievements and tries to maintain his unrealistic self-image. When his power is threatened in the school situation, he suffers anxiety, seeks to avoid the threat and to maintain his omnipotent self-image by escaping from the threat. When he escapes to the home he is indulged and reinforced by a permissive mother. At home the child is gratified and comforted by the mother, which, in effect, aids the child to rebuild his false self-image and simultaneously avoid the reality of school (Kelly, 1973; McDonald & Sheperd, 1976). Anxiety is aroused through the fear of losing his mother or her love, and this anxiety is then displaced to another person, place, or occasion (Harris, 1980).

The major focus of the child's anxiety is on the fear of losing his own ego rather than losing his parents. For the older child, whose central task is finding security and competence in his own self-identity, the ultimate result of early over-dependency becomes an inadequate and weak ego threatened by the school, yet no longer sustained or satisfied by parental approval (Kelly, 1973).

School phobia creates a power issue, and treatment is one of tactics in which a strategy is evolved, with proper assessment of family members, methods and timing, in which persistent pressure applied along a gradient, minimally sufficient at each step to accomplish its end, is exerted to keep the child in school. The psychodynamic cycle that underlies school phobia must be interrupted through insight.
therapy based on influencing the child's self-image, correction of parental attitudes, restoring realism, and replacement of fear with pleasure as a motive (Kelly, 1973; Contessa & Paccione-Dyszlewski, 1981).

The psychodynamic cycle applicable to school phobia has four stages: (a) the fostering of omnipotence, (b) evaluation of realistic performance which threatens the child's self-image, (c) avoidance and fear of school, and (d) rage and overvalued ego. Psychotherapy is facilitated by the identification of the predominant phase of the cycle at any given time. Once the child extricates himself from the cycle, he no longer requires the school phobia and is better prepared for emotional growth and able to cope more realistically with life's challenges (Radin, 1968).

Leventhal and Sills (1964) recommended that the complicity of all family members needs to be determined, as well as assessment of the contributing influence of school personnel, activities, and classmates. Then the therapist can attend to fantasies, the unrealistic self-image, and the power issue in regard to school attendance. Confrontation and gradual pressure is applied to ensure the student's early return to school and to prevent intimidation of parents and teachers (McDonald & Sheperd, 1976).

Methods tend to be long-term, expensive, and de-emphasize
the role of the school (Harris, 1980). Power tactics are successful to get the child to stay in school not because he discovers he cannot outmaneuver his parents, but because he is forced into a situation in which he can experimentally reevaluate himself positively in relationship to reality demands (Kelly, 1973).

**Behavioral perspective.** The approach that most clearly focuses on the importance of incidents at school is the behavioral approach. This approach posits that nonreinforcing or aversive events occurring at school are a necessary component for the development of school phobic behavior. The events can be of a social or academic nature which lead to anxiety and avoidance of school. The school phobic then remains at home where he avoids anxiety and gains reinforcement. If the child is allowed to stay at home, the anticipatory anxiety mounts, the symptoms then being alleviated only by being allowed to remain there, with this further increasing the reinforcing properties of being allowed to stay home (Trueman, 1984b). School may be aversive because: (a) the student is exposed to punishing situations, or (b) school is an effective time-out for positive reinforcements at home (Doleys & Williams, 1977).

Recent behavior therapy approaches to the reduction of fear-related behavior have introduced objective and structured treatment procedures focusing on the fear-arousing school situation and actual school avoidance behavior as well as
anxiety over separation from parents (Tahmisian & Reynolds, 1971). Behaviorists have viewed school phobia as behavior that has been consciously or unconsciously rewarded by one or both parents, which is then reinforced by further school avoidance behavior (Cooper, 1973).

The traditional distinction between behavioral treatments has tended to conceptualize the approach as based on classical or operant conditioning principles. Most of the applications of behavioral techniques in the schools have focused on operant procedures (Prout & Harvey, 1978; Trueman, 1984b).

Within the classical conditioning paradigm, school phobia has been seen as a conditioned anxiety response elicited by the school situation. Treatment has involved either deconditioning or counterconditioning and typically involves reciprocal inhibition. The most common treatment in this model is reciprocal inhibition with relaxation used as an antagonist to anxiety. Reciprocal inhibition models attempt to alter behavior by actively counterconditioning the anxiety (Trueman, 1984a).

Desensitization, reciprocal inhibition, may be used to neutralize the child's fears to school-related situations, activities, or objects. In systematic desensitization the child is induced or taught to relax, and while in a state of relaxation, is presented with real or imaginary threatening situations. These school-related situations or activities are
arranged hierarchically from the least to the most threatening (McDonald & Sheperd, 1976).

Behavioral therapists use reinforcement and response-shaping procedures by giving carefully designed and powerful rewards contingent upon gradually increased school attendance and by desensitizing the child to the feared situation with the use of imagery techniques, shaping, relaxation, confrontation with the feared situation, modeling, implosive therapy, and anxiety-reducing stories (Prout & Harvey, 1978; Hsia, 1984).

Implosive therapy accepts the classical conditioning model of aversive conditioning and hypothesizes that, if the anxiety-evoking stimulus is presented in the absence of the aversive stimulus, eventually, the anxiety response will extinguish. Since the patient has consistently avoided the anxiety-provoking stimulus in the past, he must be kept from avoiding the situation in order for the treatment to be effective. In addition, the anxiety must be intense for extinction to occur. In implosive therapy, the individual is imaginarily presented with the anxiety-provoking situation (Trueman, 1984a).

Counterconditioning involves engaging the child in an enjoyed activity that is incompatible with a feared activity or situation. An anxiety-evoking stimulus is placed within an activity the child likes and then introduction to new stimuli is paced so the pleasurable features of the situation
gradually counter and overcome any unpleasant reactions (McDonald & Sheperd, 1976).

Within the operant conditioning paradigm, school phobia is seen as an operant, or series of operants, initiated by various cues and maintained by certain reinforcement patterns or conditions, arising from others, the environment, or within the individual. The approach focuses on: (a) identification of maladaptive behaviors, (b) identification of stimulus cues, and (d) alteration of stimulus cues and reinforcement contingencies (Trueman, 1984a).

Recent treatment of school phobia has involved behavior modification procedures developed primarily from the work of Wolpe in 1966. Understanding the child as well as having a good working relationship with him seems essential if the counselor is to adequately gauge the child's anxiety and assist him to move comfortably through the treatment (Long, 1971).

The literature suggested that counterconditioning approaches have been successful in dealing with school phobia. In most instances, counterconditioning has been utilized in conjunction with other treatment elements (Prout & Harvey, 1978). Although no systematic studies designed to assess the relative efficacy of behavior therapy or different behavior treatment techniques have been undertaken, case reports have indicated that behavior modification techniques have been effective in the modification
of school phobic behavior (Trueman, 1984b).

**Learning theory perspective.** Since 1960 there have been increasing numbers of explanations of and intervention approaches to school phobia based on learning theory. Learning theorists are less concerned with etiology than treatment (McDonald & Sheperd, 1976).

Learning theory explanations discuss school phobia in terms of stimulus-response conditioning and learned maladaptive ways behaving. The child may fear the loss of his mother as a result of comments about leaving by the mother. This fear becomes verbally conditioned to ideas about going to school, where he would lose his mother. As the fear of school becomes intense, he finally refuses to go and the fear is strengthened by each successive avoidance response. Staying at home has reinforcing properties in that it reduces fear and usually offers other rewards, secondary reinforcers, such as toys and television (Kelly, 1973; Boyd, 1980).

Learning theorists attribute considerable significance to the school, teachers, peers, and activities. The school frequently plays a large role in the treatment of school phobia (McDonald & Sheperd, 1976). Learning theorists stress the application of broad learning principles, reinforcement via approximations, interference, counterconditioning, and desensitization. Behavioral events, rather than underlying dynamics, are examined in order to establish an appropriate
treatment (Kelly, 1973). Learning theorist believe maladaptive behaviors exhibited by the child are learned and can be eliminated by directing treatment to them directly (McDonald & Sheperd, 1976).

McDonald and Sheperd (1976) reviewed several different perspectives to the explanations and treatments of school phobia and were impressed with the learning theory approach. Besides treatment efficacy, other factors within the learning theory approach are: (a) behavior is observed and measured directly rather than translated from parent and child recall, (b) the therapist can observe and analyze parent-child and school-child interactions prior to and during treatment, rather than relying on the accuracy of verbal reports, (c) behavioral prescriptions can be precisely described and implemented, avoiding vague translations and misunderstandings since there is usually close cooperation between the therapist, the parents, and the school, and (d) behavioral intervention requires objective, systematic, and reliable data which permits the therapist to accurately judge and report the effectiveness of treatment (McDonald & Sheperd, 1976).

Behavior therapy is also favored because of its multi-disciplinary team approach; that is, the cooperative efforts and expertise of educators, psychologists, administration, and physicians. The child is benefitted directly through symptom relief and return to school. A team approach has the advantage of including parents in the entire program (McDonald & Sheperd, 1976).
Summary

The treatment of school phobia has taken many forms. Although not all theoretical issues have been resolved completely, a review of the literature revealed a range of useful explanations of dynamics and treatment modes to give the therapist many concrete suggestions to help the school phobic child (Kelly, 1973). The selection of a treatment method for school phobia depends on the nature and severity of the presenting problem and the theoretical orientation of the therapist (McDonald & Shepard, 1976). Regardless of the perspective taken, the main emphasis has been on getting the child back into school for legal, educational, and psychological reasons (LeUnes & Seimsglusz, 1977).

A prominent, specific issue that appeared under all theoretical approaches concerned the amount of pressure that should be exerted to have the child stay in school. Some stressed the need for time, while others stressed the necessity of getting the child back to school, even if some force must be used. Almost all authors indicated that, regardless of the resolution of the force issue, it is essential to get the child back to school as soon as possible, even if only for a short while each day (Kelly, 1973).

The prognosis is seen as favorable if treatment is begun early. This expectation is lessened by such factors as: (a)
duration of the problem, (b) the child's age, and (c) the time between the onset of the problem and the start of therapeutic measures. The honest desire on the part of the parents to be positive change agents is also a significant variable (LeUmes & Siemsglusz, 1977). Weinberger and Leventhal (1977) suggested that the probability of a successful return to school and resolution of the child's fears has been enhanced by the degree to which the school assumed the responsibility to carry out strategies designed to effect the child's return.
CHAPTER III

Interpretation of the Literature

It is often held that school phobia is a misnomer for school refusal on the grounds that the condition is not a fear of school at all but rather a fear of leaving the mother. This is too one-sided a view. Many children are more afraid of school than of leaving their mothers. Some are afraid both of school and of separation from their parents (Marks, 1978). Gittleman (1976) felt it was wrong to think of school as a specific feared situation that is the major source of the child's difficulties. Those who act on this assumption try to make school more benign and less demanding. Gittleman believed this should not be done because school phobic students have problems adjusting to a new situation, so introduction of a novel school environment is more likely to worsen the child's problems.

Bamber (1979) stated there is considerable doubt as to what the term school phobia really implies and with what success cases of truancy can be differentiated from cases of school phobia. Other authors have suggested that school phobia cannot be considered on a par with other fears. Bamber implied that school phobia should be considered as a separate entity from phobias described on a fear scale since it represents a multifarious problem unrelated to other forms of manifest anxiety.

Kelly (1973) stated that findings by Miller in 1970 suggested
that while separation anxiety may predominate in younger children, the phobia of older children is specific to school and is generally characterized by depression and withdrawal. Even among the school phobic children for whom separation anxiety is an important contributing factor as evidenced by a history of a recent death or health problems in the child's environment or excessive family moves, they are found to readily separate from their parents in other situations such as visits to relatives or friends, or to leave their parents to join their therapist on their first visit (Hsia, 1984).

Sperling (1968) noted that a phobia, a neurotic illness, may often be more painful than a physical illness. Getting a child back to his classroom may simply eradicate a symptom rather than the illness. Symptoms of school phobia are often mistaken for disciplinary problems and improper measures are often taken in futile attempts to correct them (Lall & Lall, 1979).

The wide application of the psychoanalytic model has lead to the tendency to view school phobic students as a relatively homogenous group. This trend obscures the complexity of the problem in adolescence. Separation and individualization are critical issues, but these tasks involve much more than resolution of the mother-child relationship (Rubenstein & Hastings, 1980).

Treatment within the psychoanalytic framework has been
characteristically ill-defined and has provided few behavioral guidelines for dealing with school phobic behavior (Tahmisian & Reynolds, 1971). According to Hsia (1984), the psychoanalytic model and the power theory are too simplistic to allow consideration of parent-child interactions, the varied developmental tasks in different age groups, and problems in the school environment.

Arguments against the psychodynamic theory included: (a) the mother-child relationship in most families does not produce school phobia, (b) why is only one child in the family affected?, and (c) children do not have problems separating from their mothers in areas of life other than school (Goldenberg & Goldenberg, 1970).

Many authors utilizing behavioral techniques have reported significant treatment success with school phobia. However, Trueman (1984a) stated that no comprehensive comparison of these reported results was available. Miller, Barrett, Hampe, and Noble (1974) investigated the treatment of phobias in 67 children aged six to fifteen in 1974, comparing reciprocal inhibition, psychodynamic therapy, and a waiting list control group. Treatments contained a number of common elements such as removal of secondary gains and training in coping and assertive behaviors, making it difficult to isolate the effects of the treatments. Also, the important independent variable of school attendance was not included in the study. Although a
significant reduction in symptom severity occurred over time, it was not due to either a treatment or a therapeutic effect. Reduction in symptomatology was seen as a result of time and the age of the child (Prout & Harvey, 1978; Trueman, 1984a).

Trueman (1984a) reviewed several case studies and indicated that many of the studies incorporated different treatment techniques, making it impossible to discern the differential effects of each. A lack of consistent criteria for treatment efficacy limited comparisons of treatments across studies.

Trueman (1984a) listed three problems in the understanding of the efficacy of various treatment techniques. First, the distinction between classical conditioning and operant techniques is easily blurred in terms of application and kind of theoretical foundation. Although authors distinguished between desensitization and shaping, precisely what was being distinguished was questionable. In the case of the former, concomitant techniques utilizing relaxation and/or emotive imagery are likely to be present; whereas, in the latter, these are usually absent. Secondly, most therapeutic encounters are between only two people and involve verbal interactions only. Third, criteria for improvement are not uniform across studies, either in terms of content or time of assessment.

Kennedy (1965) reported on the successful treatment of 50 cases of school phobia using a rapid-treatment approach utilizing
several methods. He stated concerns regarding the study: (a) the claim of complete remission for all 50 cases was inconsistent with actual child guidance clinic rates, although these rates were not stated, (b) criterion for success was too narrow, (c) no diagnostic evaluation was done on any of the 50 students in a follow-up study, and (d) perhaps what is called school phobia is not really a severe phobic attack but borders on malingering of a transient nature which would spontaneously remit in a few days anyway.

Trueman (1984b) listed many problems regarding the study of school phobia. These are delineated in the following sections. A review of the literature yielded few systematic, reliable investigations of the characteristics of school phobic children. Most studies described case studies with little, if any, attempt to determine the characteristics of the children or even if the sample was representative of school phobic children in general.

In general, studies of school phobic children have not been systematic and reflect sampling biases due to the group available and the location and time when the study was conducted.

There have been no investigations of the incidence of school phobia. Kennedy (1965) made no mention of where he collected his data or how he knew the frequency of occurrence was increasing. A general incidence of 17 per 1000 is too great since that would mean that one out of approximately 59 children is school phobic.
A review of the literature shows inconsistent and variable estimates of the average age of school phobic children.

No systematic assessment of the proportion of boys and girls with school phobia have been conducted. No examination of socioeconomic, ethnic, or religious variables has been conducted. It has been speculated that younger children and only children are more likely to become school phobic since they will have a more difficult time with separation and loss of parental attention. Parental, especially maternal, difficulties with their own separations may exacerbate the situation and provide the groundwork for a phobic reaction. Other than this speculation, there have been no hypotheses about birth order and family characteristics.

It is assumed that a phobic child has fewer than average social contacts and he will use his intellectual abilities to achieve academically and reap important gratification from his parents. Most studies supporting this have not been systematic and have not assessed the representativeness of their sample. Many studies do not even indicate the administration of intelligence tests but give only clinical impressions. No studies have assessed the school situation and possible precipitating events occurring there.
CHAPTER IV

Implications

This chapter reviewed interventions authors have recommended for dealing with adolescent school phobia. Interventions were reported as those useful for parents, educators, and school psychologists/counselors.

Parents

Parents who want to help their child overcome school phobia must be prepared to tolerate the child's crying the first few times he is returned to school. Parents should ignore complaints of headache or stomach pain which the child will present in the morning just before it is time to go to school. Firm but loving and consistent pressure toward school should help the child overcome the fear (Marks, 1978).

Communication between parents and the child is a valuable resource in treating school phobia. In talking to the child, parents may discover that the child's school phobia stems from something unrelated to school (Kennedy, 1984). In the treatment of school phobia, one must check that conditions in the school are tolerable, that the child is not being bullied, and that unreasonable academic demands are not being made.

The parents must be able to assume a uniformly authoritative role; that is, both parents must agree and work cooperatively with each other in order to return their school phobic child to school (Leventhal, Weinberger, Stander, & Stearns, 1967). Ideally,
the entire family of a phobic child should seek psychological help (Whiteside, 1974). Counseling for the entire family as well as therapy for the child can be useful since school phobia may be related to emotional stress in other family members. In some families, despite real efforts and good intentions on the part of everyone involved, the child is unable to overcome his fear or the mother is unable to resolve her own difficulties. Since such anxieties stem from deep-seated, often unrecognized, feelings and attitudes, it is helpful in such cases to seek psychiatric aid (Wilner, 1966).

Parents should have the final say in the treatment used; however, the child must be listened to and encouraged to take part in finding a solution to his problem (Lall & Lall, 1979).

Teachers

Children with school phobia are generally capable of experiencing pleasure in nonschool areas. If this pleasure is shifted into the field of learning, the threat of failure in school is lessened. Acceptance based on intrinsic worth without overemphasis on performance should prevail (Radin, 1968).

An important point in treatment is firm insistence that the child return to school and stay there however much he dislikes the idea. Interest in what he does at school and praise for work he accomplishes can help. Returning the child to school may require the cooperation of the teachers who need to understand
The disruption of the normal school routine by a youth suffering from school phobia tends to act as a threat to school personnel. This threat often becomes directed against the child. Studies have shown that it is important to inform personnel that conditions for school phobia existed within the family unit before the child ever entered school and the school is not to blame. The teacher, either by attending to the child's inappropriate behavior or by exposing him too quickly to fear-provoking situations, could be contributing to his phobia. The way in which the fearful child comes to regard himself is partly a result of how the teacher acts toward him. The teacher should provide circumstances, under pleasant and relaxed conditions, through which the child is assured of success. His successes should be followed by positive reinforcement while the teacher gradually introduces him to more challenging situations. During such procedures, the child should not be deprived of the chance to make mistakes (Long, 1971).

Information on treatment methods available through various agencies should be made available to school personnel to help resolve their problems of not knowing what to do with school phobic students (Marine, 1968). Teachers who see a child showing symptoms that might suggest school phobia should refer the child for diagnosis and counseling. Consultation with the therapist or counselor may help the teacher identify strategies to help the
child feel more comfortable in the classroom. Teachers who can combine enough firmness to keep a reluctant child in school with the patient gentleness to allay his anxieties may play an important part in prevention of the development of simple forms of school phobia (Kelly, 1973). Gittleman (1971) suggested home-bound instruction should not be encouraged as it communicates to the parents and the child that he does not have to go back to school quickly.

School Psychologists/Counselors

In an attempt to establish a hierarchy in which the parents are in charge regarding school attendance, the therapist needs to be skillful in motivating the parents to return the child to school against his will. The therapist needs to be able to lend the parents the power they believe they may have lost in their struggles with their child (Hsia, 1984).

Hsia (1984) stated that good case management in treating cases of school phobia is of great importance. Good case management includes: (a) the therapist's speed in responding to the referral, (b) the therapist's availability to the family, (c) the importance of finding therapeutic allies, (d) the need to obtain cooperation from school personnel, (e) rewards and recognitions for resumed school attendance needs to be built into the therapeutic program, (f) the need to stress minimal interference with school attendance, and (g) the importance of
striving for a rapid and complete return to school.

An important consideration in the use of any approach with older children is to foster independent self-acceptance and not mere compliance. In the case of adolescents whose phobias may be long-standing, resistant to treatment, and involved with other neurotic tendencies in the child and/or his family, a more extensive clinical diagnosis with resulting intensive treatment may be necessary. Institutionalization and drug therapy are drastic steps to be used only with severely disturbed children unamenable to other treatments (Kelly, 1973).

The therapist may need to investigate what contribution the school makes to the development of the school phobia and initiate action at the institutional or community level for changes in the school and its relationship to the community. Most, if not all, schools possess structures, practices, and personnel that cause, occasion, or aggravate the development of school phobia (Kelly, 1973).

**Summary**

Teachers, counselors, psychologists, administrators, physicians, and parents must be alerted to the signs of school phobia so recognition, correction, or referral to outside agencies is prompt and effective. The goal of all people concerned and involved with the school phobic student must be that of returning the child to school as quickly and as painlessly as possible (McDonald & Sheperd, 1976).
REFERENCES


