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SCHOOL PHOBIA: CAUSES AND TREATMENTS

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Diane Smith Dingman

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Candidate: Diane Smith Dingman

I recommend acceptance of this seminar paper in partial fulfillment of this candidate's requirements for the degree Master of Science in Education: Special Education.

5-1-85                      *Patricia J. Rayburn*  
Date                              Seminar Paper Advisor

This seminar paper is approved for the College of Education.

5-2-85                      *Howard C. Rose*  
Date                              Seminar Paper Advisor

## ABSTRACT

SCHOOL PHOBIA: CAUSES AND TREATMENTS

Diane Smith Dingman

This study examined the causes and treatments of school phobia from the behavioral, the psychodynamic, and the psychopharmacological perspectives. School phobia is the most commonly seen phobia in school age children. Children who experience school phobia exhibit an extreme aversion to school or to some aspect of the school situation. The child displays symptoms of crying, whining, and tantrums while in the classroom or while preparing to go to school. The child's somatic symptoms may hinder his ability to enjoy or learn from the school setting. Results of the literature indicated that the school phobic child can be treated with behavioral methods, using either a respondent model, or the operant model of conditioning. In contrast, psychotherapy can be used to treat a school phobic child, alone or in conjunction with drug (imipramine) therapy. Research studies reviewed indicated that the behavioral and psychodynamic treatments were 100% effective, while imipramine treatment achieved 81% success. Educators and parents alerted to the earliest symptoms of a school phobic child can prevent a lengthy treatment. This study presents a parent questionnaire and a self-rating scale designed by this author. Use of these two devices may alert parents and educators to a child's anxiety surrounding the school situation.

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CHAPTER I  
INTRODUCTION

Statement of the Problem

A "phobia" is commonly defined as, "a fear or anxiety that exceeds normal proportions or an obsessive or irrational dread that has no basis in reality" (Random House, 1966, p. 1082). School phobia is the most frequent phobia for which children in the first three grades of school are referred to mental health clinics (Gresham & Nagle, 1981). Kahn and Nursten (1962) found that between 2% and 8% of the referrals to a child guidance clinic were elementary age "school phobics." The true frequency, however, is difficult to determine because various agencies, such as schools and clinics may deal with the problem. However, Trueman (1984) in his examination of the treatments for school phobia, estimated that from 1972 to 1980, the incidence of school phobia increased from .3% to 1.7%.

A child, in order to learn and grow in the school environment, must be able to give his attention to the educational stimuli. "When a phobia exists the child focuses all his attention on the concern, which in the case of school phobia is the educational setting, and is too anxious to learn or to enjoy school" (Welch & Carpenter, 1974, p. 205). In order for school phobic children to get the maximum benefit from their school experience, educators

must be knowledgeable about the behavioral problem known as school phobia. The prognosis for school phobic children is better when the phobia is dealt with at the onset (Welch & Carpenter, 1974). Educators' awareness of the first symptoms of school phobia will be crucial in bringing about a quick return to school (Gresham & Nagle, 1981). The question of whether to treat the child in the school setting, with behavioral methods, or refer the child to a mental health clinic for therapy, are two of the choices parents and educators will have to examine (Gresham & Nagle, 1981; Harris, 1980; Johnson, 1956).

This study will examine the causes and treatments of school phobia from the three schools of thought most often represented in the literature: the behavioral perspective, the psychodynamic perspective, and the psychopharmacological perspective. Examining the perceived causes of school phobia from each of these perspectives will help educators understand the different types of treatment. The type of treatment chosen is directly related to the perception of the cause.

The psychodynamic theorists view the problem as separation anxiety, or a neurotic state, in which the mother and child are involved in a mutually hostile dependent relationship (Johnson, 1956). The child's anxiety stems from his fear of being separated from his mother. Kahn and Nursten (1962) state, "from the psychodynamic perspective, the mother is viewed as being overprotective of the child, and the child as being highly dependent on the

parent (p. 707). A conflict occurs when the child goes to school and needs to be independent, and the mother has difficulty encouraging that independence (Johnson, 1956).

The psychodynamic school of thought treats the separation anxiety with therapy (Johnson, 1956). The therapist is a psychiatrist or psychoanalyst who examines the interdependent relationship between the mother and the child and the resulting separation anxiety. The psychodynamic therapist tries to encourage insight into the child's repressed feelings and fears (Johnson, 1956).

The other school of thought most commonly represented is the behavioral perspective. School phobia is viewed as a series of behaviors maintained by reinforcing actions" (Gresham & Nagle, 1981, p. 104). The behavioral characteristics of school phobia include somatic complaints, crying, and tantrums. The behaviors are reinforced by attention from significant adults, and permission to stay home from school (Gresham & Nagle, 1981; Harris, 1980; Johnson, 1956).

A variety of behavioral treatment approaches have been used in treating phobic children. A behavioral treatment program can involve contingency contracting where the child is deprived of reinforcers unless he makes responses in the direction of going to school (Welch & Carpenter, 1970). Behavioral therapy can also involve ignoring the inappropriate behaviors and reinforcing the desirable behaviors (Marine, 1969).

The psychodynamic and the psychopharmacological perspective both view the cause of school phobia to be the unresolved, hostile interdependent relationship of the mother and child. The psychopharmacological perspective treated school phobia with a combination of drug treatment and therapy. A therapist counseled both the parents and the child, and used an antidepressant to treat the symptoms of anxiety that the child experienced (Gittleman-Klein & Klein, 1973). The psychopharmacological perspective is not highly representative of the literature on school phobia, but the Gittleman-Klein & Klein (1973) study is often mentioned.

The role the parents play is extremely important, whether the problem is viewed from the behavioral, psychodynamic, or psychopharmacological perspective. From all theories, the role of parents is one of encouraging or reinforcing the child's school avoidance (Gresham & Nagle, 1981). The behavioral school emphasizes the child's access to special attention and privileges when he stays home from school. The psychodynamic and psychopharmacological theories both focus on the unsatisfied mother, whose needs have not been met by her husband, encouraging the dependence of her child. As long as the mother has a dependent child to care for she feels needed (Chess & Hassibi, 1978; Gittleman-Klein & Klein, 1973).

Educators will need to understand the various roles the parents play in the cause and treatment of school phobia, in order to involve them in the treatment program and bring about an expeditious

return to school. It is important for parents and teachers to work together to effect a successful return (Harris, 1980).

The question of whether the school system should treat the problem of school phobia or refer the child to a mental health clinic is one educators and parents will have to answer. In the chapters that follow, the options that are available for the treatment of school phobia will be discussed.

Available research has not yet identified a treatment model that is effective for all students. The purpose of this study was to review perceived causes of school phobia, and to examine the different treatment models so that educators will be informed as to the different options available.

Chapter II includes a brief review of the three different psychological perspectives. This is followed by an in-depth review of case studies of school phobic children from each of the three perspectives. The roles that parents, educators, and therapists play are also examined in Chapter II.

Chapter III focuses on the comparative effectiveness of the treatments of school phobia and the implications of these treatments for parents and educators. Chapter III also compares the involvement of educators, parents, and therapists from the three perspectives, and the duration of the treatments.

Chapter IV presents a self-rating scale, written by the author, which is intended to be used with the child to determine if he could become school phobic. The questions are drawn from both the

behavioral and psychodynamic schools of thought. The self-rating scale would be used to determine if the child experiences anxiety about leaving home or about being in school. Also presented in Chapter IV is a screening device to use with parents to determine if the child is predisposed to school phobia. The parent questionnaire was designed to determine if the parents are reinforcing school avoidance and somatic complaints.

CHAPTER II  
REVIEW OF THE LITERATURE

Introduction

The review of literature on school phobia will be organized around the three most frequently cited etiological perspectives: the behavioral perspective, the psychodynamic perspective, and the psychopharmacological perspective.

The first section of the review will discuss the behavioral theories of school phobia including both the operant and respondent conditioning models. Treatment approaches based on these two models of learning will also be presented. The next two sections of the review will discuss the psychoanalytic and psychopharmacological interpretations of school phobia and the corresponding approaches to treatment.

Behavioral Perspective

The behavioral perspective views all behaviors as learned, and a result of practice (Skinner, 1969). "By identifying practice as a key condition for learning, the effects of heredity and maturation are excluded" (Welch & Carpenter, 1970, p. 117). In other words learned behaviors can be unlearned (Gresham & Nagle, 1981). The behavioral perspective includes both respondent and operant conditioning models.

### Respondent Conditioning

The general term "behavioral therapy" is often used to describe treatment based primarily on respondent conditioning. Newcomer (1980) states that, "Pavlov discovered that a neutral stimulus such as a tone could elicit a response like salivation, if that stimulus had previously been paired with an unconditioned stimulus such as food" (p. 39). This learning paradigm, called classical or respondent conditioning, depends on close association of the conditioned and unconditioned stimulus through repeated pairings. For example, food placed in a dog's mouth is an unconditioned stimulus for the unconditioned response of salivation, and turning on a light is a neutral stimulus. Then through practice, called acquisition trials, the neutral stimulus is presented. The light is turned on, the dog receives food, and he salivates. Eventually, the light is presented alone, and it will elicit salivation (Newcomer, 1980).

The symptoms of school phobia according to Harris (1980, p. 263) a school counselor, consist of "somatic complaints, such as chest pains, palpitations, stomach aches or sore throats, and crying and whining". According to the respondent conditioning model, these symptoms become a conditioned response upon repeated presentations of the school stimuli (Welch & Carpenter, 1970). There are several types of treatment for school phobia which rely heavily on respondent conditioning, including implosive therapy (Smith & Sharpe, 1979); and desensitization (Lazarus, 1961; Wolpe, 1961).

The implosive therapy approach to treating school phobia, is based on a classical extinction model, and consists basically of presenting scenes which evoke strong anxiety responses (Smith & Sharpe, 1970). Smith and Sharpe (1970, p. 239) state, "it is assumed that the presentation of the anxiety evoking stimuli (conditioned stimuli) in the absence of a primary aversive stimulus (unconditioned stimuli) will result in extinction of the response".

Therapists Smith and Sharpe (1970) used implosive therapy to get their subject, Billy, age 13 years, back to school after a 7-week absence. Billy's somatic complaints began at breakfast and consisted of trembling, chest pains, and crying. These symptoms ceased when Billy returned home from school and did not occur again until the next morning.

Operant techniques (behaviors are shaped by the consequent reinforcers) were employed in the Smith and Sharpe (1970) case study. The therapists worked with only the parents in the first therapy session urging them not to reinforce Billy in any way if he stayed home "sick" from school. Billy's parents were instructed to remove sources of reinforcement from his room, e.g., books, toys, and games. The basis of implosive therapy was explained to the parents as "flooding the child with extremely fear provoking thoughts of school while the child is provided with an anxiety free atmosphere" (Smith & Sharpe, 1970, p. 230). After the parent's support was secured, the therapists began their treatment sessions.

Billy was seen for a total of six consecutive daily sessions of implosive therapy. During each session he was asked to imagine scenes involving the anxiety producing stimuli and describe them vividly (Smith & Sharpe, 1970). The therapists presented scenes in which Billy was ordered to school by a cold and rejecting mother. He was met at the school door by an evil, sadistic principal and taken through an extremely hostile school day. The therapists reported, "Billy cried and wept during the first session and complained of severe chest pains" (Smith & Sharpe, 1970, p. 239). The greatest amount of anxiety, according to the therapists, dissipated after the first therapy session.

The next morning and for three consecutive mornings, Billy attended school for half of the day. Each afternoon he returned to the clinic for an implosive therapy session, during which he was presented with anxiety producing visions of school. After the fourth session, Billy returned to school for the entire day with only fleeting anxiety (Smith & Sharpe, 1970). Billy's therapy was terminated after the sixth session since he reported that he had experienced no return of the anxiety in school. In six sessions, Smith and Sharpe (1970) reported that they were able to successfully treat a school phobic child who had been absent from school for 6 weeks.

Desensitization is another technique used to treat school phobia, based on respondent conditioning (Newcomer, 1980). "The process of desensitization is based on the principle of

counterconditioning," explains Lazarus, Davison, and Polefka (1965, p. 235). The goal of desensitization involves substitution of a relaxation response for the inappropriate anxiety response. For example, a child who has a fear of school is exposed to related stimuli that are below his anxiety level, such as pictures of school, video-tapes of gym class, or recess. In response to the pictures the child is helped to learn and practice relaxation. The stimulus is gradually made more similar to the actual school setting which originally provided anxiety. The child is taken closer to the school, or spends more time in the classroom, while practicing relaxation techniques, until no more fear is exhibited (Lazarus et al., 1965).

Harris (1980) reported that, "a guidance counselor was successful in helping Sue, a 5-year-old kindergarten child overcome her intense fear of school by gradually approaching the activities going on in the room" (p. 266). On the first day of treatment, Sue and the counselor sat outside the room and listened, talking calmly about what might be going on inside. The next day they entered the room, held hands, and stood next to the door. On succeeding days, Sue and the guidance counselor gradually took an increasing part in the classroom activities. "By the fourth day Sue was no longer anxious about the noises and activities in the school day, and no longer cried or spoke negatively about school," reported Harris (1980, p. 266). In gradual steps the researchers reported that Sue had become desensitized to the school situation.

### Operant Conditioning

Another form of behavioral therapy is based on operant conditioning. Early psychologists made no distinction between respondent and operant conditioning (Paul & Epanchin, 1982). However, Skinner (1969) focused on the differences between respondent and operant conditioning. Paul and Epanchin (1982), p. 188) state, "respondent conditioning occurs basically by association, whereas operant conditioning is under the control of reinforcement." The basic principle of operant conditioning is that behavior is a function of its consequences (Gresham & Nagle, 1981; Lazarus et al., 1965; Trueman, 1984).

Operant behavioral therapists view school phobia as a series of behaviors maintained by reinforcing actions (Lazarus et al., 1965). These behaviors include somatic complaints, such as crying, tantrums, and stomach aches. Gresham and Nagle (1981), p. 104) report, "the behaviors are maintained by attention from adults, which is reinforcing, and by avoidance of school, which removed the aversive stimuli: the school environment."

\* In a case study by school psychologists Welch and Carpenter (1970), a child's somatic complaints ultimately prevented the occurrence of stimuli in the school situation that were aversive. When the child stayed home from school, supposedly ill, his mother gave him extra attention, he watched television, and had other pleasurable experiences. According to the operant model of learning, the avoidance behavior and the reinforcements created the school phobia for this child (Welch & Carpenter, 1970).

In treating school phobia, Welch and Carpenter (1970) employed the operant technique of contingency contracting where, "the child is deprived of reinforcers until he makes responses in the direction of going to school" (p. 117). In the case study of Bobby, an eight-year-old boy, the intensity of his "somatic complaints" kept him from school for 1 week (Welch & Carpenter, 1970). The authors reported that, "his mother attended to him during this week, and as long as school was not mentioned, he was not sick" (Welch & Carpenter, 1970, p. 177). When Bobby's mother brought him to the authors for assistance, she was interviewed as to what reinforcers were maintaining his nonattendance, and what could be used as potential reinforcers. After this information was obtained and the mother agreed to fully cooperate, the therapists and Bobby wrote a behavioral contract.

Welch and Carpenter (1970) reported that, "in the contract the reinforcers were made contingent upon Bobby's appropriate behavior" (p. 118). He was first deprived of reinforcers, by isolation in his room, until he made appropriate responses in the direction of going to school. Bobby was given points for getting dressed, for going to school, and for staying there. The points Bobby earned by going to school could only be spent after school on activities that involved going out to play or having a friend over (Welch & Carpenter, 1970). If Bobby stayed home, he had to stay in his empty bedroom, and no issue was made of it.

The therapists reported that, "on the first day Bobby tested the contract and spent the day in his room" (Welch & Carpenter, 1970, p. 118). Thereafter, he attended school every day and the recordkeeping was discontinued after 3 weeks. Many of the reinforcement contingencies were continued, although Welch and Carpenter (1970) did not say which contingencies were continued.

Operant behavioral therapy can also involve ignoring the inappropriate behaviors at school and reinforcing the child when he begins to participate in class (Gresham & Nagle, 1981). As school consultants, Gresham and Nagle worked with the teacher and parents of Sally, a 6-year-old girl. Sally exhibited crying and whining behaviors upon arrival at school. Gresham and Nagle (1981) reported, "when the teacher was asked how she responded to Sally's behavior, she said she held Sally on her lap and rocked her" (p. 104).

Baseline data indicated that Sally's crying and whining behaviors lasted an average of 18 minutes each day for 5 days (Gresham & Nagle, 1981). The treatment consisted of a mild timeout procedure in which Sally would be placed in a corner contingent upon crying. Sally could remove herself from this corner when she stopped crying. Gresham and Nagle reported, "after she returned to the group, any appropriate behavior she exhibited was reinforced" (1981, p. 104). The timeout from reinforcement technique was used to get the aversive behavior under control so that more appropriate behaviors could be reinforced.

In the 10-day intervention period, the duration of Sally's crying and whining behaviors decreased to an average of 3 minutes per day. On the sixth day of treatment, the behaviors totally ceased and did not return during the follow-up period (Gresham & Nagle, 1981).

In the case studies presented above, which are representative of the behavioral literature, the teachers and parents played a major part in the operant treatment of school phobia. Both parents and teachers were seen as providing or removing reinforcers as the child earned them (Harris, 1980; Lazarus et al., 1965; Smith & Sharpe, 1970; Welch & Carpenter, 1970).

The respondent treatment emphasized the more crucial role the therapist played in the treatment of school phobia (Harris, 1980; Smith & Sharpe, 1970). The parents' support and verbal encouragement were still an important part of the respondent treatment (Harris, 1980; Smith & Sharpe, 1970; Trueman, 1984; Welch & Carpenter, 1970).

In contrast to the behavioral model of school phobia, the psychodynamic theory of school phobia places even greater emphasis on the importance of the therapist in implementing the treatment (Kahn & Nursten, 1962). At the same time, the psychodynamic perspective stresses the major role of the parent in the cause of school phobia (Chess & Hassibi, 1978; Johnson, 1956; Kahn & Nursten, 1962; Marine, 1969).

### Psychodynamic Perspective

The problem of school phobia is viewed from the psychodynamic perspective as a "separation anxiety," a mutual neurosis shared by mother and child (Johnson, 1956). Adelaide Johnson, a psychiatrist at Mayo Clinic in 1956, wrote the definitive study of separation anxiety. Dr. Johnson described separation anxiety as "an emotional state in which mother and child are involved in a hostile dependent relationship" (Johnson, 1956, p. 682). This relationship is characterized by a need on the part of both the child and the mother to be in close physical contact with each other. This extreme attachment occurs because the infantile mother child dependency relationship has never been successfully resolved (Johnson, 1956).

Proponents of the separation anxiety theory believe that the mother's needs have not been met by her husband, nor her mother (Johnson, 1956; Kahn & Nursten; 1962). The mother encourages the child's dependence as a route to satisfying her own needs. Often in the family of a school phobic child there is marital discord, with the father contributing to the mother's unhappiness. From the psychodynamic perspective, the mother is seen as emotionally hungry, encouraging her child to be dependent so that she feels needed (Chess & Hassibi, 1978).

Psychodynamically oriented therapists believe that release or separation between mother and child can be accomplished without anxiety by a mother who has experienced satisfaction of her own

needs, and has been permitted to grow into an independent person herself (Chess & Hassibi, 1978; Coolidge, Brodie, & Feeney; 1964; Johnson, 1956; Kahn & Nursten, 1962). A mother can not give emotionally to her child if she has not been nurtured and released by her mother. Johnson (1956) has observed that, "separation anxiety in school phobic children is often triggered by an intense experience in their lives which necessitates more comforting from the mother" (p. 684). Thus, physical illness, birth of a sibling, or remarriage may cause a child to turn to his mother for support. The mother may be unable in each situation to give comfort and release the child, and hostility and anxiety may be experienced by the child (Coolidge et. al., 1964).

Kahn and Nursten (1962, p. 707) reported that psychodynamic theorists believe, "the hostility within the child is transferred to an authority figure in the anxiety causing situation." School is often a stressful setting for these children and since teachers must set limits for children and may occasionally frustrate them, the child transfers his anger to the teacher (Coolidge et al., 1964).

The psychodynamic model treats the school phobia with a therapy process which probes the anxiety experienced by mother and child upon separation. The psychodynamic perspective views the mother as an integral cause of the school phobia so this model also includes the mother in the therapy.

Johnson (1956) treated Joe, a 12-year-old boy, who had been allowed to stay home from school for 9 months. When Joe's parents brought him to Mayo Clinic he not only feared going to school, but feared being away from his mother. Johnson (1956) reported, "Joe's parents had a poor marriage with much arguing and little companionship" (p. 687). When Joe stayed home from school his mother helped him with his schoolwork and admitted that Joe was a great source of satisfaction to her. She also stated that, "when Joe stayed home they had little parties together or went shopping"(Johnson, 1956, p. 687).

At the time of the first therapy session Joe sat on his mother's lap and shared the same room at Mayo Clinic with her. The first step the therapist took was to assign separate therapy times for Joe and his mother. Initially, it was extremely difficult for each one to come in individually for treatment. Johnson (1956) stated that, "the neurosis originated in the mother and seeing the child alone would not be successful" (p. 689). Thorough treatment of the mother was believed to be necessary to prevent her from again involving Joe in her neurosis.

Dr. Johnson (1956) saw her client, Joe, concurrently, and for the same duration of therapy as his mother. Johnson (1956) conducted therapy by bringing the conflicts of both clients out into the open and discussing the hostility. Johnson analyzed the particular conflicts with Joe and his mother that precipitated the the difficulty. She ultimately provided a situation in which the

dependency of each client could be resolved on a mature level. By the time therapy was over Johnson (1956) reported, "Joe was going to a tutor alone and his mother was permitting it (p. 690). She even went out of town to visit friends without Joe accompanying her (Johnson, 1956).

Johnson (1956) did not specify the duration of the therapy. She did state, however, that at the end of treatment it became necessary to deal with each client's anxiety about separation from the therapist (Johnson, 1956).

Kahn and Nursten (1962) presented a case study of "Paul," a 12-year-old boy who was diagnosed by the therapists as school phobic. Paul was the youngest boy in the family and had apparently adjusted to his parent's divorce 2 years prior to treatment. Paul was 12-years-old when he began to develop anxiety about going to school. He did not seem overly upset about his mother's recent remarriage and stated that he liked his stepfather (Kahn & Nursten, 1962).

Kahn and Nursten (1962) reported, "Paul went to summer camp, but after a week, wrote to his mother complaining of headaches" (p. 708). He came back home and was healthy for the remainder of the vacation. Paul visited the pediatrician and was assured that nothing was wrong with him. The first week of school Paul was tense, said all of the subjects were hard for him, and began to worry about performing. He began having more somatic complaints

and remained home with his mother a few days at a time. After 4 weeks, he refused to go to school (Kahn & Nursten, 1962).

When first seen by the therapists, Paul had been home for a month. He was depressed, anxious, and hopeless about his future. He refused to talk about his stepfather and denied having any affection for his father.

Kahn and Nursten (1962) reported, "Paul was seen in therapy and a course of an antidepressant drug was initiated"(p. 710). He was maintained on home instruction for 4 months during which time the therapists probed the interdependent relationship of Paul and his mother. When Paul was free of depression and anxiety, his parents were informed that only their complete agreement could give Paul the final push to return to school. "After 4 months of therapy and faced with the firm attitude of his parents, Paul returned to school with little resistance," reported Kahn and Nursten (1962, p. 710).

The psychodynamic treatment of school phobia has involved the parents as well as the child in the therapy sessions. Chess and Hassibi (1978) stated, "the only reason we see the child is in order to treat the parent" (p. 245).

The Kahn and Nursten study (1962) included the use of a mild antidepressant in Paul's treatment program. Another dimension of the psychodynamic approach is seen in the following case study, in which the use of drugs appears to play a large part in the therapy.

### Psychopharmacological Perspective

Psychopharmacological therapy combines aspects of the biological and psychodynamic schools of thought. The psychopharmacological perspective views the cause of school phobia to be separation anxiety, the same belief that the psychodynamic school holds. The psychopharmacological process uses drug treatment and in some cases involves therapy (Gittleman-Klein & Klein, 1973). The goal of the psychopharmacological treatment is to solve the hostile interdependent relationship between the mother and child.

At Hillside Hospital, Glen Oaks, New York, psychopharmacological therapists have treated school phobic children with imipramine, a tricyclic antidepressant (Gittleman-Klein & Klein, 1973). Therapists had noted a similarity in the symptoms experienced by agoraphobic adults and the symptoms experienced by school phobic children or children suffering from separation anxiety. The two terms, school phobia and separation anxiety, were used interchangeably in this study. The agoraphobe fears open places and progressively restricts his activities until he is unable to leave the house independently. The symptoms that both groups suffered from included rapid breathing, heart palpitations, unsteadiness, and panic attacks (Gittleman-Klein & Klein, 1973).

Gittleman-Klein & Klein (1973) reported, "about 50% of agoraphobic adults experienced separation anxiety as children and difficulty adjusting to school" (p. 202). Due to the proven effectiveness of using imipramine to block the onset of panic

attacks in agorophobic adults, the therapists at Hillside Hospital initiated a course of imipramine therapy with school phobic children (Gittleman-Klein & Klein, 1973).

A double blind study was conducted on 34 children, 6 to 14 years of age, who had refused to attend school for at least 2 weeks (Gittleman-Klein & Klein, 1973). The treatment program consisted of giving 15 children imipramine daily, and giving 19 children a placebo daily. The children and their families all received weekly therapy sessions exploring the interdependent relationship between mother and child, and the resulting separation anxiety. Gittleman-Klein and Klein (1973) reported, "the parents were told to maintain a firm attitude towards school and to expect an abatement of fear" (p. 203).

At the end of the 6-week period, the authors reported that 81% of the imipramine group were back in school full time, and only 47% of the placebo group were attending school full time (see Table 1). The school attendance data were further analyzed to determine whether, among the school returnees, the imipramine group, or the placebo group returned more quickly to school. Of the nine placebo patients who were in school after 6 weeks, seven of the children were back in school after 3 weeks. A different pattern emerged in the imipramine group. Among this group, only six children were in school after 3 weeks of treatment (Gittleman-Klein & Klein, 1973).

Children in the Gittelman-Klein Study (1973) also completed self-ratings using the Quay Behavior Questionnaire, at the beginning and end of the 6-week period. The children in the imipramine group all reported feeling better about themselves, including the three children who did not return to school (see Table 2). The results indicated by the placebo group were very different (see Table 3). Relatively few children (21%) reported feeling better about themselves whether they were back to school or not (Gittelman-Klein & Klein, 1973).

To summarize the psychopharmacological perspective combines drug therapy and counseling in an attempt to resolve the conflict surrounding the separation of mother and child.

Chapter II presented the three major perspectives on the causes and treatments of school phobia. Chapter III will compare different aspects of the three approaches, examining the roles of parents and school personnel in the treatments, the duration of the treatments, and the ease of replication of the treatments.

Table 1

School Attendance After 6 Weeks of Treatment (Mother's Report)<sup>a</sup>

Drug	Back to School	Not Back to School
Placebo	9 (47%)	10 (53%)
Imipramine	13 (81%)	3 (19%)

Note. From "School Phobia: Diagnostic Considerations in Light of Imipramine Effects" by Gittleman-Klein & Klein, 1973, Journal of Nervous and Mental Disease, 156, pp. 119-215.

<sup>a</sup> N=35

\* $p < .05$ , Fisher-Exact, one-tailed

Table 2

Children's Self-Ratings of Improvement<sup>a</sup>

Drug	No Change or Slightly Better	Much Better
Placebo	15 (79%)	4 ( 21%)
Imipramine	0 ( 0%)	15 (100%)

Note. From "School Phobia: Diagnostic Considerations in Light of Imipramine Effects" by Gittelman-Klein & Klein, 1973, Journal of Nervous and Mental Disease, 156, pp. 119-215.

<sup>a</sup>N=of 34 reflects missing ratings of 1 subject on imipramine.

\*p .05, Fisher-Exact, one-tailed.

Table 3

Relationship Between School Return and Self-Ratings of Improvement<sup>a</sup>

Drug	Back to school and feeling better	Back to school but <u>not</u> feeling better	Not back to school but feeling better	Not back to school and not feeling better
Placebo	4	5	0	10
Imipramine	12	0	3	0

Note. From "School Phobia: Diagnostic Considerations in Light of Imipramine Effects" by Gittelman-Klein & Klein, 1973, Journal of Nervous and Mental Disease, 156, pp. 119-215.

<sup>a</sup>N=of 34 reflects missing ratings of 1 subject on imipramine.

CHAPTER III  
INTERPRETATION OF RESULTS

The review of the literature presented treatments of school phobia from the behavioral, the psychodynamic, and the psychopharmacological perspectives. The author will not attempt to decide which treatment is best but only to help the reader decide which treatment would best fit his purposes. Some cases of school phobia will need a referral to a mental health clinic and this chapter will attempt to help educators decide when a referral to a mental health clinic is in the best interest of the child and family.

Interpretation of Behavioral Perspective

Welch and Carpenter (1970) state, "by identifying practice as a key condition for learning, the effects of heredity and maturation are excluded" (p. 117). Behaviorists believe that learned behaviors can be unlearned. The Smith and Sharpe (1970) study took Billy through a six-session course of implosive therapy, after one consultation with his parents. His parent's agreement to not reinforce his school phobia set the atmosphere for the therapists to begin their work. The parents cooperated by not commiserating with Billy's complaining and by not letting him watch television if he stayed home. The six implosive therapy

sessions were the responsibility of Smith and Sharpe and after the initial session, therapy did not involve the parents. During the period of therapy, and at a 13-week follow-up session, Billy was never able to identify which factor in school caused the initial anxiety. Implosive therapy was successful in six sessions even though Billy was "unable to identify the original aversive conditioning situation which led to the development of the school phobia" (Smith & Sharpe, 1970, p. 242). The results of Smith and Sharpe's study leads this author to believe that implosive therapy could be successful with minimal participation of parents and minimal introspection on the part of the client.

Desensitization, another behavioral technique based on respondent conditioning, substitutes a relaxation response for the inappropriate anxiety response. Harris (1980, p. 266) reported that, "Sue became desensitized to the loud noises and activities in the school day and no longer spoke negatively about school." The desensitization program took only 4 days and the minimal involvement of the parents to drop her off at school where she was met by Harris, the guidance counselor (1980). Positive reinforcement in the form of verbal praise and encouragement, for each increase in movement toward the goal of staying in school, was helpful in desensitizing Sue (Harris, 1980).

Another form of behavioral therapy, based on operant conditioning places more emphasis on reinforcement (Lazarus, Davison, & Polefka, 1965). The reinforcement in school phobia is seen as coming directly

from the home, where the child is allowed to watch television and is given attention when he stays home from school. In a case study by Welch & Carpenter (1970) the child stayed home from school (the avoidance behavior) and was treated to special attention from his mother (the reinforcement) which together created the school phobia. Welch and Carpenter (1970) treated the school phobia "by depriving the child of reinforcers until he made responses in the direction of going to school" (p. 117). In the case study of Bobby, whose mother had treated him to special attention for 1 week when he was home from school, it was necessary for the therapists to write a behavioral contract with the parents as well as the child. The parents agreed to not reinforce Bobby at all unless he made movements in the direction of going to school. The parents' participation in this treatment was an important as that of the therapist, who only made up the contingency contract. The parents were responsible for exchanging the points after school, for activities that Bobby helped choose himself. In this case a successful return to school took only 1 day, although the recordkeeping was continued for 3 weeks, and the parents continued some of the reinforcements after the recordkeeping ended (Welch & Carpenter, 1970).

Operant techniques can also involve ignoring the inappropriate behavior at school as in the case reported by Gresham and Nagle (1981). The therapists enlisted the aid of Sally's teacher, who had been reinforcing Sally's crying and whining by holding and

rocking Sally on her lap. Sally's teacher placed Sally in a corner, contingent upon her crying, and Sally could remove herself from this corner upon cessation of the crying. The only involvement of the therapists in Sally's case was in taking the baseline data and in formulating the intervention plan. Sally's parents were only involved in dropping Sally off at school and not responding to her complaining. By the sixth day of Sally's program she no longer cried or whined (Gresham & Nagle, 1981).

X In the literature, the behavioral treatments reported were all relatively short with none taking longer than 6 days. The involvement of the parents, the therapists, and the child were all important, but the major emphasis in these programs was on results: the child's return to school.

#### Interpretation of the Psychodynamic Perspective

The emphasis of the psychodynamic treatment lies in dealing with the anxiety surrounding the separation of mother and child (Chess & Hassibi, 1978; Collidge et al., 1964; Johnson, 1956; Kahn & Nursten, 1962). Although the goal of the psychodynamic therapy is the return of the child to school, the immediate purpose of therapy is in helping the mother satisfy her own needs so that she can release her child. The therapist helps the child realize that he is transferring hostility towards the mother to his teacher in the schoolroom (Kahn & Nursten, 1962). The psychodynamic case studies do not go into step-by-step detail of the therapy process,

as was evident in the behavioral case studies. Instead, the psychodynamic case studies of school phobia focused on the original cause (e.g., the separation anxiety).

Johnson (1956), in her report of a 12-year-old Joe states, "the neurosis originated in the mother and seeing the child alone would not be successful" (p. 689). Johnson conducted the therapy sessions by bringing the conflicts of both the mother and Joe out into the open and discussing the hostility. Johnson did not specify the duration of the therapy but the therapy involved a psychiatrist, the mother, and Joe working intensely together. Joe had been absent from school for 9 months, the longest absence reported in the literature reviewed by this author. The length and intensity of the treatment reviewed in this study appeared to be directly related to the length of absence from school.

Kahn and Nursten (1962) saw Paul in therapy after he had stayed home from school for 1 month. The therapists worked with Paul for 4 months during which time he stayed home from school on homebound instruction, and on an antidepressant drug. During the 4-month therapy period, Kahn and Nursten (1962) reported, "they probed the interdependent relationship of Paul and his mother" (p. 710). The therapists did not report how often they worked with Paul during those 4 months of therapy and antidepressants, but it was likely to be a more expensive treatment than a behavioral treatment program, because of the expense of therapy and antidepressants. Paul's mother was also seen in therapy. The involvement of the parent

is often very intense in the psychodynamically oriented treatment approaches.

### Interpretation of the Psychopharmacological Perspective

The psychopharmacological perspective combines aspects of the psychodynamic perspective, the therapy sessions, and the drug treatment. The goal of the psychopharmacological therapy was the same as the goal of the psychodynamic therapy: to solve the hostile interdependent relationship between mother and child.

In the Gittleman-Klein and Klein (1973) study all parents and children received counseling. The children received a daily dosage of imipramine, a tri-cyclic antidepressant, for a 6-week period. The psychopharmacological treatment took longer than the behavioral treatment programs reviewed, but not as long as the psychodynamic treatments reviewed. It is also likely to be more expensive than either previously mentioned approaches, because of the additional drugs. The Kahn and Nursten (1962) study used an antidepressant only when Paul needed it, as determined by the therapists, not on a daily basis as in the Gittelman-Klein & Klein study (1973). Even at the end of the 6-week period only 81% of the imipramine group were attending school.

The results in the behavioral and psychodynamic case studies were much better than in the Gittelman-Klein & Klein (1973) study. The case studies reported 100% success in the behavioral and psychodynamically oriented perspectives, while only 81% of the

imipramine group successfully returned to school, and only 47% of the placebo group returned to school full time.

### Summary

The decision of which treatment to use should take into consideration the duration of the child's absence from school, the amount of awareness the child has about the source of his anxiety, the willingness of the parents to cooperate in the treatment plan, and the interest of the educators to participate in formulating a treatment plan.

Behavioral treatments will only work if the parents are willing to cooperate, and if the teachers will help. The psychodynamic treatment will work if the child is able to reflect upon the source of his hostility. The psychopharmacological treatment, because of its expense and investment of time, should be the last plan chosen.

According to Dr. L.J. Goodlund, February 14, 1985, 1 hour of therapy with a psychiatrist at Gundersen Clinic costs \$110.00. In a March 26, 1985, interview with L.M. Payne, a pharmacist at Degen Berglund Pharmacy, it was indicated that a month of imipramine therapy would cost a minimum of \$20.00. The success rate (81%) of the psychopharmacological treatment program does not justify the expense.

School personnel, alerted to the initial signs of a child with school phobic tendencies, could immediately work with the

parents to prevent a school absence from occurring. Chapter IV will present a parent interview and a self-rating scale, developed by this author, which may help the school identify students who could possibly become school phobic. A simple screening device, if used upon the child's entrance to kindergarten, may eliminate the need for a treatment of school phobia.

## CHAPTER IV

ACTION PLAN: A SCREENING DEVICE

School phobia manifests itself in an avoidance of school. Once the child is absent from the classroom, it is difficult for educators to treat the symptoms. The prognosis for school phobic children is better when the phobia is dealt with on the onset (Welch & Carpenter, 1974). If the school phobic child is identified before the onset of the symptoms, a lengthy treatment may be avoided. The parent questionnaire and the self-rating scale presented in Table 4 and Table 5 were designed as screening devices to alert educators to a potential problem. With this information the school can alert the parents and the child's teacher to work together to support the child's attendance at school.

The parent questionnaire (see Table 4) combines questions from both the behavioral and the psychodynamic perspective. It should be administered to parents at the fall kindergarten parent-teacher conference, but could be given when the child is in the higher grades. The parent questionnaire (see Table 4) should be administered to all parents of kindergartners but the teachers could use their discretion in administering it to higher grades. Older children, with a pervasive mood of unhappiness or with frequent absences from school would be good candidates for screening with the self-rating scale (see Table 5).

Table 4

Parent Questionnaire

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1. What is your child allowed to do when he stays home sick from school? \_\_\_\_\_  
\_\_\_\_\_
  2. Does your child pretend to be sick to get out of doing things he doesn't like? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_
  3. Does your child get upset upon being separated from you, e.g., temper tantrums or crying, pleading with you not to leave?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  4. Does your child worry about you dying or abandoning him?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  5. Does your child refuse to sleep away from home?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  6. Does your child complain of physical symptoms on school days, e.g., headaches, nausea, vomiting? Yes \_\_\_\_\_ No \_\_\_\_\_
  7. Does your child adjust easily to new situations, e.g., school, babysitters, new people? Yes \_\_\_\_\_ No \_\_\_\_\_
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## Table 5

Self-Rating Scale

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Directions: Circle the sentences that describe you best. Circle as many or as few as you need to.

1. When I don't like to do things, I sometimes say I'm sick.
  2. I'm afraid of the dark.
  3. I'm afraid of going to school.
  4. I worry about being teased.
  5. I worry that the teacher will yell at me.
  6. I don't like to be away from home.
  7. When I get worried, I get a headache or a stomach ache.
  8. I would rather go places or do things with my parents than with my friends.
  9. When I am home sick from school, I get to do "fun" things.
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Parents of kindergartners would be able to answer these questions quickly while waiting for their conference and could give the interview to the teacher immediately. If the parent answered "yes" to any questions, this information could be incorporated into the conference. Teachers, having been previously instructed in the importance of not attending to a child's somatic complaints, could impart this information to the parents. The teachers could also stress the importance of the parents not reinforcing the child's avoidance of school with extra treats and attention at home. The parents should also be asked to alert the school immediately if the child begins to exhibit somatic complaints or school avoidance behavior. The parent questionnaire, as shown in Table 4, consists of "yes" and "no" answers, or simple one sentence answers.

The other measure that could be included in the school phobia screening is a self-rating scale (see Table 5), which would be administered to all children at the beginning of school. The questions would be read aloud to primary level children and upper elementary children would be able to do them independently. The self-rating scale (see Table 5) is intended to indicate if anxiety exists in the school setting, and to alert teachers to the anxiety. Children completing the self-rating scale would be asked to circle the items that best describe them and to circle as many items or as few as are applicable to them. There is no score which indicates that the child is school phobic, but if the child circled items 1,

3, 6, 7, 8, or 9, it would alert teachers to a potential problem. A teacher who is aware that a problem could exist would be careful not to attend to a child's somatic complaints, and to supportively encourage a child in a potentially stressful situation, e.g., a divorce, or death, or remarriage.

Affirmative answers to items 6 or 8 would indicate difficulty in separating from the parent, a possible cause of school phobia (Chess & Hassibi, 1978; Coolidge et al., 1964); Johnson, 1956; Kahn & Nursten, 1962). If the child circled items 1 and 9 (see Table 5) this could mean, from the behavioral perspective, that the child's avoidance behaviors are being reinforced at home (Lazarus et al., 1965; Marise, 1969; Shapiro & Olukayode, 1973; Stempf1 & Lewis, 1967). A teacher can use his discretion but if any of the relevant items are circled, a parent conference should be quickly scheduled to discuss with the parent the importance of supporting the child's attendance and not reinforcing him when he stays home.

With the self-rating scale administered at the beginning of school, and the parent questionnaire administered at conference time, the symptoms of school phobia may never manifest themselves. If the child did exhibit school phobic symptoms, the parents and teachers would be alerted to them quickly.

### Summary

This paper presented causes and treatments of school phobia from the behavioral, the psychodynamic, and the psychopharmacological perspectives. Each treatment from the behavioral and psychodynamic perspectives reviewed in the literature was 100% effective. The psychopharmacological treatment was less successful with only 81% effectiveness with imipramine.

The conclusion drawn in this paper is that if the tendency towards school phobia is noticed, before the symptoms manifest themselves, a lengthy and conceivably costly treatment can be averted.

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