Severe School Phobia*

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The setting is a kindergarten in the basement of a church several years ago. Mothers are bringing their children who, for the first time, will be away from home several hours a day. Reactions differ, but all the mothers are a little anxious and so are the children.

Jerry did not want to stay and when his mother started to leave he ran to her, an expression of fear on his face; he grasped her hand and would not let go. She remained in the back of the classroom that morning, and soon Jerry was participating in the activities. The next day he was a little more relaxed, but wanted to leave when his mother started to leave. As long as she remained in the room Jerry was fine, but he watched with a "peeled" eye.

This kindergarten started the children in conversational French, and the enthusiasm of the teacher soon involved all of the children in repeating after her in French the names of various objects in the room: la porte, la plume, le crayon, etc. On the third day of nursery school the teacher introduced the word Madame. The children repeated in chorus—MA-DAME, MA-DAME. They were all absorbed.

A small hand shot up in the front of the room and a boy's voice said, "Teacher, teacher, my mama says God-damn. He repeated, "Madame, God-damn."

Jerry's mother no longer sat in the back of the room. She was on her feet, out of the room, in her car, and on the way home. Jerry did not notice that she had gone until later and the teacher reassured him with relative ease. Jerry's mother said later, "I figured if he could say that he could stay in school without me."

There was no further trouble in separating from Jerry, and he has gone to school quite happily ever after.

At the beginning of any school year in thousands of classrooms around the country, some variation of this theme is repeated. The mutual anxiety surrounding the separation of mother and young child is probably, to some extent, a universal phenomenon. Fortunately, for most children it is mild in nature and short-lived. Being able to tolerate the anxiety surrounding these early, temporary separations, soon represents a giant step forward on the long road of individuation which must be traveled if the child is to succeed in becoming a person in his own right.

That the term "school phobia" is inaccurate is generally agreed. None of these children whose pattern of occasional, irregular or non-attendance at school (which we call school phobia) have a fear of school as the primary concern. They are all anxious, but the basic anxiety is concerned with the child-mother relationship; hence, when this relationship is threatened, the separation anxiety surfaces and is expressed in the child's inability to reach or remain in school. Children with this pattern of behavior are to be distinguished from those with truant or running away behavior. The clue to the school phobic child is his continual physical-emotional proximity to his mother and the anxiety that ensues when this closeness is threatened. The truant or run-away may be anxious about many things—a bully at school, inability to achieve up to parental expectations, fear of failure at sports, discord at home, or poor motivation. The difference is that this child can separate from mother.

Where are the origins of this prevalent problem? It's roots are to be found in the periods of development prior to school age—at a time when partial failure to master early psychological development leaves the child vulnerable. The child with any marked degree of school phobia may be viewed as a child who has not progressed satisfactorily in his development of autonomy. He is generally a child with a high level of ambivalent feelings regarding compliance and non-compliance, affection and anger. To a great extent this child has progressed through this early stage of mastery in such a tenuous manner that he has large remnants of insecurity woven into his fabric. Such a child has unusual difficulty in establishing clear, comfortable relationships with father and mother. He

has difficulty finding out where he fits into the family picture. In other words, the poorly resolved conflicts at these early stages of development hinder the child from continuing his development of autonomy—that he might have an ever increasing sense of his own identity as an individual. Almost invariably it is this kind of insecure pre-school development which the school phobic child has as his psychological heritage.

This problem develops in the early relationships of the family. Mothers of school phobics are usually emotionally insecure individuals themselves who have marked dependency needs that have not been met. They have a common history of unhealthy dependency relationships with their own mothers which never have been resolved. They perpetuate this dependency with their own offspring through spoken words, the way the child is held, the limitation to explore that is imposed, and an overall attitude of restriction of freedom. These are a few of the many channels of communication open to the mother, and the dominant emotional message that she sends to the young child is that she needs him with her. This starts early and soon a symbiotic relationship exists.

What about the fathers in this family problem? Though it may be expressed in a number of ways, the fathers generally conform to a pattern which accentuates the problem. Predominately there is a history of being linked to an over-solicitous, dominating mother who had difficulty allowing her son the freedom to be. Usually the fathers of the phobic child are described as “being away” from the family, either physically or psychologically. It would often appear that they have chosen marriage partners with many of the same personality characteristics as their own mothers. Then, in order to escape the self-made trap, they have functioned on the periphery of their own family. Occasionally the father’s own unmet dependency needs are expressed as a competitiveness with his wife in an over-protectiveness of the phobic child.

The attendance pattern of school phobias is varied. Attendance may be irregular, or not at all. They may refuse to go on Mondays. Refusal may come after some illness either in the child or a member of the family, after a move or a transfer to a new school, or when a new baby is in the family. It can be almost anything which upsets the delicate balance of the child’s adjustment and with which his brittle ego cannot cope.

There are many related signs in the severe school phobic. He may be afraid to go other places. Enuresis is common. Frightening dreams and sleepwalking are common. There is the fear that he will die, or that parents or siblings will die. Many of these children are withdrawn and depressed; the older ones may express suicidal threats or make actual attempts. Somatic complaints are commonplace—stomach aches, headaches, vomiting, anorexia, dizziness, diarrhea, and sometimes asthma.

By the time the symptoms are full-blown the picture is extremely complicated. The entire life of the family may revolve around the phobic child. Frequently one hears, “This child controls the whole household.” The total stance of the child is to prevent the separation from mother and to avoid the accompanying anxiety and panic that follows. He often accomplishes this in adroit ways—through promises, threats, denial that there is a problem, projection of all causes onto the external world, and many others.

None of the principals (child, mother or father) of course recognize the basic factors involved in the phobia. Thus the charged relationships continue, the heat of the mutual anxieties feeding each other, and matters do not improve; they often get worse.

Most clinicians who have investigated and studied school phobias view it as a psychoneurotic reaction, based on unconscious conflicts. Many reasons are given by the child and family for the refusal to go to school; but these reasons are rationalizations, and the true reasons are unknown to them. This is an all-important point for anyone to know and remember who is trying to deal with a school phobic child, but it is often overlooked by physicians, school personnel, and sometimes psychiatrists. There is danger in trying to handle by common sense a child whose anger and rage and ability to control others is obvious, a mother whose ambivalence tells a child in words to go to school and who at the same time communicates her anxiety if he does, and a father who is often emotionally unable to help. “Common sense” may take the form of reassurance, physically dragging the child to school, repeated whippings, bribery and threats of all kinds. It may be possible to return a child to school with such methods, but the problem is hardly ever solved, particularly in the severe cases. Inside, the child is panic stricken and doesn’t know why; the anxiety is so great that he disorganizes and can do nothing. This is hardly an ideal situation under which to pursue knowledge. Treatment must be aimed at relieving the underlying conflict in the child and helping the parents, particularly the mother, to understand their part in the matter.

Treatment plans may take many forms and depend on many factors: age of the child, time of onset, circumstances under which the refusal begins to develop, whether it is sudden or gradual in developing and amount of awareness of the parents.

For children like Jerry, professional help is not needed. However, if the refusal is frequent or persists for any length of time, not only a pediatric examination is called for, but a psychiatric evaluation as well. The latter is to include the child, mother and father. It is a family problem. Most of these cases can be handled on an out-patient basis, the mild ones often in a very short time. Others take considerably longer.
Severe School Phobia

Over the past seven years 35 difficult cases have been treated as in-patients at the Virginia Treatment Center for Children. Their ages have ranged from eight years to 15 years, with the vast majority falling in the 11–12–13 year age group; boys and girls were about equal in number. This group of children has proven very refractory to any attempt to help. Overt symptoms have been present from several months to several years, and school attendance patterns varied at the time of admission from an occasional day to complete refusal. Several of these children had been out of school for a year or longer. The most common pattern was a dragging on of symptoms, with complete refusal coming as the child moved into puberty. In several instances a move, change of school or illness had been the most obvious factor precipitating complete refusal.

All of these children had a long history of many somatic complaints and all were extremely anxious. As a group they had a pervading, low self-esteem. Their behavior was immature, and most were extremely afraid to express aggression, though their controlled simmering anger was obvious to the casual observer. Practically all of them were average to superior in intelligence, but most were behind academically.

In each case the child and mother were linked in a mutually hostile-dependent relationship. Most mothers were characterized as dominating and overprotective, while fathers were characterized as rather passive and usually having little meaningful association with the child. All had undergone various attempts at treatment by family physicians, local mental health clinics, psychiatrists, psychologists or many combinations thereof. Duration of treatment was for months to years and often intermittent in nature. Too often coercion and bribery had been used to get a child back to school, but ultimately it had been 100 percent ineffective.

Pre-admission plans at the Virginia Treatment Center for Children were as follows:

1) Child and parents were brought to the out-patient clinic for psychiatric evaluation.

2) If the picture was clear, an interpretation was made to parents and child (sometimes all three together). The seriousness of the problem was pointed out and it was emphasized that it was a family problem with in-patient treatment needed. The family was told that change was unlikely without intensive treatment and, though often they did not like it, this they could understand in view of the many efforts that had been made already without sufficient change.

3) Parents and child were told to return home and think about the matter for a week and to let us hear from them. If they wished, we could then set a prompt admission date. Before leaving they were given a tour of the Center, including children’s living units, and were introduced to several staff and children. Referral sources were notified of our findings and recommendations, and often were of great help in supporting the idea of admission. If we did not hear, family was reached by telephone and asked to come back for further discussion. Only a few cases did not follow through with admission, but each was filled with hesitations, starts and stops, reflecting great anxiety.

On the date of admission parents and child could be seen moving with slow, measured steps from the parking lot, the child and mother usually holding to each other. Parents were permitted to go with child to the living unit and separate there; often they wished to “get it over with as quickly as possible” and preferred not to go to the unit. In either case mother and child (and sometimes father) flooded the floor with tears, and the child had to be separated physically from mother. This was done decisively, and parents usually left at once. Younger children usually publicly cried and wailed, while older ones preferred to be alone to cry.

However devastated the child appeared to be immediately after the separation (and this was the rule) he frequently began to pull himself together within the hour. No one chastised him for crying and no one “babbled” him, but nursing staff was always nearby and available. Other children became curious and asked the child questions. Pretty soon he would be drawn half-heartedly into some activity, and the uncontrolled crying and sobbing ceased. It recurred at times often for a week or two but with a diminishing intensity.

Although not permitted a visit home for at least two weeks after admission, short visits were arranged at the Center if parents became too anxious. Letter exchanges and occasional telephone calls from child to parents were encouraged. Parents were seen in the out-patient department once a week if possible, and often twice weekly in the beginning. They would drive for great distances to keep appointments, and in a few instances distance was so great and circumstances such that parents could seldom visit. Local public health nurses made home visits each week and a member of the VTCC Field Unit made a home visit from time to time.

In his day-to-day functioning the child’s progress was often amazing. With rare exception they were involved in the intra-mural school program within three days and attendance was no problem. It was characteristic that these children were often “picked on” by other children and sought protection from staff. This was given to prevent a child from being hurt by another, but the phobic child was continually reminded that he had to learn to fend for himself. Remember that he had had little practice at this.
All children were seen in individual psychotherapy one to five times a week with the aim of helping each child discover the sources of his ambivalent feelings and his tactics of evasion and avoidance. A therapeutic daily program was tailored for each child, aimed at helping him succeed in the different areas of living, to foster a developing independence, and to function as a part of a group. For instance, many times arrangements were made for a child to travel home by bus, sometimes for long distances. Many similar practices were directed toward building in the child the knowledge that he could do things for himself, causing his inventory of accomplishments to increase quite rapidly.

Treatment can be quite stormy and trying for staff, for these children with their great ambivalence have an expertise in manipulation of adults, with the result that they create animosity. In the therapeutic endeavor, considerable attention must be directed toward helping child-caring staff understand the child's behavior to avoid their reacting with counter hostility to the child's reservoir of anger. This would only recreate the unhealthy situation from which the child came.

The 35 children in this study stayed in residence at the Center on an average between four and five months, and a few stayed a year—the maximum allowable by law in this children's psychiatric hospital. The shortest stay was three weeks, with the child being taken out against medical advice.

Of the 35 children, 28 were considered to be successful. The measure of this was that on return home: they went back to school, the related symptoms diminished markedly or disappeared, and they were much happier children who did not have to spend all their time and energy in defending against separation anxiety. This is not to say that these children have no problems, but at least they are not major ones and the children have been able to go on in a productive healthier adaptation. At this time follow-up information covers several years to a few months, and the more recent cases will be followed for several years.

The seven cases that were considered unsuccessful deserve brief comment. All of these children made considerable school progress while in the hospital. All increased their self-esteem, and all showed a diminution in related symptoms.

Five of these children were adolescents. Each of these seven children came from extremely disturbed and chaotic families with whom our staff thought we had been unable to effect any change in basic attitudes.

One of the girls did not return to school and was married promptly. Another adolescent girl returned to school, but continued to have many other problems. A third much improved girl soon refused school, and her mother would not return her for readmission.

One adolescent boy made much progress in all areas, but when he returned to his home where his father was an emotional invalid and his mother a near invalid, he did not go back to school. No follow-up was possible on a fourth adolescent girl, but it is doubtful that she returned to school. A pre-adolescent girl was removed against advice and did not return to school. A pre-adolescent boy, although markedly improved here, continued very erratic attendance at school.

In each of these seven cases staff was of the opinion, even during the diagnostic phase, that the possibility of the child's returning home and living a fairly normal life was extremely unlikely. None of these parents could entertain the idea of the child going somewhere else to live. Apparently our efforts were too late and too little in the face of odds that were too great.

The Advantages of In-Patient Treatment

Our thoughts about the in-patient treatment of severe school phobias, on which little information has been reported, is as follows:

1) Though separation of parent and child in a situation in which both panic at the thought appears to be a drastic move, it may be the last heroic effort that can be made to solve the conflicts and return a child to school. The longer a child is out of school despite all therapeutic efforts, the less likely he is to return. He continues to fall behind academically and this becomes a deterrent to his returning.

2) If admission does occur, staff must be geared to an all out effort to deal with the pinnacle of anxiety and panic that is likely to occur in mother and child. This is often easier to deal with in the child than the parents. Caseworker and child psychiatrist must be available for impromptu appointments and telephone calls from anxious parents. After the initial phase, parents and child learn that, even though uncomfortable, each can survive on his own. Children handle this with greater facility than parents. For both this holds a promise for their future.

3) The separation often gives all concerned a chance to breathe, to sort out their conflicting emotions, and many parents become highly motivated to find a better way to live with the child. Often mother and child have become physically and emotionally exhausted in their day-to-day struggle with their hostile-dependent relationship. Frequently parents discover a new relationship between themselves that has been absent or dormant for years; they find time for an interest in each other.

4) The child finds himself in an environment with certain expectations that he can stand up for his rights. He is thrown into close relationship with other children where he cannot be omnipotent, and he begins to learn how to cope with group living. He is in a
living situation where his assets are recognized and
where adults express trust in him. He begins to trust
himself. Though the child may protest admission, and
scream “bloody murder,” he actually appears to be
relieved that someone has intervened and to an extent
taken the power away from him. This would make
good sense in light of frequent comments in the
psychoanalytic literature that this child is terrified of
his seeming omnipotence and magical thinking which
he has carried over from early childhood.

5) He is back in school and achieving, and at
some level of awareness this must demonstrate to him
that school is not the main problem. It makes it easier
for him to make sense out of his defensive maneuver­
ing. He sees other children with problems, some with
school phobia, and he sees children return for visits
who have largely solved their problems. He becomes
curious about these other children and sees some hope
for solving his problems.

Summary

This presentation has emphasized that the under­
lying conflict in school phobias begins as a bilateral
separation anxiety between mother and young child.
This unhealthy symbiotic relationship, occurring during
the time that the child is trying to develop his own
autonomy, cripples his ability to cope with the separa­
tion anxiety when he goes to school, or in the face of
certain life events such as a move, illness, or birth of a
sibling which revive this early anxiety. The response
is a disturbed pattern of school attendance which
may range from mild to severe and acute to chronic.
These basic conflicts represent a neurotic reaction of
which child and mother are not aware.

General information has been presented about
35 cases of severe school phobias treated at the Vir­
gaia Treatment Center during the past seven years.
Twenty-eight of these cases have been successful and
seven are regarded as unsuccessful. From this experi­
ence it is our impression that in-patient treatment for
severe school phobias should be tried, rather than a
continuance in a variety of other efforts at treatment
which have been ineffective. The longer these con­
flicts continue without effective treatment, the further
the child falls behind and the chances of his successful
return to school lessen.

We have emphasized the importance of early psych­
iatric diagnosis and treatment once a school phobic
pattern evolves and have highlighted the difficulties
and viscissitudes surrounding treatment of the severe
school phobic child.

Unfortunately, not all children have the healthy
base that Jerry had for handling his early school
anxiety. Many children reach the severe proportions
described previously. Even so, this study demonstrates
that many severe school phobias can have a reasonably
successful outcome.