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SCHOOL PROBLEMS

Learning Disabilities and School Phobia

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The school is an important segment of the life of the child, taking, in many ways, the position of work in the life of the adult. Psychologically, it requires some ability for the child to separate without undue anxiety from his family and to relate to the teacher and his school peers as an enlargement of his social experience. He must tolerate a new and possibly less protective authority figure and test his own abilities in comparison with age mates. If he approaches this situation with sensory or neurological handicaps, anxiety about competition in this situation as well as the effect of the actual disabilities will be experienced.

Some school learning disabilities are known to be due to various and different etiological factors that affect brain functioning. These causative agents may be genetic, infectious, endocrinological, metabolic, or traumatic in nature; all result in organic brain dysfunction, maximal or minimal. In addition to these, deficiencies or abnormalities related to the sensory modalities are also known to impair and modify learning achievement. Impairments of this nature will be dealt with in another section of the present volume. In this chapter we shall be dealing primarily with the school difficulties of children in which an organic factor does not appear to be primary.

Learning Disabilities

In children not handicapped by sensory or perceptual deficits there are two major possibilities to be considered as contributing to the child's inability to learn in school. One of these is that he comes to school with cognitive deficits from an impoverished environment that has failed to develop his capacity for perceiving spatial relationships, time, number, classification of objects, and vocabulary in a way that will make his school experience a process continuous with his previous learning. Poorer performance of intelligence tests and a higher rate of dropping out of school have been consistently shown in children from lower socioeconomic levels. Preschool education has been shown to have a favorable effect on first-grade IQ scores. Reports of studies of structured preschool experiences for children with their mothers being involved shows that from preschool programs conducted in a variety of centers there is a favorable effect on cognition as pleasured by conventional intelligence tests. The impact of such studies has been seen in the Head Start Program for preschool education and the television program "Sesame Street." The parent-child centers advocated by Hunt rest on his theoretical analysis of the effects of poverty on cognitive development.

Children from a low socioeconomic status emerge in the literature as being less well prepared also in the socialization processes needed for successful school attendance. Numerous sociopsychological studies have

found the lower-class child more likely to be hyperactive, to have more difficulty in delaying gratification, and to be more hostile toward authority than his middle-class age-mate. Negro children have also been found to share many of the characteristics attributed to the lower class, with special disadvantages due to the caste system.

The problem of Negro children's ability to score as well as white children on school-oriented intelligence tests lends itself to biological interpretations partly because a degree of dark skin color is an easily ascertainable piece of research data, though it may not, in fact, define a unitary heredity. The American child with dark skin frequently comes to school from a highly disadvantaged urban or rural situation with a family history whose known origins are in the period of enslavement in the United States. His self-image and achievement motivation are affected by his history as well as by the prejudice toward him and the adult members of his group in American society.

The growing theoretical position in psychological theory is that biological endowment and the environment interact from the beginning, that attempts to measure abilities determined by biology as separate from the effects of the environment surrounding their development are unsound.

The problem of school integration posed by the 1954 Supreme Court

decision, that public schools in the United States must achieve an effective integration of black and white students, has probably affected the reemergence of the nature-nurture controversy at a time when scientifically it should have become a logically irrelevant issue. Fortunately, the problems of the integrated urban schools have also stimulated important contributions from such psychologists as Martin Deutsch, who is concerned with compensatory measures to stimulate more complex aspects of cognitive development in children whose early environments provided less cognitive stimulation than the preschool environments of more advantaged children.

The lower-class children and their parents are also more frequently vulnerable to mental illness than are their middle-class counterparts and are more often subjected to precarious living conditions and traumatic events. If one were to think in terms of statistical findings with regard to class membership, one might conclude that being a member of the middle class should make children relatively immune to school learning problems. Unfortunately this is not true. Though cultural deprivation is mainly characteristic of the lower socioeconomic groups, emotional disturbances are present in children of all social classes and commonly affect school learning. Of the children with emotional disturbances who came to an urban child guidance clinic (Judge Baker Guidance Center) during the past year about 50 percent came with disturbances in school learning as a major presenting complaint.

As in many other childhood disturbances, the number of boys referred for learning disabilities far exceeds the number of girls who are referred for similar disabilities. Various theories have been used to account for this, dealing essentially with three factors: (1) presumed slower neurological maturation in males; (2) greater achievement pressures in this society on males, and hence a greater vulnerability to conflict around achievement; and (3) the fact that elementary school teachers are predominantly female, and therefore may be seen as attempting to feminize the boy in the learning situation. Definitive evidence for the saliency of these factors in creating the sex differential in the incidence of learning problems is not known to us, but it seems quite probable that each may contribute something of explanatory significance.

The types of learning problems most intensively studied as individual cases by mental health clinicians are those in which family relationships and individual emotional reactions have combined to produce in children of normal intelligence neurotic reactions around various aspects of the learning processes. These reactions have been commonly viewed as psychological inhibitions about knowing and about growing up.

The refusal to learn in school is seen as a defense against anxiety; the child is defending himself against a deeper and more important fear than that involved in school failure itself. Liss pointed out that failures in the

management of sadomasochistic feelings made it difficult for the child to manage the alternation of receptivity and activity that are necessary for effective learning; Mahler-Shoenberger pointed out that the assumption of stupidity made it possible for parent and child to enjoy certain libidinal pleasures that would otherwise be forbidden. Sperry, Staver, and Mann reported cases in which the child's mobilization of aggressive activity in the service of learning appeared in fantasy to be the equivalent of destroying his interpersonal world. The psychoanalytic literature involves primarily theoretical formulations in which the child's fears of his impulse life have become unconsciously involved with symbolic aspects of the learning situation: the forms of letters and numbers, the operations involved in their manipulation, and the acquisition or display of knowledge through them. At an intrapsychic level these conflicts appear to be mediated by pictorial imagery replete with interpersonal and body referents.

By a complex process of denial of anxiety in other life situations and a displacement of its residues into school learning, many children are able to maintain a restricted way of life without acute anxiety. School learning is dealt with by avoidance through a flight into fantasy or excessive motor behavior that prevents attending to the precision learning tasks with which children are confronted in school. Their school failure functions as a moderate punishment to the child and as a reproach to his parents without involving the cataclysmic effects that the repressed fantasy would have

should it be activated. The neurotic balance achieved by such a relationship to learning is often a difficult one to shift for both child and parents.

An intensive study of twenty-six elementary school boys with neurotic learning problems was carried out at the Judge Baker Guidance Center in Boston during the 1960's. The group studied were boys who previously had been tutored, both at school and at home, with little effect on school performance. They came from intact homes and social-class membership included all but the lowest social class. Representation from the middle- and lower-middle classes was most frequent. These children and their parents were seen in weekly treatment sessions as well as being studied by psychological tests and research interviews. The following family problems were found to be frequent:

1. The presence of a family secret involving either present or past activities thought by the family to be disgraceful, for example, alcoholism, illegitimacy, financial misdealings, brutality with the family group.

2. A defensive pattern involving the family communication; a policy of non-mention or minimal mention spreading beyond the particulars of the situation being concealed and, less frequently, a cruel overexposure of the child to painful information without adequate opportunity to integrate it by reasonable discussion.

3. Sibling-like rivalry on the part of the parent or parents (most frequently the father) toward the son's possible achievements.

4. Parental derogation of the child's ability to learn or to assume independent and responsible roles. (Though this may be in part a secondary effect of the children's school failures, the parental attitudes seemed in the case material to be more pervasive than current school achievement deficits and related at least in part to painful parental experiences in which they felt defeated or less favored than their own siblings.)

In addition to these parental attitudes, the children had in fact been exposed to traumatic circumstances within the family group or to illness or injury to themselves in excess of what is expectable within the preschool years. Although one criterion of selection for this study was family intactness, threats to life by illness in a family member, temporary separations, and threats of separation were common. A later study confirmed the earlier clinical hypotheses of more frequent trauma in children with neurotic learning disabilities as compared with a matched control group of good achievers. Earlier, Liss reported a high incidence of respiratory disorders in learning-problem children seen by him.

In this population two types of learning problems were discriminated:

1. The acquisition problem was seen in children whose prevailing

mode of relating to school learning was characterized by an inability to acquire basic school skills in reading, spelling, and arithmetic. They were usually inattentive in school, and when they tried to relate to the learning their performances were characterized by anxious blocking. Though they appeared willing to comply, they frequently were unable to understand the teachers' directions, engaged in excessive preparatory activity before task engagement, and tried to get the teachers' help and confirmation of the correctness of each step taken. Their comprehension of meaning from material presented by symbols was poor, and a frightened rigidity was characteristic of their approaches to the technical aspects of reading.

2. Children with the production problem showed fairly intact skills on individually administered achievement tests in spite of minimal productivity in school. They were often considered willfully uncooperative by their teachers, and sometimes were in fact defiant and derogatory of both the teacher and the tasks assigned. Though this was their prevailing mode of behavior and some of them believed that they could produce when they wished to do so, experiments in meeting the demanding conditions for productivity revealed their anxiety and limited ability to produce work even under highly specialized conditions.

These groupings are somewhat overlapping, and from time to time individual children manifested some aspects of each problem. Clinically both groups were seen as dealing with depressive affects stemming both from

traumatic life experiences and their devalued role in the family.

Children with the confusion and blocking characteristic of the acquisition problem showed a pattern of interpersonal relationships oriented to the role of the victim. Many were beaten or teased by a sibling without adequate countermeasures, and they were reluctant to ask parents or teachers directly for things they wanted but used their helplessness as an appeal for attention. Their social roles were primarily as appeasers; their affects were mildly depressive with occasional outbursts of irritability.

Boys with the production problem type of difficulty were as a group more provocative and seemed more openly angry rather than depressed. From time to time they were subject, however, to acute depressive episodes. From the clinical material it appeared that they used a defensive, unstable identification with the aggressor as a defense against depression.

Identity conflicts characterized both groups. Although neither group evidenced marked feminine tendencies, discomfort with the masculine role and what they viewed as the necessary hostility to maintain it was common. Enuresis had been a problem for about one-third of the boys. Few in either group had comfortable relationships with peers, and most tended to function as marginal members of the peer group without close friendships. The discrimination between assertive activity and hostility was poorly made in

the life styles of the boys as well as in the school learning situation.

In the learning situation both groups appeared to be lacking in goal direction with regard to the primary school tasks. They were occupied with the acting out of more personal conflicts. Teachers acquired a highly personal significance of a transference type, and school learning operations had affective connotations displaced from interpersonal conflicts.

All young children normally have fears when they confront the learning situation. These fears are partly inculcated by parents in an effort to protect him from real dangers in his environment and are partly the product of his own imaginative organization of his observations. He has not learned to distinguish possibilities of danger from probabilities, nor does he have causality with regard to illness and injury completely separated from personal systems of causality in which his own aggressive feelings may play an important role. Children who have or are experiencing within the family traumatic events, communication patterns that fail to make life sequences understandable, and covert or open derogation of their own coping and learning abilities are vulnerable to the displacement of anxiety onto the precision learning required in school.

The successful treatment of an entrenched pattern of marginal learning in school with a dependent, devalued role in the family may require

prolonged psychological intervention and some remedial education. Milder learning disorders that are reactive to immediate life crises are sometimes responsive to shorter interventions. The assessment of the sources of anxiety in the child's life and of his own and his family's coping maneuvers is important in planning intervention.

In psychotherapeutic treatment, bridges between intrapsychic conflicts and actual difficulties in learning operations are frequently necessary in order to facilitate symptom change. Therapeutic activity is also necessary around avoided areas in the child's life. Since defenses that cluster around avoidance and denial of unpleasant reality are most commonly used by children with neurotic learning disorders, a passive therapeutic attitude may prolong treatment unduly or foster mutual discouragement of the participants. On the other hand, since many children with this disorder also tend to assume the passive victim position in interpersonal relationships, a careful nurturing of the child's initiative interspersed with judicious therapist activity is necessary. If conflicts are not dealt with in relation to the confusion in learning operations, the child may improve socially, while the learning symptom retains a negative autonomy little altered by the general considerations and affects discussed in therapy.

In less severe difficulties supportive tutoring that takes into account the fears of the child and furnishes an external support for the ego in confronting

tasks onto which these fears have been displaced may be sufficient to neutralize the learning problem. In fact, tutoring of this kind may be a profitable adjunct to psychotherapy in the most severe cases of neurotic learning disability.

We have dealt in this part of our presentation with the neurotic learning problems in childhood occurring as a primary symptom. Learning problems are well known to occur frequently as a secondary complaint with psychosomatic disorders, acting out problems, and delinquency and borderline schizophrenic problems. Clinical observations confirm the existence of problems around separation and sadomasochism to be also important in the learning problems of these patients, but a more systematic review of these will not be attempted in this chapter.

We have outlined two sources of difficulty in school learning: inadequate cognitive stimulation and anxiety displaced by intrapsychic defense mechanisms to schoolwork. The investigations of these difficulties have not been parallel in methods or in choices of populations. The difficulties of cognitive development have been concerned with the lower-class child as the target population; the therapeutically oriented investigations have a middle-class to lower-middle-class bias in population sampling since this is the group that seeks this type of intervention. The lower-class child does sometimes get clinical diagnosis and treatment for severe learning disorders;

the assessment of such cases makes it clear that suffering from one kind of deficit does not exclude difficulties with an emotional source. Some middle-class children in the clinic population have also shown deficits in cognitive organization that resemble developmental immaturities. There are at this point no systematic data relating these two major sources of difficulty in the development of effective school learning, but the presumption from existing data would be that the lower-class child is more vulnerable from two sources: The cognitive apparatus receives less positive stimulation from the environment during the early years, and he is subjected more frequently to a chronically traumatic milieu.

School Phobia

A not infrequently encountered neurosis in middle childhood and preadolescence is the school phobia. In its classical form its symptomatology is triadic in that the child exhibits (1) severe anxiety, (2) dread and apprehension, and (3) psychosomatic complaints associated almost exclusively with the necessity to attend school. When the child is permitted to stay home during weekends and vacation periods when school is not in session the symptoms usually disappear in a matter of a few hours, only to reappear when school attendance is anticipated or forced.

The most helpful instructional method to emphasize and clarify the

cogent items relating to this neurosis (symptoms, reaction of parents, cause, psychodynamic motivation, meanings, treatment emphases, and prognosis) is to cite a classical clinical case and then refer to the research impressions and research results of those workers who have dealt with statistically important numbers of cases of this syndrome. We shall follow this format in the present communication and cite the case of seven-year-old Alice.

> Alice was in the second grade when she was referred to the Judge Baker. She lives with her father and mother and an older brother Frank, aged ten, who is in the fifth grade. She lives in a good neighborhood, and her home is a comfortable one. Her brother has never had any difficulty in school or any fears of attending it.
>
> Mother stated that she was bringing Alice to the Clinic because of her intense fear of going to school and her intense fear of being separated from Mother at any time. Mother said Alice does very well in school when she goes, but she has not been in school during the first three months of this school year and missed considerable time from school at the end of last year. Alice has remained out of school on the advice of the family pediatrician, who, along with the school nurse, recently recommended the Judge Baker. Mother said that she first noticed Alice's concern two or three years ago (at four and one-half years), when she went into town for an evening and left Alice with the paternal grandmother. That evening Alice complained of pain in the abdomen, vomited after eating her supper, and seemed in a "panic" because her mother and father had not returned. When Mother returned home she called the pediatrician, who decided to wait till morning before referring Alice to the hospital with a question of appendicitis. Alice went directly to sleep and the next morning seemed entirely well.
>
> At this point Mother abruptly switched to the current situation and stated that school this year was to begin on Tuesday, and that the Sunday before, Mother found Alice in bed crying. This continued until the following day,

and Mother reassured Alice that she did not have to go to school if she really felt she could not. Mother stated that although Alice says she wants to go, enjoys school, and reads avidly, she seems literally terrified. In an attempt to handle the situation this year, Father stayed home from work the first day of school; but even so, Alice was not able to go. Mother said that last year, when Alice was in the first grade, she had taken her to school and remained with her until she seemed to be absorbed in the work. Then Mother would leave. Now Alice will not believe Mother when she says she would not leave her like that now.

In the first grade Alice was fearful but did not have too much trouble until six months ago, when she told Mother she had decided not to go to school any more. Previously she had been complaining for several weeks that she did not like school. In May the teacher began telling Mother to come to school and get Alice because she was nauseated and vomiting. When this continued she finally had to be taken out of school. Prior to this, Mother said, she would send Alice to school but the child kept coming back, claiming to have forgotten something—"she did not know what." Mother said that Alice hates to admit that she does not want to go to school and that she is afraid. She hates anyone to see her crying and they usually find her alone in her room crying. But even then she will deny that she is afraid.

About Alice's early years, Mother feels that Alice was always inclined to be shy, even as a baby. Mother said that Father was in the Service when Alice was born. During Alice's first year he came home nearly every weekend, and after that was home permanently. Father took over Alice's care on weekends—and to a greater extent after he was discharged from the Service. At that time Father had his own business and frequently took Alice to the office with him. Mother remarked a little sadly that Alice never bothered with her then. She was, and still is, Father's favorite and seems at times to actually dislike her mother. In association with this, Mother said that Alice has never been corrected in the same way that Frank has and that there has never been any necessity to scold or discipline her. Mother remarked that Frank, in contrast to Alice, does not get very good grades in school but is not particularly troubled about this. He is very easygoing and has many friends and outside interests. Alice, on the other hand, always brought home perfect papers from school, and on one occasion when she

had made one error on a paper she had first refused to show it to her parents. Mother laughingly commented that she could perhaps understand Alice's fear better if they had been harsh with her, but she said that if they ever even scold her mildly, she looks as if she is going to cry, and Mother just does not have the heart to say anything to her.

Mother said very frankly that she feels at a loss to know how to help Alice. The worker's feeling was that Mother has considerable warmth and sympathy for the child. Mother has talked on many occasions with the pediatrician, who, she says, blames her for leaving Alice in school last year and "sneaking out." Mother has tried to talk to Alice about what she fears will happen if she is separated from Mother, but Alice is unable to tell her anything. Mother stated, as one would expect, that Alice never volunteers to recite in class and is very fearful on being made to stand up and sing alone in front of the class. It is only very recently that Alice will go into the candy store and ask the clerk for candy herself, even when Mother is with her, although she is very fond of candy.

Mother brought up the fact that she thinks she may have some idea as to what Alice is afraid of even though Alice cannot tell her. Recently the mother of a child in the neighborhood had to be hospitalized for a chronic illness. For several days Alice acted out in play the story of a family in which the mother and father both died. Last year Father was in the hospital. The day before he was to go to the hospital Alice began vomiting; Mother assumed that she had a virus infection since this was going around at the time and Frank had it.

Mother said that Alice seems to be very bright and alert and wants to learn. She apparently reads quite well for her age, and Mother tries to keep her supplied with books. Mother had asked either for a home teacher or that she at least be given some help in guiding Alice in her reading at home. The principal refused both requests on the basis that if Alice is permitted to stay at home, she will then make no effort to get over her fears and go back to school.

Similar illustrative classical cases are cited by Coolidge et al., Kessler,

and Waldfogel, Coolidge, and Hahn. We shall comment on the features that recur again and again in such cases.

Sex Ratio

School phobia is one of the very few behavioral disabilities in childhood that occurs somewhat more frequently in girls than in boys. A compilation of 124 cases in six studies by Kessler indicated that of the 124 cases, 68 were girls and 56 were boys, meaning that for every six girl patients referred for clinic treatment, there are five boys referred with the same disability. One's general impression is that the sex difference is greater than this, and most writers in any general discussion of the condition will refer to the patient as "she" or "her." The figures, however, do not substantiate the impression. This sex preference in school phobia becomes all the more interesting and unusual when one considers childhood emotional disorders in general. Bentzen, for example, in reviewing numerous studies of sex ratios in childhood learning and behavior problems, emphasized the agreement in the results of investigators that there is a marked preponderance of boy patients in at least seven diagnostic categories (reading disorders, learning difficulties, school behavior problems, stuttering, autism, childhood schizophrenia, and juvenile delinquency) and suggested that boys from the very beginning are more vulnerable to stress than girls, probably due to the fact that the maturation rates of boys are slower. Many of the ratios cited by Bentzen ran as high as

four boys to one girl, or even eight boys to one girl. Bentzen, however, did not include reviews of the studies on school phobia and anorexia nervosa, the two not infrequently encountered neuroses where girls tend to outnumber boys slightly as patients. And investigators dealing with these latter two conditions rarely attempt to explain or account for this fact of altered sex ratio in their case series.

Age at Onset

There is a general agreement among research workers that a school phobia can and does appear at any age in the child's school career. It occurs at the kindergarten age level, but its onset may be noted for the first time in the preadolescent or adolescent in the junior or senior high school grades. However, there seems to be a clustering of cases at two very particular age-grade levels: (1) at the seven- to nine-year third-grade level, and (2) at the twelve- to fourteen-year eighth- to tenth- grade level.

Intelligence or Learning

The child with school phobia rarely states that she is afraid to go to school because the work is too hard or because she cannot do the work, and the reports of teachers' and parents' impressions almost universally allege that these children are good to excellent learners in those periods before and

after their illness when they have been able to attend school for any appreciable length of time. However, in one of their follow-up studies, Coolidge, Bro- die, and Feeney stated:

Many clinicians have noted that school-phobic children, particularly younger children, are of superior intelligence and perform at an advanced level in school when they are able to attend. We were impressed by the frequency of such remarks in the school reports written by kindergarten teachers or teachers in the first two grades. School IQ tests were available on thirty-six subjects and yielded a median Otis IQ of 113 with a range of 84 to 135. Thus the median IQ, while well above average on national norms, falls slightly below the median for the suburban area from which most of the sample was drawn. The clinical impression of the original research group, that these children are intellectually alert, eager, and prepared to excel, was not born out by their subsequent intellectual development.

It is probably correct to conjecture that a large series of cases tested on standardized reliable tests of intelligence would show that the distribution of IQ figures would approach a normal bell-shaped curve slightly skewed to the right with the median at or somewhat above the 113 found by these authors. Such a skew to the right at the kindergarten and first two grades age levels probably can be attributable to the excess in any such series of girls with the expected earlier maturation that they have attained when compared with

boys of the same age.

A second impression that has taken on the respectability of a clinical fact is the repeated statement that school-phobic children are almost invariably excellent achievers in school learning. This impression has led to the balanced and antithetical clinical statements that "The school-phobic child is always an excellent achiever; the learning disability child is never school phobic." Both of these allegations are myths. For in respect to the learning achievements of the forty-nine children in the Coolidge group study the authors stated:

With respect to actual school achievement, IQ scores were compared with school grades and teachers' reports. The children's IQ-Achievement was then rated on a five-point scale, ranging from being significantly below to significantly above expectation. Forty-three percent of the children were performing below, while only twelve percent were performing above expectation. Although we recognize that IQ scores alone are a dubious criterion for predicting academic success, it does appear that the weight of the evidence points to a large number of learning problems among these children, predominantly of the production type.

And they add, "It was of interest to us that proportionately more boys than girls were showing [accompanying] problems in learning."

Associated Physical Complaints

In from 50 percent to 75 percent of school-phobic children, in addition to their voicing of feelings of anxiety and dread in relation to school attendance they will complain of pains in various parts of the body or of a feeling of a general sickness. Such complaints typically are abdominal pain, nausea, vomiting, and, less common, pain in the extremities. It has been pointed out by some authors that the primary associated physical complaint pattern (abdominal pain, nausea in the morning, vomiting) in these patients is quite similar to the "morning sickness" of pregnant women. Be that as it may, Gardner stated:

> Inasmuch as these physical complaints usually emerge at the point in time when the child is supposed to go to school, either in the sense of daily attendance (in the morning) or at the close of the summer vacation when school attendance is imminent, they give rise to the suspicion in the minds of many people that these physical complaints are entirely faked and that the child is, in essence, a malingerer. Such, however, proves not to be the case on intensive investigation, because the physical disabilities that emerge usually have specific reference to some of the underlying unconscious conflicts and are not at all seized upon "just in order to stay out of school."

Etiology or Psychodynamic Meanings

There is a general consensus as to the cause, or better, meaning, of the symptomatology exhibited by the school-phobic child. In its interpretive dissection by the therapist it is noted that the child is not afraid primarily of

going to school or afraid of the schoolwork or of the teacher but rather that she is afraid of leaving her mother. Inevitably the child selects and names any number of things, objects or people that she states are the loci of her dread and anxiety, but these are projections on selected external factors and are seen to be such after the mother carefully investigates each and every one of them in her anxious concern, bafflement, and lack of understanding of the child's sudden terror of school attendance.

The consensus that we mentioned above is best outlined by Coolidge et al., as these authors deal with the patterns of aggression existing in the overt behaviors of the phobic child and her mother:

The central concern in the child is the fear of abandonment by the parents. The child fears that some danger from the outside world will befall the parents, particularly the mother, and that thus abandoned, he will either die of lack of care or because of lack of protection be a victim of violence from the outside world.

To see that this annihilative result is not carried out, the child stays at home, as close to the mother as possible. The Coolidge team continue as follows:

> This underlying fear is considerably intensified at the outbreak of the symptoms, bringing with it an increase in the dammed-up aggressive fantasies which stem from murderous wishes toward the parents. These

> are experienced as too dangerous, and the child defends herself by regressing to increased dependence on the mother while displacing [projecting?] the anger associated with her hostile wishes to the outside world, notably the school.

However, most authors emphasize, too, the possible evoking (and demonstrable furtherance) of the child's neurotic dread by the mother herself. The child and mother have set up (or continue) a seeming symbiotic relationship, one with the other, and this relationship is a sadomasochistic expression that has needed neurotic gains for both mother and child. An extreme overprotective and antiseptic attitude on the part of the mothers of these patients was stressed by Waldfogel et al. and Estes, Haylett, and Johnson, and they attributed the cause of the child's condition to the mother's own neurotic needs responses. In addition, Waldfogel et al. included the fathers of these children as being partners with the mother in the creation of the child's psychopathology in that they too were not infrequently noted to be overprotective and to act competitively with the mother, acting thereby more as anxious mothers than as fathers.

Eisenberg stressed the fact that it is the mother's own anxiety that is transmitted to the child. This transmission is not through words but by means of cues or gesture language that involve facial expression, attitudes, and moods. The mother fears the cold, impersonal attitude of the school and its teachers and fears that the other children attending it are bad or hurtful. The school-phobic child has picked up these fears from the cues of the mother and

responds in the same vein in an attempt to please the mother.

Finally, Cramer attributed the causation of this childhood condition not specifically to the responses of the mother or the father but indicated rather that the neurotic expression in the child is due to the total family climate. The etiological importance of the family situation is stressed by him as follows:

The unconscious involvement of the total family in reciprocal systems of neurotic adaptation frequently provides a climate, before the child has to go to school, in which the tolerance of his defenses forestalls the breakthrough of symptoms. His [later] attempts to deal similarly with exacerbations of anxiety in the school environment cannot be so easily tolerated.

Presumably, with the additional stress involved in school attendance the child's previous defenses against family-engendered and family-member-associated anxiety break down and the neurosis emerges.

Jane Kessler, on the basis of her clinical studies of school-phobic children, outlined serious doubts as to the repeated allegations that the child's mother is the cause of this condition in the child and cited the need for further research to establish its truth. Kessler stated:

The literature on school phobia abounds with statements to the effect that it never exists in isolation but is always intimately associated with a

complementary neurosis in the mother, leaving the impression that the other is the cause. This explanation must be regarded as a partial one for several reasons. First, the same dynamic conflicts have been observed in mothers of children with different kinds of problems (e.g., psychosomatic problems and psychoses), so it is questionable that there is a specific cause-and-effect relationship between the mother's problem and the child's. Secondly, school phobia does not especially run in families. Why is only one child so affected? Third, investigations of parental psychopathology have not involved the use of control groups, so one cannot know how many mothers with the same conflicts are raising children who are free of phobias. . . . However, whatever the origin of the child's school phobia, there is no doubt that the mother's reaction will affect its duration and intensity. . . . Reading the clinical case material, one wonders what was primary and what secondary—that is, how much of the mother's anxiety was engendered by the child's obvious distress, and to what extent her anxiety created his distress. Even when the separation anxiety starts with the mother, the psychopathology will, after a time, be internalized, becoming an integral part of the child's personality structure. The child learns the psychology of the mother and makes it his own. In most of these cases, one sees only a continuous cycle with no clear-cut starting point.

To add to the heuristic value of her discussion, Professor Kessler suggested: "It would be worthwhile to investigate patterns of maternal

behavior in respect to children's fears. All children are reluctant to go to school at some time or other, but no effort has been made to see what parents normally do about it. Careful study might define more sharply the unique features of the 'phobogenic' mother."

Kessler's alluding to the separation anxiety of these children leads one to comment on the general diagnostic classification by numerous researchers of these children with school phobia as residing under the rubric of separation anxiety. Though this may not be specifically stated by the score or so of investigators who over recent years have worked intensively with this childhood clinical condition, it is certainly implied as their preferred clinical diagnosis. To this Anna Freud outlined a serious objection that should give us pause. She stated:

In clinical diagnoses one hears it, [i.e., separation anxiety] applied indiscriminately to the states in separated infants as well as to the states of mind causing school phobias (i.e., the inability to leave home) or homesickness (a form of mourning) in latency children. Here also, to employ the same name for two sets of disorders with similar manifest appearances tends to obscure the essential metapsychological differences which are characteristic of them. To separate, for whatever reason, a young infant from his mother during the period of biological unity between them represents an unwarranted interference with major inherent needs. It is reacted to as such

by the infant with legitimate distress which can be relieved only by the return of the mother or, in the longer run, by establishing a mother substitute mother-tie. There is no correspondence here, except in behavior, with the states of mind of the homesick or the school-phobic child. In these latter cases the distress experienced at separation from the mother, parents, or home is due to an excessive ambivalence toward them. The conflict between love and hate of the parents can be tolerated by the child only in their reassuring presence. In their absence, the hostile side of the ambivalence assumes frightening proportions, and the ambivalently loved figures of the parents are clung to so as to save them from the child's own death wishes, aggressive fantasies, etc. In contrast to the separation distress of the infant, which is relieved by reunion with the parent, in ambivalent conflicts reunion with the parents acts merely as a palliative; here only analytic insights into conflict of feelings will cure the symptom.

In this passage, with the clear enunciation of the differing unmet physiological needs of the infant and the existence of the ambivalence conflicts of the school-age child in respect to separation or abandonment, Anna Freud warned us of a needed differentiation of each of these specific clinical conditions.

What seems to be lacking in all of these observations and reports on the possible genesis of the school phobia that involves in its causation both the

parents (usually the mother) and the child (usually the daughter), is a genesis referable to the problems for solution faced by the child at this particular stage and age in its development. In the light of usually agreed on milestones in the personality development with which the usual school-phobic child is still struggling are the problems attendant on, and associated with, an unresolved (or imperfectly resolved) oedipal conflict. It is in the unfinished business of this stage in development that most of the children are caught.

These patients seem to be still battling with the conflicts engendered by the rejection of the parent of the opposite sex and the (for whatever reason) continuing negative and aggressive impulses toward the parent of the same sex. The response of renunciation of oedipal impulses has not yet been acceptable to the child, and she or he still harbors, but resists, the feelings of defeat and loss of prestige within the family group. And the parents by their reactions continue to contribute to the child's delay in the satisfying and satisfactory resolution of the conflict. Put in another context, the child's phobic reaction seems to be a continuing and delayed grief reaction, a delay in the modification of the love and hate of a lost love object. Out of this continuing conflict arises the manifest ambivalence and the demanded closeness to the parent (mother) to ensure that unconscious death wishes will not be carried out through the magic power of the wish or the thought. In the florid disabling stage of this condition, the child would seem to need a psychotherapeutic process aimed sympathetically at the child's attainment of

insight relating to his or her unconscious conflicts.

Prognosis

It can be stated with reasonable certitude that the prognosis for the child suffering from school phobia is excellent. In a large percentage of cases the condition lasts a few weeks, a few months, or recurs in a few episodes spread over one or two months' time.

It should be remembered that there are scores of children who manifest, for a time, some of the well-known symptoms of school phobia but go undetected, or certainly undiagnosed as such, because of the shortness of the duration of the attack or because the condition does not develop to a florid state of disability. The child is not referred for clinic treatment nor, indeed, is she or he referred for help to the school psychologist or school counselor by the teacher. (In such cases it is reasonable that both the parents and the teacher feel that the child's reluctance to go to school because of being afraid is nothing but malingering.)

It is just these items of self-limitation and the absence of an accurate diagnosis of the condition that make certain aspects of research difficult or render research studies unreliable. For example, if a clinical condition is for the most part self-limiting and may in appreciable numbers terminate itself, all claims to the efficacy of one treatment approach as compared to a different

treatment approach are questionable. For the recovery could have been spontaneous, no treatment at all being necessary. Also, if appreciable numbers of school-phobic children are not considered to be suffering from the condition, that is, are undiagnosed, any research results relative to the incidence are open to question. Corroboration of this unreliability of incidence figures was one of the interesting items that came to light in the classical intervention study of Waldfogel, Tessman, and Hahn. When this research team actually went into the selected schoolrooms to observe the children, to talk with the teachers and with parents, during a two-year period, thirty-six cases of mild to severe school phobia were noted whereas the alleged incidence previous to that time was said to be five or six cases per year. If one were permitted to generalize on the basis of these figures of incidence, one might assert that probably less than one case of school phobia in three is detected and so diagnosed.

Even though the prognosis, as above stated, is excellent and the recovery rate high, as shown by the results of a ten-year follow-up study of sixty-six cases by Coolidge et al., this same investigator in two other studies called attention to the fact that though the recovery rate is high in school children aged seven, eight, and nine, the recovery rate in the preadolescent or adolescent child is by no means as high. In fact, these two research teams emphasized the fact that the adolescent school phobia can be a manifestation of a severe character disturbance or become a way of life rather than

indicating a neurotic crisis, as seems to be so evident in children in the lower grades of the elementary school.

Intervention and Treatment

The effectiveness of the treatment of the child suffering from school phobia depends on the presence of at least three propitious conditions: (1) early detection, (2) prompt intervention, and (3) the cooperation of the child, his family members (mother and father), and the school in a broad-gauged treatment program.

The remarkable results of early detection and intervention are clearly demonstrated in the study of Waldfogel et al. These investigators became observers somewhat after the manner of teachers' aides in selected classrooms with the hope of detecting the first signs of a developing school-phobic condition in the various pupils. The teachers of these classrooms were welcomed and utilized as important members of the research team and were made thoroughly acquainted with the signs and symptoms of the condition.[1]

During the two-year period of the study, thirty-six children were thought by the investigators to be exhibiting the prodromal signs of school phobia. The parents of the child were interviewed immediately, and in twenty-five cases they cooperated in the treatment

program. Sixteen of the twenty-five cases were treated through counseling in the school setting (in the schoolroom itself or an adjacent office), four were referred to a child guidance clinic, and five were cases of spontaneous recovery. In a follow-up study twenty-two of the twenty-five treated cases showed no signs of a return of the phobia, whereas three of the eleven untreated children were still school phobic. The results of this study seem to indicate clearly that whatever treatment method used—individual psychotherapy, group therapy, family therapy, psychoanalysis, or behavior therapy—early intervention in its utilization offers the best chance for early recovery and minimal loss of important school attendance. (And all investigators agreed that at the earliest possible moment the child should face the phobic situation, that is, return to school.)

Additional general suggestions in regard to treatment approaches are made by Gardner:

> Here again one can begin by stating first what single devices or actions do not seem to be efficacious or effective in treatment. In the first place, it seems to be of little help to change the child to another teacher or to another school. Nor is it surprising that this is so, in the light of the true meaning of the condition. As you can see, it is not primarily school-centered. Again, from time to time, the plan has been used of having the mother always accompany the child to school or, very frequently, of having the mother sit in the classroom with the child. This usually works, but it cannot be used indefinitely because of its impracticability, both from the point of view of the mother, who must attend to other duties in the home, and from the point of view of the teacher and other pupils, both of whom do not relish the indefinite presence in the schoolroom of a mother of one

> of the pupils. Usually, too, when the mother withdraws or for the first time does not stay, the child's symptoms return with all their former acuteness. Allowing the child to stay home and be taught by a home teacher, though temporarily solving the difficulty, also cannot be resorted to forever. In addition, with regard to such treatment as the only treatment, although it may result in a long protracted self-recovery, the child taught at home during this long period is losing much in respect to social development and social adjustment that accrues to association with other children through day-by-day attendance at school.

Finally, it should be emphasized again that the cooperation of the school administrator, and particularly of the child's teacher, must be sought and maintained throughout the treatment procedure. Many problems in the overall management of the child with school phobia involve one or both of these school personnel; it is not mere speculation to assume that a large number of those children who recover spontaneously do so through the day after day individual help and guidance extended to them by an insightful and sympathetic classroom teacher.

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Notes

1 In any such intervention programs contemplated one must bear in mind that not infrequently the child patient sometimes, and the mother more often, blames the teacher for the existing fear of going to school. Teachers have suffered because of this palpably unjust accusation. To gain their very necessary cooperation, either in intervention studies or, indeed, in treatment programs for the patient, it is well for the members of the research team, or the therapists, to realize it is important to eliminate one's adherence to this traditionally held notion that the teacher is to be discovered to be the psychogenic agent causing the condition.