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School Phobia: Classification and Treatment

By HAZEL BAKER and URSULA WILLS

SUMMARY Ninety-nine cases of school phobia seen at a child guidance clinic over a period of twelve years were divided into acute and chronic groups and investigated in several ways. The results indicate that the children of both groups are more likely to be the eldest or youngest in the family. Acute school phobia is more likely to occur in youngest children with two or fewer siblings, and mothers tend to be older. It is most common in adolescence and seems often to be precipitated by stress. Chronic school phobia is likely to occur in a child from a larger family and with a younger mother. It is more common in social class V and in children of mentally ill parents. Implications for treatment are discussed.

Introduction

This investigation explores further the division of school phobia into acute and chronic types (Berg, Nichols and Pritchard, 1969) and discusses its relevance for treatment.

The 99 children under discussion were among 1,300 seen at a child guidance clinic during a period of twelve years. They were selected in accordance with Berg's (1969) classification of school phobia:—

"(1) severe difficulty in attending school often amounting to prolonged absence

(2) severe emotional upset shown by such symptoms as excessive fearfulness, undue tempers, misery or complaints of feeling ill without obvious organic cause on being faced with the prospect of going to school

(3) staying at home when they should be at school with the knowledge of the parents at some stage in the course of the disorder

(4) absence of significant antisocial disorder, such as stealing, lying, wandering, destructiveness or sexual misbehaviour".

Our cases differed from those of Berg *et al* (1969) in that none of them received in-patient treatment. However, this difference may have been due to regional variations in the availability of in-patient psychiatric treatment rather than to the severity of the illness.

Berg's classification of school phobia as acute or chronic depended upon the child's history before the onset of the phobia. The acute school phobics were those who had had at least three years trouble-free attendance at school before the illness began, however long the condition continued subsequently. The others, with long-standing difficulties were classed as chronic school phobics. The present investigation confirmed most of the differences between the two groups, and also revealed others.

Method

The clinic records of the children were examined by the team and the 99 cases of school phobia were divided by mutual agreement into 63 acute and 36 chronic cases in accordance with Berg's criteria. A random sample of one in five was examined by an independent assessor. Complete agreement was obtained on 19 of the 20 cases; on the twentieth the assessor could not reach a decision on the written records alone. Basic information was analysed by computer. (Details of information collected will be supplied on request). The two groups were then compared.

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Results

There were 38 boys and 25 girls in the acute group and 20 boys and 16 girls in the chronic group.

The results of the analysis are as follows:—

Familial Variables

1. Social class

The picture that emerges is dependent on how the data are dichotomized. If we add the cases falling into Social Class I and II together as

TABLE I

Analysis of social class in acute and chronic school phobics

Social class	Acute	%	Chronic	%	Total
I and II	15	(24)	3	(8)	18
III	11	(17)	13	(36)	24
IV	26	(41)	7	(19)	33
V	9	(14)	11	(31)	20
Not known	2	(3)	2	(6)	4
Total	63		36		99

$\chi^2 = 11.78$; $P < 0.01$

TABLE II

Mental illness in the parents of acute and chronic school phobics

Mental illness of parents	Acute	%	Chronic	%	Total
Yes	15	(24)	17	(47)	32
No	48	(76)	19	(53)	67
Total	63		36		99

$\chi^2 = 5.73$; $P < 0.05$

TABLE III

Position in family of acute and chronic school phobics

Eldest child	Acute	%	Chronic	%	Total
Yes	30	(48)	23	(64)	53
No	33	(52)	13	(36)	46
Total	63		36		99

(NS)

Youngest child	Acute	%	Chronic	%	Total
Yes	22	(35)	5	(14)	27
No	41	(65)	31	(86)	72
Total	63		36		99

$\chi^2 = 13.07$; $P < 0.05$

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against those falling into Social Class III, IV and V, there is only a trend towards a higher proportion of acute cases falling into the upper social class group. If we take Social Class V on its own, there is a significantly higher proportion of chronic cases falling into this category compared to the acute cases ($\chi^2 = 4.1$; $P < 0.05$).

2. Parental illness

A significantly higher proportion of children in the chronic group had parents with mental illness. However, the incidence of chronic physical illness in the parents, or of parental death, was not significantly different between the groups.

3. Age of Mother at birth

The mothers of the acute group tended to be older (mean age 30.1 years; s.d. 6.4) at the time of the birth of the child than the mothers of the chronic group (mean age 25.4 years; s.d. 5.5).

4. Position in family

Over half the total were eldest children, and all but 20 per cent either eldest or youngest children, but there were significantly more youngest children in the acute group (see also Table IV).

5. Size of family

The children of the acute group were significantly more likely to have two or fewer siblings while those of the chronic group were more likely to have three or more siblings. The mean size of the sibship in the acute group was 2.6 (s.d. 1.29) while that in the chronic group was 3.44 (s.d. 1.63). The difference between the means is significant ($t = 2.66$; $P < 0.01$).

There was no significant difference between the groups in family situations such as illegitimacy, fostering, death or desertion of a parent, or second marriage.

Specific Variables

1. Age

The figure below shows that the main peak of the acute group was between 11 and 14 years, with a small peak at 8 years, and hence the distribution is bimodal. In the chronic group

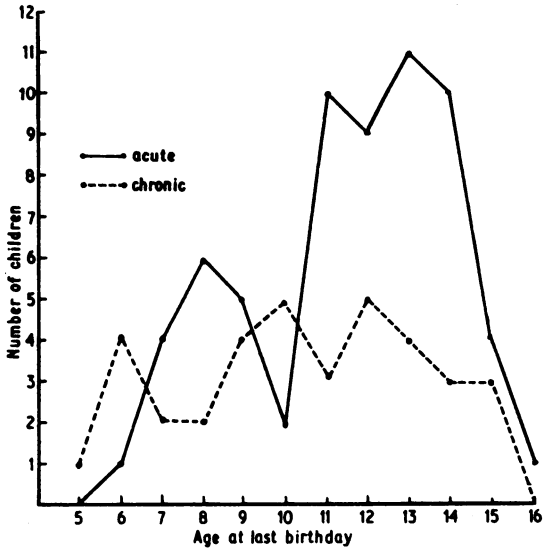

FIG. 1.—Age distribution of acute and chronic school phobics.

TABLE IV

Size of family of acute and chronic school phobics

Number of siblings	Acute	%	Chronic	%	Total
0	11	(17)	4	(11)	15
1	25	(40)	10	(28)	35
2	15	(24)	3	(8)	18
3	6	(10)	8	(22)	14
4+	6	(10)	11	(31)	17
Total	63		36		99

$\chi^2 = 13.07$; $P < 0.01$

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there was no age peak. A few children of only 5 or 6 years of age are included in the chronic group. These children had attended nursery school for a long enough period to fulfil Berg's criteria. They had persistently shown separation anxiety, but only presented for treatment when at infant school.

The average of the acute group was 11.5 years (s.d. 2.49), while that of the chronic group was 10.5 years (s.d. 2.89).

2. Intelligence quotient

There was no significant difference between the intelligence scores of the two groups as measured by the WISC test.

3. Premorbid personality

A significantly greater proportion of the acute cases had a normal character structure before their illness. Only 37 of the 63 acute cases were withdrawn or anxious before the onset of their illness, compared with 30 of the 36 chronic cases.

4. Precipitating factors

A significantly larger number of acute cases had known precipitating factors.

5. Duration of symptoms

The acute cases were significantly more likely to be seen within three months of the appearance of the symptoms, although all children referred to the clinic for school refusal were seen within two weeks of referral. Many of the acute and chronic cases were delayed in reaching the clinic, as they had first been treated by their family doctor for their physical symptoms or had been referred to a paediatrician.

TABLE V

Intellectual level of acute and chronic school phobics

Intellectual level	Acute	%	Chronic	%	Total
Above normal	19	(30)	8	(22)	27
Normal	42	(67)	22	(61)	64
Mild subnormality	2	(3)	6	(17)	8
Moderate or severe subnormality	—		—		—
Total	63		36		99

(NS)

TABLE VI

Premorbid personality in acute and chronic school phobics

Previous character	Acute	%	Chronic	%	Total
Normal	25	(40)	6	(17)	31
Other	38	(60)	30	(83)	68
Total	63		36		99

$\chi^2 = 5.64$; $P < 0.05$

TABLE VII

Precipitating factors in acute and chronic school phobics

Precipitating factors	Acute	%	Chronic	%	Total
Yes	57	(90)	22	(61)	79
No	6	(10)	14	(39)	20
Total	63		36		99

$\chi^2 = 12.27$; $P < 0.001$

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6. Diagnosis

There were significantly more children with symptoms of 'depression' in the acute group, and all except four of these were over 11 years old. There were no significant differences in the incidence of psychosis, neurosis or other conditions.

Treatment

Types of treatment are summarized in Table X. Overall treatment was dependent on the clinic philosophy and the facilities available. The proportions used in the two groups were significantly different in some areas, such as psychotherapy, pressurisation, home tuition and part-time schooling.

Outcome

The outcome was assessed firstly by whether the child returned to school, and secondly by the psychiatric condition of the child at the end of treatment. This was determined by the child guidance team who took into account the opinions of the child, the mother and the school. Outcome was divided into five classes which are defined in Table XI. We found no significant

TABLE VIII

Duration of symptoms in acute and chronic school phobics

Duration of symptoms	Acute	%	Chronic	%	Total
Under 3 months	24	(38)	6	(17)	30
Over 3 months	39	(62)	30	(83)	69
Total	63		36		99

$\chi^2 = 4.99$; $P < 0.05$

TABLE IX

Diagnosis in acute and chronic school phobics

Diagnosis	Acute	%	Chronic	%	Total
Neurotic disorder	26	(41)	19	(53)	45
Depression	21	(33)	3	(8)	24
Other	16	(25)	14	(39)	30
Total	63		36		99

$\chi^2 = 8.08$; $P < 0.05$

'Neurotic disorder' does not include 'neurotic depression'.

'Depression' includes depressive disorders not elsewhere classified and 'Neurotic depression' as defined in the multiaxial classification for psychiatric disorders in childhood and adolescence (Rutter *et al*, 1975).

TABLE X

Treatment in acute and chronic school phobics

Treatment	Acute	%	Chronic	%	Total	Significance
Psychotherapy	60	(95)	24	(67)	84	$P < 0.001$
Social work in the home	14	(22)	7	(19)	21	NS
Tranquillizers	29	(46)	12	(33)	41	NS
Pressurized	1	(2)	25	(69)	26	$P < 0.001$
Home tuition	19	(30)	3	(9)	22	$P < 0.05$
Part-time school	21	(33)	0		21	$P < 0.001$
Desensitized	8	(13)	0		8	$P < 0.05$

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difference between the two groups. Of the 88 children who returned to school 75 had a good or fair outcome and 9 out of the 11 who did not return had a good or fair outcome.

Discussion

First attempts at classification of children absenting themselves from school were made by Broadwin (1932) and Partridge (1939). Both authors studied truancy, and they distinguished a certain group of children whom they termed neurotic. Johnson *et al* (1941) used the term 'school phobia', but were of the opinion that the basic disturbance was separation anxiety. Warren (1948) published a study aiming at a differentiation between true truants and school phobics. Later a detailed study of 100 children absenting themselves from school was completed by Hersov (1960 a and b). He diagnosed 50 cases as psychoneurotic and 50 as conduct disorders. The first group could be categorized as school phobics and the second as truants.

In studies of the neurotic group, Eisenberg (1958) agreed with Johnson *et al* (1941) that the primary disturbance was separation anxiety. Bowlby (1958) agreed with this view and expanded it in his study of mother-child relationships. Berg *et al* (1969) published a very careful study of the significance of dependency of the child on the mother. They found that the children who were most dependent had high scores for neuroticism in personality tests and had a chronic commencement to their illness. Those children with an acute onset appeared to be more independent and to have more stable personalities. There were more acute than chronic cases of school phobia, and the mean age of the acute group was slightly higher than that of the chronic. The authors also noted a higher degree of neuroticism in the chronic group; our results agree with these findings. They also found that there was a tendency for the acute cases to be more intelligent and for their parents to have had a history of mental illness, although

TABLE XI

Outcome in acute and chronic school phobics

Return to school	Acute	%	Chronic	%	Total
Yes	56	(89)	32	(89)	88
No	7	(11)	4	(11)	11
Total	63		36		99

(NS)

Treatment outcome	Acute	%	Chronic	%	Total
Good	42	(67)	27	(75)	69
Fair	12	(19)	3	(8)	15
No change	1	(2)	2	(6)	3
Worse	2	(3)	1	(3)	3
Failed	6	(10)	1	(3)	7
Not known	0		2	(6)	2
Total	63		36		99

(NS)

Good— the symptoms for which the child had been referred had completely disappeared and no other symptoms had occurred.

Fair— the original symptoms had not completely cleared or other mild symptoms had appeared.

No change—

Worse— fresh symptoms had occurred.

Failed— the child failed to complete the course of treatment.

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the figures were not significant. In another study Berg *et al* (1974) found about one-fifth of the parents of all children with school phobia had a history of psychiatric disorder. We discovered no significant difference in intelligence, but we did find a higher incidence of mental illness in the parents of the chronic group. Under a quarter of the acute phobics had parents with a history of mental illness compared with almost half of the chronic phobics.

The mean age of the mothers was higher both at birth and at referral in the acute group, though the figures were not significant. There was a significantly larger number of youngest children in the acute group. This is probably interrelated with the greater age of the mother at birth in this group as described by Berg *et al* (1972). There was a significantly higher proportion of chronic cases in Social Class V.

The higher incidence of depressive symptoms with known precipitating factors in the children of the acute group occurs largely among adolescents and is probably an isolated adolescent phenomenon reactive to stress rather than the forerunner of a recurrent mental illness. (The number of cases needing further treatment, as shown in a later follow-up study 3 to 13 years after discharge, did not differ in the two groups, being 20 per cent of each). The earlier smaller peak in age of onset could possibly be related to transfer to junior school. The higher incidence of mental illness in the parents of the chronic group suggests that the children have greater problems to cope with in the family and the home and these may cause anxiety and insecurity.

Our study of treatment methods shows that the two groups of children were viewed on clinical assessment as requiring different types of management and treatment.

The acute cases were usually suffering from a variety of psychiatric symptoms, and nearly all were very anxious and depressed. The aim of the clinic was to relieve immediately the external pressures on the child from the parents or the school by recommending home tuition and concentrating on treatment of the presenting symptoms. Only when these had cleared up was a gradual return to school initiated. Desensitization techniques were used very successfully but lack of staff limited the number of cases that could be treated in this way. Part-time schooling and the co-operation of the teachers had more usually to be employed. Social work support helped the parents to understand and accept their child's illness.

In the chronic group we were usually dealing not with psychiatric illness in a normal child but rather with anxious or withdrawn personalities or with family stress, although neurotic symptoms were often present. The children in this group were encouraged to return to school immediately, and if necessary considerable pressure was used. At the same time, the clinic, sometimes with the help of other agencies, gave considerable and often long-term support to the parents and the child. Exceptions to this policy were made in the case of a few children who had already been off school for periods of about a year before being seen at the clinic, or who were within two months of leaving school. In these cases the clinic's policy was to recommend home tuition and to concentrate on increasing the child's self-confidence and maturity in other spheres. Residential accommodation of various types was available to us, but we did not feel the need to use it for school phobia during the period of this survey.

In both groups treatment was continued where necessary after school-leaving age and until the young person was settled in higher education or employment.

The overall outcome, 86 of the 99 having a good or fair outcome, compares favourably with the figures of Berg *et al* (1976).

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