School phobia is a well-defined clinical entity. The transient appearance of this syndrome in a leukemic child highlights aspects of the relationship between psychopathology and adaptation. Throughout the course of this fatal illness, the sensitivity of families to separation is increased. Separation anxiety becomes particularly acute when there is evidence of deterioration in the child's condition. How this anxiety is handled in any given instance is related to the quality of the original resolution of the separation-individuation phase of the child's development as well as to the nature of the danger at the moment. Transitory symptom formation, such as school phobia, may occur as part of the adaptive process. In general, coping with the fatal illness involves complex combinations of regression and growth, disturbance and restitution, failure and mastery.

Over the last four years, we have been studying the adaptation of families to the fatal illness, leukemia, in a child. Through recorded
interviews with family members, play groups conducted in the clinic waiting room and on the hospital ward, informal contacts during clinic visits, and discussions with physicians and hospital personnel, we have explored the psychological impact of fatal illness on these families. From the moment of diagnosis, family members must deal with the expected loss of the child within months or years. During most of his illness, the child is in remission, completely free of symptoms. He makes periodic clinic visits and takes medications regularly. He may develop side effects from medications and he may become symptomatic during relapses. Otherwise, leukemia, itself, forces no changes in life style during remissions, which may be long and medically uneventful. A fatal outcome is, nevertheless, inevitable at some undetermined time. It is this reality, more than the demands of medical care or the debilitation of disease, that profoundly affects the adaptation of the family members.

**Separation Anxiety and Leukemia**

In the face of an actual threat of impending death, the ultimate separation, anxiety with regard to day-to-day separation is universal. Investigators report the presence of intense separation reactions in parents and children, ranging from demands for physical closeness to parental overprotection and overindulgence (Bozeman et al., 1955; Friedman et al., 1963; Natterson and Knudson, 1960; Orbach et al., 1955; Richmond and Waisman, 1955). When their children are in the hospital, many mothers cannot sleep or eat (Orbach et al., 1955).

We have observed all of our families struggling with their inclinations to be oversolicitous to the sick child, to relax discipline, to reorganize the family around his needs, to pamper, and to cling. Parents report intense anxiety when the child is not in sight. They feel guilty about any self-indulgence and reassured by anything they can do for the child in the face of their ultimate helplessness. The children, too, demand more attention, wanting to be cuddled, held, and indulged. One mother reports of her six-year-old daughter, “She wants me to pick her up, just like I used to when she was a baby, and carry her to bed. She was never this way before. Maybe this is how she wants me to remember her.”
School attendance often becomes less important. A father told his 15 year old daughter, “Now if you don’t feel like staying in school just call your mother and she’ll come right out and get you.” Despite these tendencies, parents usually send their children to school; they allow them to engage in normal activities; they maintain their standards of discipline; they resist their inclinations to overindulge. While we have observed many manifestations of separation anxiety between children and parents, we have encountered only one case resembling a school phobia in our series of 25 cases, nor are any reported in other studies of leukemic children.

School Phobia

Definition

School phobia, as it is currently defined, refers to a sudden refusal to attend school, associated with anxiety in a school-age child (Warren, 1948). The presence of anxiety, the absence of rebellion, the absence of other evidence of delinquent manifestations, and the stability of the family environment distinguish this disorder from truancy and chronic poor school attendance on the basis of delinquency and/or parental neglect (Hersov, 1960).

Clinical Features

Although some investigators question the importance of separation anxiety in school phobias (Leventhal and Sills, 1964; Radin, 1967; Suttenfield, 1954), most consider it to be the core problem (Coolidge et al., 1957; Estes et al., 1956; Johnson et al., 1941; Sperling, 1967; Waldfogel et al., 1957). There may be displacement of fear onto some aspect of the school experience or onto an individual in the school. The anxiety may be expressed through somatic complaints related to school attendance (Leventhal and Sills, 1964; Millar, 1961; Radin, 1967; Suttenfield, 1954). It may be expressed directly as fear of leaving the parent (Davidson, 1961; Kahn and Nursten, 1962). In general, anxiety is greatest at the point of separation. If no attempt is made to send the child to school, while he may appear clinging and somewhat withdrawn at home, there is no overt anxiety unless the issue of school attendance is raised (Millar, 1961; Warren, 1948). Paradoxically, if the child can be successfully brought
to the school and left there, he may become anxiety-free after the separation has been accomplished.

The problem is often linked to a particular parent. If the other parent or another individual is able to intervene between the child and the vulnerable parent, the separation obstacle may be overcome (Sperling, 1967). Other manifestations of separation anxiety are often present. Frequently there is a history of clinging behavior, problems with babysitters, night fears, or homesickness (Leventhal and Sills, 1964; Millar, 1961; Warren, 1948).

Pathogenesis and Dynamics

Estes, Haylett and Johnson (1956) describe the following steps in the development of school phobia:

(1), An early, poorly-resolved dependency relationship between mother and child. (2), Inadequate fulfillment of the mother’s emotional needs, usually because of a poor marriage. (3), A temporary threat to the child’s security, causing a transient increase in the child’s dependency needs. (4), Exploitation of this situation by the mother, and fostering of exaggerated dependency of the child upon her. (5), A similar relationship between the mother and her own mother. (6), Expression of hostility to the child not only by making him more dependent upon the mother, but also by direct inhibition of any opportunity for the child to express aggressive or hostile feelings toward the mother, and also by seductive behavior toward the child. (7), Development of strong hostility in the child toward the mother largely unconscious, and expressed by exploitation of the mother’s guilt toward him, and also by fears of the mother’s safety caused by his unconscious destructive wishes, thus forcing him to be with her to insure himself of her safety. (8), Displacement of this hostility toward his teacher so that she becomes a phobic object [pp. 691-693].

Most authors describe similar dynamics (Coolidge et al., 1957; Davidson, 1961; Eisenberg, 1957-58; Talbot, 1957). Anna Freud (1965) presents the child’s conflict as follows:

The distress experienced at separation from 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 hos-
tile 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." (p. 113).

In similar terms, Colm (1959) describes what the child experiences: "He feels he is expected to serve the needs of his mother, overlooking his own, and the prospect of going off to school and leaving her evokes the familiar pattern; hate, resulting panic and the fear of giving up his substitute for love and trust—his power over her."

As indicated, unconscious collusion by the parent is considered central to the development of a school phobia in the child. Eisenberg (1957-58) graphically describes the means by which anxiety is communicated to the child by the vulnerable parent. Deutsch identifies one type of vulnerable parent: "In a certain type of hysterical, infantile woman who was excessively tied to her own mother, the fear is a direct reaction to separation ... when the child is out of sight, she is seized with anxiety." (Colm, 1959). Mothers, in particular, are seen as overprotective, ambivalent and narcissistic (Davidson, 1961; Eisenberg, 1957-58; Talbot, 1957).

The children are described as timid, sensitive, and fearful (Coolidge et al., 1957; Warren, 1948), but also spoiled (Warren, 1958) and willful, tending to rule the roost (Klein, 1945; Leventhal and Sills, 1964; Talbot, 1957). In general, anxiety about separation is seen as an inevitable response to a mutually ambivalent, hostile-dependent, parent-child relationship (Broadwin, 1932).

What precipitates a school phobic episode may be a threat to the child's security or to the parent's. The threat may take the form of a real illness or a feared illness of the child or the parent, a death in the family, an accident or a narrow escape, a change in home or school. Most authors conceptualize these as acute separation threats and describe the response as exaggerated in relation to the degree of actual threat present (Johnson et al., 1941; Leventhal and Sills, 1964; Sperling, 1967).

**Prognosis**

School phobia is generally regarded as a serious disturbance requiring immediate and intensive therapeutic intervention (Millar,
The possibilities of spontaneous remissions (Waldfogel et al., 1957; Warnecke, 1964) and "formes frustes" (Broadwin, 1932) have been raised, but most writers emphasize the intransigence of the disorder.

Emergency intervention is considered necessary to re-establish regular school attendance in the school-phobic child. In general, the longer the period of nonattendance at school, the more difficult it becomes to return the child to school (Eisenberg, 1957-58; Waldfogel et al., 1957; Warnecke, 1964). While energetic efforts may re-establish school attendance, psychotherapeutic follow-up is generally recommended to deal with the underlying neurotic problems. Treatment is often difficult and prolonged, especially with adolescents (Coolidge et al., 1960; Estes et al., 1956; Johnson et al., 1941; Suttonfield, 1954; Warren, 1948). "Even a voluntary return to school, without treatment, makes a relapse more likely" (Kahn and Nursten, 1962). Sperling, however, describes success for certain cases with a brief therapeutic approach described as "Analytic First Aid" (Sperling, 1961).

**Betty and Her Family**

Betty had been diagnosed as suffering from leukemia when she was two-and-a-half years old. She developed a transient episode of school phobia when she was in second grade at the age of seven and a half. At that time, she was suffering from her first relapse which was overtly asymptomatic and detected only by changes in her blood and in her bone marrow. When she demonstrated a bone marrow response to change in medications, the school phobic episode ended. There was another partial school phobic episode, related to an upper respiratory illness six months later. This second episode resolved after a clinic visit during which a bone marrow test showed that the child was still in remission. The mother describes the first school phobic episode as follows:

Everything bothers her. She's upset. This hurts; that hurts. She don't want to go to school. You should see the aches and pains she has in the morning when it's time to go to school; and if I give in to her and let her stay home, which I've been doing, it seems like she has a miraculous recovery about a quarter to nine when school is already in session. Then she recovers.
The investigators have had the opportunity to conduct tape-recorded interviews with this family in their home several times over a period of three years. In addition, we have maintained informal contact with them during their clinic visits. We have been able to note their behavior in the waiting room and in the examining room, as well as to observe the child in a play group conducted in conjunction with the Tumor Clinic. On one occasion the family made a tape-recording of a dinner at home without the presence of any outside observers.

The household consists of the father, a successful 45-year-old private contractor, the mother, 42, the maternal grandmother, 83, two sons, age 22 and 14, and Betty who is now eight and a half. A married daughter of 25 lives with her husband in a nearby community.

The impact of the fatal illness on the family and on Betty's development is a significant one, and it is only in this context that her school phobic symptomatology can be fully appreciated. As the mother stated:

I go to bed at night, and I don't even know whether we're going to get through the night without any problems, or she's going to wake up, and she's going to be singing or crying. But thank God, she's really done beautifully. But that doesn't mean that for four and a half years I've been breathing easily. I haven't. Just like— you know I feel like I'm sitting on top of a powder keg and any minute it's going to go off.

She expresses here what many parents describe. "God must be punishing me. He's going to take this baby away from me. Why? What did I ever do?"

**Pathogenesis of Betty's School Phobia**

*Mother and Child*

The stage was set early for an ambivalent relationship between the mother and this child. As in a third of the cases of school phobia described by Davidson (1961), the pregnancy was unwanted.

It wasn't planned. It was, believe me, I swear to God, it was an immaculate conception (laughter). It had to be. And, well, we were shocked. That's putting it mildly. I think, for three months,
I was hysterical. I thought "This can't be." And then of course I got used to the idea and hoped and prayed it would be a little girl because I was losing Annette. She was getting ready to get married and I thought it would be nice to have a little girl.

Mother describes an indulgent relationship with all her children and in particular with Betty. As she said to her doctor:

Well, I'll tell you what you told me three years ago and I always think of it. You said to me, "Remember, this can go on for a long time. Please don't spoil that baby." I thought to myself, "He can say that to me because it's not his baby." Of all people to say it to, because I'm chicken-hearted in the first place and we spoil our babies. I mean they don't have to be sick. They're rotten spoiled. This is how we are, especially me. I can't help it. My children are so precious to me. Oh, I scream and holler and you should hear what I call them, but I love them. I love them so much that it hurts, really. But I remember you saying that to me and I thought, "Well, I'm going to do what I think is best for my child." But you know, you were really so right and I know that you were right, but I still am not following your advice!

*Family Interaction*

Although the couple presents itself as a united front without overt conflicts or dissatisfaction, many of their statements suggest covert marital tensions. As mother jokes, "Well, as long as my husband lets me do the talking and he does what I want him to, we get along great." When allusions are made to problems in the marriage, they are ascribed to the consequences of living under the threat of fatal illness. For instance, father, hinting at his sexual deprivation during the time of the child's relapse, states:

I give and forgive more than other husbands would; I mean, I know they wouldn't put up with it. That's probably when some of your fellows would start beefing to you, and what not. Me, that doesn't bother me. I mean, Betty comes first regardless. But then, there's a limit. You know what I mean?

As characterized by Hersov (1960), the family pattern has become one of an overindulgent mother and a passive father dominated by a willful, stubborn and demanding child.
Father: Ever since the first of the year, now, we've had no private life at all. I mean, if Betty isn't sleeping with us, even if we go into the bathroom to talk for a minute, we got the kids knocking on the door asking questions. We just . . .
Mother: Oh, we can't ever be alone. If we come down here to have a drink before dinner, they're right with us.
Father: They're down here. I get aggravated once in a while and say "Can't I even go to the toilet and talk with my wife?"
Mother: Do you have to say "toilet?"
Father: Alright, washroom.

The following excerpt from a recording of a family dinner is typical of the interaction of mother, father and child:

Betty: (Interrupting and whining) Mommy.
Mother: What?
Betty: I'm so tired.
Mother: Well, why don't you go and lay down?
Father: You want to go and lay down, huh?
Mother: If you're so tired.
Father: We'll lay down with a storybook, okay?

The unctuous, tense, indulgent responses to Betty in this interaction contrast strikingly with the sharp, terse, and angry retorts to bids for involvement by the 14 year old son. Betty is special.

Mother and Her Mother

The hostile-dependent bind characterizing the mother's relationship with Betty is paralleled in the mother's relationship with her own mother. Mother explains:

You see, I even feel guilty about my mother and I shouldn't. We have four girls, and I'm the baby. My mother has been with me for 42 years. Let's face it, that's already too much. And I love my mother and I respect her, but it's not fair because we have never been alone. You know what I mean? If I didn't tell her to stay in her own room, she'd be down here.

The mother is able to talk about her hostility toward her own mother and to admit negative feelings which she cannot express with regard to Betty:
Mother: I had the nerve to holler back for the first time in I don’t know how many years.

Father: Forty!

Mother: Well, she got so hysterical that she threw herself on the floor. Now, if you can imagine this and she was pulling her hair and pulling her clothes. She was praying that God would take her. And I’m going, “What the hell!” Do you know what I said to her? She said that I made her sick. And I told her that she made me sick. That was the only thing that was said to hurt her. So, I got hysterical and called my sister up and said, “I think you’d better come. Your mother is having a nervous breakdown. She’s on the floor right now, pulling her hair.” Of course, my sister said, “Oh my God.” So she got her son-in-law to drive her here and then I said, “Listen! I’m tired of being a martyr. I’m tired of taking all this baloney that she is throwing at us. We don’t deserve it because my husband is a saint.” For all these years, to put up with my mother, believe me. My other brothers-in-law wouldn’t do it. No other son-in-law would build a room on for her and put up with all this garbage. So, I told my sister, “You tell her. Just tell her the problem, and tell her about Betty because I can’t.” I’m not close to my mother . . . she was a cold person . . .

Father: I don’t think we even kiss in front of her. The last time we kissed was when we got married—in front of her.

Mother: Yeah! Well, when we were kids, you know, when we got married and were going together, just when he started getting affectionate, I’d say, “Don’t you kiss me in front of my mother, you embarrass me.” So to this day, poor guy, he watches himself.

**Development of Overindulgence**

From the onset of Betty’s leukemia, both parents have been reluctant to frustrate any of her demands. They have devoted themselves to her well-being, experiencing guilt for any self-indulgences. Catering to the child has been particularly evident in situations requiring temporary separations. Thus, bedtime routines were affected from the beginning:

Mother: You know that, when I touch her, I don’t sleep at night. I’m crying and I have these terrible dreams and I think “Oh God, what did I do to that baby”; and then I’m hugging her and I just can’t help it. When she was three years old, daddy
bought her a bedroom set, all white French Provincial, gorgeous. She didn’t like it because she was afraid of the big bed. So I says, “Okay, mommy will lay down with you” (which I have never done in 23 years). I mean, my oldest daughter is almost 23. I never lay down with any of my children because I don’t believe in it. I don’t believe in them coming into the bed and sleeping with their parents. I just never did. So I lay down with her, and do you know I’ve been laying down with her for three years, every night.

Father: We take turns.

Mother: Someone has got to lay with her . . . and this has ruined our life, really. This has ruined our social life for anything you ever want to plan. Let’s see! What else do we do with her that we never did with the others? Of course, coming into the bed, three o’clock, four o’clock, five o’clock—anytime of the night.

Father is equally indulgent of Betty, cooking special foods for her, inundating her with presents, and altering his work routine to spend more time at home.

Mother: Ben’s (father) whole life is Betty. His work has suffered. I mean, he is a contractor. He builds the stations. He does what he has to but there’s no one that comes home in the afternoon like he does just to be with his Betty. Surprises every day. He has really got her spoiled rotten. And now he walks in the door and she says, “You got a surprise for me?”

Father: Or, “What have you got for me?”

These efforts at indulgence are not merely unambiguous expressions of love toward a child soon to be lost. The parents are clearly burdened by Betty and her illness, resentful of the attention she demands and guilty about their own negative feelings toward her. Such indulgence is a product of their ambivalence and defends against emergence of their hostile feelings.

Precipitating Threat

The fatal illness constitutes the underlying, prolonged threat evoking anxiety about death and separation. With the reality of the illness comes the reality of death as an outcome. Only when the family had good reason to anticipate deterioration in the child’s
condition, so that the threat became immediate, were school phobic episodes precipitated. Under these circumstances, parental anxiety was realistically high and, along with the physician's concern, was communicated to the child. In addition, Betty's experiences as a patient changed concretely at these times. She had greater contact with the hospital and was subject to additional procedures and to changes in medication. The additional threat led to intensified anxiety manifest as a school phobia. With medical reassurances about Betty's physical status, the school phobic episodes subsided.

The School Phobic Episodes

Mother: Tuesday morning she pulled the act, her tummy. So I fell apart. "It's okay. Stay home." So then she went over to her girlfriend's. See, I let her go. Then I'm thinking, she plays me for a fool. Well, I know it and then I'm getting real mad. I'm talking to myself and getting mad thinking: "If she were really sick, she wouldn't be over there playing." So I called up my friend and said, "How's Betty?" and I called her every ten minutes. She says, "Why, there's nothing wrong with this kid. She's running. She's jumping." And I said, "Has she complained of a tummyache?" "Heck no, and she just ate this and that." You know she's eating her out of house and home! "Okay," I said, "Tell her I'm coming to get her and she's going to school." Then, I get real brave 'cause she doesn't hear me. I says, "You tell her the teacher called, and that she's got to go to school this afternoon, and that's it." Plunk, I hung up. So my girlfriend says, "Betty, your mother called. Your teacher called and you've got to go to school this afternoon." She says, "Aw, I was afraid of that." So I brought her clothes over there and I dressed her, real businesslike. I didn't show any feelings and put on a big act for her. We got dressed. We went to school, and she went to school a whole week then. So now this week was another story. Monday she had breakfast and I'm holding my breath. It's about ten after eight, she goes, "My tummy hurts!" I think "Dear God, not again!" I know this is an act by now, you know. Well, she started to cry, really, so pitifully. Then she starts with her father. "Daddy, I'm going to stay in my nightgown all day because I love it." She goes, "And I'm not going to get dressed, but I really have a tummyache" . . . Well, the windup was, we're hugging each other and crying, the two of us. I'm crying with her because I'm frustrated with her, you know. I'm
going, “I don’t know what to do.” I don’t want to be firm and send her because what if she really has got a tummyache. Then I’m going to kill myself. So I said, “Okay, Betty, you don’t have to go to school.” So she says, “Okay.” She jumps into bed and then I really worry because she never did this before: “Oh, I love these covers, I love this and that,” and I’m going, “Oh, this is something new!” So then I lay down with her for just a minute and I hugged her and I said, “How do you feel?” “Oh, I feel good, but I just love these covers.” I said, “Okay, you stay in bed then!” It lasted just ten minutes. She was out of that bed, she started playing, and I thought, “I don’t get it! Ten minutes ago she was crying and we were both crying!” She just does not want to go to school. Actually, she’s not too crazy about school.

**Comparison with “Classical” Picture**

In many ways, Betty seems to have experienced a classical school phobia with typical dynamics and symptomatology. She suffered from acute paralyzing anxiety with respect to school attendance. When not confronted with the need to separate, her anxiety decreased. There is clear evidence of a mutually ambivalent, hostile-dependent mother-child relationship. The mother’s hysterical, narcissistic personality, her ambivalent tie with her own mother, the overindulgence of the child, the communication of anxiety to the child, and the parental anxiety over separation are apparent.

There are features of this case, however, which place it in a different light from the classical model, centering around the fact that the child is suffering from a fatal illness. The threat of death has influenced Betty's development, family interactions, symptom formation, symptom choice, and outcome. Unlike other school phobias, the episodes were transient and self-remitting, without the need for vigorous intervention.

The family dynamics were ripe for the formation of a school phobia. Mother spoiled all her children. But symptoms did not emerge in Betty's siblings. For instance, Annette suffered from a serious infantile illness (bacterial meningitis) which might have set the stage for a similar separation problem; but this never materialized. Even in Betty's case, intense protectiveness and indulgence occurred only after the diagnosis of leukemia was made. While
vulnerability to separation problems was present, the balance was maintained prior to the actual threat of death.

The child was stricken with leukemia during her third year of life—a time when individuation has not been completed and separation anxiety is normally high. We speculated that becoming ill at this critical juncture interfered with developmental processes leading toward individuation and encouraged a quasi-symbiotic mother-child relationship, in which the fantasy of magical control served to deal with the threat of loss. However, the mother and child apparently found sufficient ego resources to allow them to emerge from symbiosis and to permit articulation of ego boundaries between them. The child then moved on to further growth. Nevertheless, the vulnerability was established at this critical point, so that regression occurred when the threat of death became acute.

The mother's strength is apparent in her self-awareness and self-critical attitude and in her efforts to strike some balance between her wish to cling to her fatally ill child and her wish to allow Betty to lead a reasonably normal life. Even when the threat of death became acute, precipitating the school phobia, the mother was sufficiently resilient to help her daughter to overcome the acute separation problem without external intervention. While at times she may have been in collusion with the child's clinging and unable to help the child to separate, at other times she could let the child go. The mother's ego strength, reflected in her level of insight, results in a continuous conscious struggle—sometimes successful, sometimes not—to overcome the impulse to "hold on for dear life." The timing of the appearance of the phobia and of the actual indications of deterioration of the child's condition are linked. The regression, moreover, seems to have adaptive value, bringing partial relief at moments of severe distress.

All of these features may be contrasted with the classical case of school phobia where the threat is more fantasied than real, capacity for insight is minimal, and inadequate resolution of the separation-individuation phase of development leads to increased vulnerability.
Two conflicting perspectives have been advanced concerning the nature of separation anxiety. It has been defined as "a pathological emotional state in which child and parent, usually the mother, are involved in a mutually hostile-dependent relationship characterized primarily by an intense need on the part of both the child and the mother to be in close physical proximity to each other" (Estes et al., 1956). Similarly, Sperling (1967) defines it as "inability to accept separation from a parent figure and to function independently away from home."

On the other hand, separation anxiety has been viewed as a developmental concomitant of the infant's movement from dependency to emotional self-reliance during the separation-individuation phase of development beginning in the second year of life (A. Freud, 1965; Mahler and Gosliner, 1955). Bowlby (1960) insists that the "capacity to experience separation anxiety must be regarded as a sign of the healthy personality." Anna Freud (1965) points to the lack of clarity associated with the term, noting that it is "applied indiscriminately to the states of distress 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" (p. 113).

We have found it most useful to consider separation anxiety as originating in a specific developmental stage and not, in itself, pathological. Its derivatives may take the form of feeling states and/or adaptive and defensive strategies designed to deal with threats of separation throughout life. Any of these derivatives may assume pathological proportions. Manifestations may range from the normal distress of preoedipal children during hospitalizations and other brief separations to pathological school phobia in older children.

Inherent in these concepts are developmental norms with the implication that, at particular ages, clinging and difficulty with separation are not pathological, while, at other ages, they might be. Examples of normal derivatives of separation anxiety include the protests of the two-year-old being left with a strange babysitter, and of the three- or four-year-old adjusting to nursery school. The same behavior would suggest pathology if it occurred in older children.
In extreme situations, these norms cannot easily be applied. When life is threatened, separation anxiety is universally evoked, regardless of age. This is evident, for example, when a parent undertakes a bedside vigil during hospitalization of a terminally ill child. Under these conditions, not to separate may be the norm. But clear-cut norms for school attendance among nonhospitalized fatally ill children have not been established. Our data suggest the following: children do attend school during remission without excessive difficulty; they may stay home for a few days or a week when they have physical symptoms or are found to be in relapse; rarely do they become overtly school phobic. Differences in the timing of the onset of the illness along with differences in underlying family dynamics may account for the fact that overt school phobia did not appear in the overwhelming majority of our cases, nor is it reported elsewhere in the literature.

The presence or absence of a school phobia is related to the interactions among the nature of the separation threat, the degree of resolution of separation and individuation during development, and the potential for parental insight to deal with separation problems as they arise. Sperling (1961) discusses three cases in which the nature of separation threat was more immediate and profound than is generally described, and in which rapid cure was achieved by brief insight-oriented therapy. In these cases resolution of the relevant developmental crisis apparently had been sufficient for the introduction of insight to overcome the regressive effects of the external threat. In the case we have presented, the mother’s capacity for insight serves as an adaptive resource, facilitating a spontaneous remission of the phobia. Within a general population of school children we might expect to find other transient episodes and school phobic “equivalents.” Some of these may have adaptive meaning in relation to external threats.

Separation anxiety is expressed on a continuum from adaptation to maladaptation as a function of ego resources and external challenges. In most of our families, extreme danger to the child’s life did not result in symptomatic expressions of separation anxiety. Even in Betty’s case, where resolution of the developmental crisis had been less than optimal, school phobic symptoms did not occur so long as the child was in remission. When symptoms did appear,
they were precipitated by an acute situational crisis, and did not have a maladaptive outcome. As Hartmann (1939) states, "the very mechanisms which lead to obvious pathology can, under different conditions, serve adaptive reactions."

**CONCLUSION**

We have presented a case of transient school phobia in a fatally ill child in which an actual threat of irreversible separation (death) played a major role in the genesis of the phobia. With reduction of the immediacy of the danger and appropriate parental response, spontaneous remission occurred. The impact of the prolonged threat of death is critical in distinguishing families with a leukemic child from other families coping with day-to-day separations. When the threat interacts with family vulnerabilities during a particular developmental period, potential for regression at a later time is enhanced. Further threat can lead to symptoms. In this child, school phobic symptoms appear which are less refractory and more responsive to ego control of mother and child than previously described in the literature.

In this family, as well as in many of the other families of fatally ill children whom we have observed, usual criteria for psychopathology are difficult to apply. Our data indicate that, in the face of severe threat, families often demonstrate great resources along with great distress. The route to adaptation is often circuitous, with transitory symptom formation related to coping processes.

**REFERENCES**


