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Ligne éditoriale

La revue a pour dénomination **ZAOULI** qui désigne à la fois une danse et une musique populaires pratiquées par les communautés gouro, dans les départements de Bouaflé et de Zuénoula, en Côte d'Ivoire. Hommage à la beauté féminine, le ZAOULI s'inspire de deux masques : le Blou et le Djela. Son autre nom, « Djela lou Zaouli », signifie « Zaouli, la fille de Djela ». Le Zaouli associe, dans un même spectacle, la sculpture (le masque), le tissage (le costume), la musique (l'orchestre, la chanson) et la danse. Le masque Zaouli se décline en sept masques faciaux traduisant chacun une légende spécifique. Les détenteurs et les praticiens sont les sculpteurs, les artisans, les instrumentistes, les chanteurs, les danseurs et les notables (garants des coutumes et des traditions de la communauté).

Dès lors, le ZAOULI possède une fonction éducative, ludique et esthétique. Porteur de l'identité culturelle de ses détenteurs, il contribue également à la préservation de l'environnement, et favorise l'intégration et la cohésion sociale. La transmission de l'élément s'opère à l'occasion des représentations musicales et des séances d'apprentissage. Les amateurs en apprennent la pratique sous la supervision de praticiens expérimentés. La viabilité du ZAOULI est assurée grâce aux représentations populaires, organisées deux à trois fois par semaine par les communautés. La chefferie traditionnelle, garante des traditions, joue également un rôle clé dans le processus de transmission. Les festivals et les concours de danse inter-villages constituent également d'autres opportunités de revitalisation.

En définitive, le ZAOULI est réputé détenir des pouvoirs permettant l'accroissement de la productivité du milieu dans lequel il est pratiqué. Inscrit sur la liste prestigieuse du Patrimoine Mondial de l'UNESCO, le ZAOULI est une synthèse de la sculpture, la musique et le tissage. Elle a donc pour but de mettre un point d'honneur sur la beauté féminine. C'est pourquoi, il se

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distingue par la finesse des traits du masque, la beauté de la danse et la grâce qui en font un spectacle fort apprécié dans les manifestations publiques.

Cette nouvelle revue vise donc à promouvoir la recherche et la réflexion dans les domaines suivants :

- Arts et Culture ;
- Lettres et Langues ;
- Sciences de l'information et de la communication ;
- Sciences Humaines et Sociale ;
- Sciences Juridiques et Politiques ;
- Sciences Economique et de Gestion ;
- Sociologie ;
- Anthropologie ;
- Psychologie ;
- Criminologie.

Elle vise également à publier les résultats des recherches menées par les chercheurs et à développer la production scientifique chez cette nouvelle génération de chercheurs. C'est une revue pluridisciplinaire dont l'enjeu est de favoriser un enrichissement entre chercheurs dans une relation de mutualisation des connaissances tout en s'inscrivant dans les normes scientifiques et éthiques du CAMES.

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Style et volume d'un article : Book Antiqua; taille de police : 12, interligne : 1 volume 15 à 20 pages maximum.

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La structure d'un article scientifique en Lettres et Sciences Humaines se présente comme suit :

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Les articulation du texte : A l'exception de l'introduction, de la conclusion, de la bibliographie, les articulations doivent être titrées, et numérotées par des chiffres (Exemples : **1. ; 1.1. ; 1.2 ; 2. ; 2.2. ; 2.2.1; 2.2.2.; 3. ; etc**.). (Ne pas automatiser ces numérotations).

La conclusion doit être brève et insister sur les résultats et l'apport original de la recherche.

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Exemples :

Le processus du sous-développement résultant de ce choc est vécu concrètement par les populations concernées comme une crise globale (S. Diakité , 1985, p. 105).

En effet, le but poursuivi par M. Ascher (1998, p. 223), est « d'élargir l'histoire des mathématiques de telle sorte qu'elle acquière une perspective multiculturelle et globale ».

NB : Les sources historiques, les références d'informations orales et les notes explicatives sont numérotées en série continue et présentées en bas de page.

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ouvrage, d'un mémoire ou d'une thèse, d'un rapport, d'une revue ou d'un journal est présenté en italique.

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Exemples :

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School Phobia and Approaches to Cognitive-Behavioral Care

Abderrahmen SENOUSSAOUI
Faculty of social and human sciences
University of Oran 2 Mohamed Ben Ahmed
senoussaoui13@gmail.com

Djamel RAHMANI
Faculty of social and human sciences
University of Tizi Ouzou Mouloud Mammeri
rahmanidjamel13@gmail.com

Ali HOUICHE
Mohamed Boudiaf University of M'sila
houiche.ali@univ-msila.dz
Orcid: 0009-0001-3470-8221

Abstract :
School Phobia is a type of anxiety disorder observed in pupils, characterized by excessive and irrational fears associated with being at school. Affectedstudentsoftenexhibitsignificantanxietyduringschoolattendance and attempt to remain at home by offering various justifications, such as psychosomatic complaints, fear of teachers, or difficulties with academic subjects. This intervention aims to address school life phobia through the application of ***Cognitive Behavioral Therapy (CBT)****, which offers a range of evidence-based techniques designed to reduce anxiety and alleviate pathological fears. The objective is to help the student perceive the school environment as safe and non-threatening, thereby fostering a sense of acceptance and encouraging active participation in learning.*

The therapeutic approach incorporates methods such as behavioral modeling, acceptance strategies, attention modification, relaxation techniques, and structured homework assignments. These tools collectively support the student's psychological adjustment to the school setting and promote healthier interactions with peers both in the classroom and during other school activities.

***Keywords**: Cognitive Behavioral Therapy; School Phobia; School Absenteeism; School Avoidance; School Refusal.*

Phobie scolaire et approches cognitivo-comportementales

***Résumé** :*
La phobie scolaire est un type de trouble anxieux observé chez les élèves, caractérisé par des peurs excessives et irrationnelles associées au fait d'être à l'école. Cette intervention vise à traiter la phobie scolaire par l'application de la Thérapie Cognitive du Comportement (TCC), qui offre une gamme de techniques basées sur des preuves et conçues pour réduire l'anxiété et soulager les peurs pathologiques. L'objectif est d'aider l'élève à percevoir l'environnement scolaire comme sûr et non menaçant, ce qui favorise un sentiment d'acceptation et encourage une participation active à l'apprentissage. L'approche thérapeutique intègre des méthodes telles que la modélisation du comportement, les stratégies d'acceptation, la modification de l'attention, les techniques de relaxation et la structuration des devoirs. Ces outils soutiennent collectivement l'adaptation psychologique de l'élève à l'environnement scolaire et favorisent des interactions plus saines avec ses pairs, à la fois dans la salle de classe et pendant les autres activités scolaires.

***Mots-clés** : Thérapie cognitivo-comportementale ; phobie scolaire ; absentéisme scolaire ; évitement scolaire ; refus scolaire.*

Introduction:

School phobia (or *phobie scolaire* in French) is one of the common disorders that may affect children and hinder their adaptation to the school environment. In most cases, it leads to school avoidance and early dropout. In the absence of accurate statistics and serious management of such cases within Algerian schools, some studies (Tayeb et al., 1982) estimate that the proportion of children who experience fear of school ranges between 1% and 3% of the total student population. Other studies report five cases out of every 172 children. In France, one study showed that the prevalence of school phobia among enrolled students ranges from 1 to 5 out of every 100 pupils (Sérès, 2008).

Due to the lack of available school programs aimed at psychologically preparing students to accept the school environment, and the noticeable absence of efforts to make the school climate appealing and enjoyable, this disorder tends to remain both widespread and under recognized among educational professionals.

In recent years, school phobia has attracted increasing attention from scholars and researchers in the fields of mental health and psychology. Initially, this disorder encompassed a variety of clinical manifestations, such as separation anxiety, school refusal, unexplained absenteeism from kindergarten or school, and school truancy. However, the concept has since evolved into a more precisely defined clinical condition and has come to be recognized as a pathological phenomenon that warrants dedicated research and study (Hussein, 2014).

In its simplified form, school phobia is associated with irrational fears related to the school environment. Yet, from a deeper psychological perspective, it holds significant underlying meanings and appears in various forms, accompanied by a range of symptoms. Its causes differ from case to case and vary according to the explanatory theories applied.

By focusing on emotional problems and anxiety disorders characterized by an anxious structure, cognitive-behavioral therapy (CBT) offers an effective approach that can be applied to emerging cases of phobia, including school phobia. CBT is a form of psychotherapy that "includes therapeutic methods designed to modify behavior as well as procedures aimed at changing maladaptive beliefs" (Faleh, 2013, p. 116). Given the nature of therapeutic services it provides, its theoretical foundations, and the diverse techniques it employs, CBT appears to be the most suitable choice for constructing a treatment program aimed at alleviating school phobia among primary school students.

1. The Concept of School Phobia:

Like other types of fear, fear of school is considered a learned behavior acquired by the child through socialization processes such as overprotection, excessive pampering, family conflicts, and personal experiences within the school environment. As a result, a number of children and adolescents experience difficulties adjusting to the school setting, which manifest in school refusal or fear of attending school. In reality, fear of school is common among most children; it appears as a normal reaction in some cases, but in others it may be intense, persistent, and often complex. However, it generally does not correspond to a specific psychiatric disorder,

as it encompasses various fears, psychological disturbances, and personality issues.

School-related fear is one of the most widespread fears during middle childhood, a developmental stage characterized by a decline in physical fears related to bodily integrity. For instance, children's fears of illness, germs, and doctors diminish during this stage, as does their fear of dogs and darkness (Al-Asami, 2015).

This phenomenon was first described in 1932 by Broad win, who identified a pattern of school refusal and avoidance accompanied by anxiety. The term *school phobia* was later coined in 1941 by Johnson, Szureck, and Svendson (Reynolds & Fletcher-Janzen, 2007, p. 1797), who defined it based on the following features:

- Intense emotional reactions accompanied by symptoms such as excessive and unjustified fear, and complaints of fatigue or illness without an identifiable organic cause, which appear specifically when school attendance is anticipated.
- Staying at home during school hours, with parental awareness at some point during the course of the disorder.
- Absence of antisocial behaviors such as theft, lying, destructive acts, or deviant sexual behavior.

However, the term *school phobia* has not been universally accepted among researchers. Boyce (1975, p. 44) reported that in 1959, Wall Inger called for reconsidering the term *school phobia*, arguing it was a misnomer for a syndrome that in reality represented not fear of school per se, but rather fear of being separated from the mother. Miller (1961) and Clyne shared this view, suggesting that the issue warranted

further investigation. In 1965, Eysenck and Rachman proposed that the term *school phobia* should be reserved for cases involving primary anxiety about specific aspects of school, whereas *separation anxiety* should be used when the main issue is related to leaving the home. Similarly, Morgan (1959), Barker (1971), and Frommer (1972) favored the term *school refusal* over *school phobia*.

John Bowlby also moved away from the term *school phobia* (*la phobie scolaire*), preferring instead *separation anxiety* (*anxiété de séparation*), arguing that the condition reflects anxiety over separation and a near-phobic fear of losing the mother, rather than a true phobia of school. L.A. Hersov's introduction of the term *school refusal* in 1960 as a replacement for *school phobia* led to its gradual adoption in Anglo-Saxon countries, whereas Francophone countries have continued to describe intense school-related fear as *school phobia* (Lauriane, 2013, p. 12).

Kearney (2007, p. 453) noted that the interchangeable use of terms such as *school absenteeism*, *school refusal*, and *school phobia* in the educational literature leads to conceptual inconsistency and poses a real challenge for accurate terminology.

Francis Danvers (1994, p. 201) defines school phobia as "an irrational fear that causes the child to refuse to go to school, accompanied by marked anxiety or panic attacks when the child is forced to attend school." He further clarifies that the difference between school phobia and related concepts lies in the specific constellation of anxiety and refusal symptoms, which in some cases may escalate to aggression in adolescents when forced to return to school.

In general, most studies on school phobia—such as those by Kearney (2007), Hala Al-Jarwani and Nelly Al-Attar (2014), Rasha Hussein (2014), and Al-Asami (2015)—agree on three defining phenomena, provided that two behavioral symptoms are absent. The key emotional and behavioral features accompanying school phobia include:

- **Emotional and affective anxiety:** Children suffering from school phobia often experience general anxiety, particularly on the last day of the weekend, along with heightened emotional reactivity, mood swings, and episodes of crying. These emotional states peak just before school attendance but usually subside once the child is reassured that they will not have to go to school.
- **Avoidance and refusal behaviors:** The phobic child actively avoids school using various strategies, attempting to stay home. Their psychological state worsens when anticipating school attendance or while being at school.
- **Somatic complaints:** School phobia is frequently accompanied by numerous physical complaints such as fever, headaches, nausea, various bodily aches, and fatigue. These complaints may be fabricated to avoid school attendance or may be genuine, as noted by some scholars (Woolman, 2006), but they typically disappear once the possibility of attending school is removed.

Exempted from the behavioral and emotional problems of children with school phobia are the following:

- **Antisocial behaviors:** Acts such as theft, lying, aggression, and vandalism are generally seen in delin-

quent children or those with poor school or social adjustment. These children usually perform poorly in school, unlike children with school phobia, who often show average or above-average academic performance and generally do not struggle academically.

- **Truancy and street wandering:** Children with school phobia do not roam the streets when absent from school. Rather, they stay home or seek the company of their mothers. In contrast, truancy associated with street wandering—often without parental knowledge—is more typical of children who are chronically absent or who habitually runaway from school.

2. Definition of Cognitive Behavioral Therapy (CBT):

It may be more accurate to speak of *cognitive behavioral therapies* rather than a single unified approach, as multiple orientations fall under the general umbrella of CBT. What these orientations share is a set of core principles, chief among them being the notion that cognitive processes influence behavior, and that modifying these cognitive processes can lead to behavioral change (Faraj, 2008).

Cognitive Behavioral Therapy (CBT), known in French as *thérapie cognitivo-comportementale (TCC)* and in English by the acronym CBT, is, as the name implies, a combination of cognitive and behavioral therapy. It represents the integration of two psychological treatment modalities: behavioral therapy, which focuses on observable behavior and the stimulus-response relationship—often lacking attention to cognitive structures—and cognitive therapy, which emphasizes the influence of cognitive schemas on behavior.

Behavioral therapy is "a form of treatment aimed at achieving behavioral changes that enhance the individual's life and the lives of those around them. It is guided by scientific and experimental facts in the field of behavior" (Ibrahim, Al-Dakhil, & Ibrahim, 1990). In contrast, cognitive therapy emerged through its focus on cognitive schemas and their influence on emotion and behavior.

In his book *Cognitive Therapy of Depression*, Beck (1979, p. 3) defines cognitive therapy as "a time-limited, structured, and goal-oriented therapy used to treat various psychological disorders (e.g., depression, anxiety, phobias, etc.). It is based on a rational theoretical model which posits that individuals' emotions and behaviors are largely determined by how they perceive the world. These perceptions (verbal or imaginal events in the stream of consciousness) are rooted in underlying assumptions (schemas) developed from past experiences. For example, if someone interprets all experiences through the lens of competence and perfectionism, their cognitive schema may be dominated by the idea, 'I must do everything well, or I am a failure.' Consequently, they react to situations based on this belief, even if the situation is unrelated to their personal competence."

Thus, CBT can be viewed as a highly effective set of interventions that include assessment, planning, decision-making, and the application of diverse techniques. In CBT, the therapist plays an active, supportive role, employing a wide array of methods ranging from psychoeducation and guided discovery to role-playing and both in vivo and imaginal exposure. These interventions assist the client in addressing mal adaptive thought patterns and replacing them

with more rational and adaptive ways of thinking (Belhassini, 2011).

3. Theoretical Foundations of Cognitive Behavioral Therapy:

The foundational assumptions of CBT (Creen, Ruddle& Palmer, 2008, p. 30) can be summarized as follows:

- Thoughts can elicit emotions and behaviors.
- Emotional (affective) disturbances stem from distorted or negative thinking, which in turn leads to unhelpful emotions and behaviors.
- These emotional disturbances can be alleviated by altering thought patterns, which are considered learned and modifiable.

The cognitive behavioral model focuses on two types of thinking that are central to CBT: *automatic thoughts* and *underlying beliefs*. A third type—*intermediate beliefs*—helps shape and direct automatic thoughts. Below is a breakdown of each type and their influence on behavior:

- **Automatic Thoughts:** Coined by Beck, these refer to spontaneous thoughts and mental images that occur in voluntarily during the stream of consciousness. Related terms include "internalized statements," "self-statements," "things you tell yourself," and "self-talk" (Creen et al., 2008). Beck (Judith Beck, 2007, p. 125) describes them as "a stream of thoughts that exist a long side a more apparent stream of conscious thinking." These thoughts often biased and emotion ally charged, emerge during or following a triggering event.

- **Underlying Beliefs:** These are the assumptions and core beliefs that generate the content of automatic thoughts and images. In cognitive theory, these beliefs are closely related to *schemas*—abstract mental structures that function as frameworks for interpreting experiences and guiding action and problem-solving. Individuals develop a wide array of schemas starting in early childhood, and once established these schemas influence how one processes information, feels, behaves, and perceives oneself, others, and the world. They are hierarchically organized by importance and relevance, such as in cases of panic or fear in specific situations (Creen et al., 2008).

According to Beck (2010), cognitive schemas produce a range of beliefs that shape how individuals interpret their experiences. Through these schemas, individuals make sense of the world and their relationships from their own perspective. As such, schemas play a central role in the development of automatic thoughts, which are implicated in emotional disturbances and personality disorders.

- **Intermediate Beliefs:** Positioned between core beliefs and automatic thoughts, intermediate beliefs are composed of *attitudes*, *rules*, and *assumptions*. These guide behavior and cognition in context-dependent ways. The table below out lines their structure:

Table 1: Position of Intermediate Beliefs

Core Beliefs (Fundamental)	Intermediate Beliefs	Automatic Thoughts
Global	Attitudes	Stream of thoughts
Rigid	Rules / Expectations	Mental imagery
General	Assumptions	Words and statements

Creen et al., 2008, p. 32

3.1. The Cognitive Model of School Phobia:

The model proposed by Rapee and Heimberg (as cited in Al-Hariri, 2014) suggests that individuals with social anxiety disorder enter social situations holding distorted beliefs and maladaptive information-processing strategies to such an extent that the mere anticipation of a social situation is sufficient to trigger distorted thoughts and physiological arousal. Individuals with social phobia often ruminate on past social failures and anticipate future social embarrassment. They expect negative reactions in social settings and perceive the audience as a source of potential threat, imagining others as being critical, disapproving, and judgmental of their behavior.

Consequently, individuals with social anxiety divide their attention between monitoring the environment for signs of negative evaluation and self-monitoring their appearance and behaviors to detect perceived errors. Their cognitive focus also includes the social tasks and roles they are engaged in, which disrupts their performance and leads to heightened self-consciousness. As a result, they tend to ex-

aggerate the audience's performance standards and struggle to meet them.

In cases of *school phobia*, the child develops a set of negative attitudes specifically toward the school environment and attempts to escape any school-related social situation, often engaging in persistent efforts to avoid attending school. This complete refusal to attend may be accompanied by somatic complaints—real or imagined—such as pain or illness in certain parts of the body, without any clear medical cause. The child may attribute their school absenteeism to external factors, such as peer mistreatment, bullying after-school, or harsh teacher behavior, among other school- related grievances typically expressed by children with school phobia.

The primary goal of treatment for school phobiais to return the child to school as quickly as possible. Although some clinicians are skeptical about the notion of an immediate return (i.e., "soon") and advocate for initial psychological treatment to help the child uncover and analyze the roots of their anxiety before resuming school attendance, thereis-strongevidencesuggestingthatprolongedpsychologicaltreatmentoutside the school setting can reinforce school refusal behavior and delay therapeutic outcomes. It has been observed that treatment programs which help childrenunderstandtheirschool-relatedanxietywhilekeepingthemwithin the classroom setting are highly effective. Such programs have successfully facilitated the return of over 70% of school-phobic children to school within a period ranging from a few days to several months (Abdullah, 2006, pp. 247–249).

Wagner (2002) (as cited in Rasha Mahmoud Hussein, 2014) links specific cognitive patterns in children with school

phobia to various diagnostic categories or potential causes of school refusal behavior. These thoughts typically reflect underlying psychological issues or disorders, as summarized in the table below:

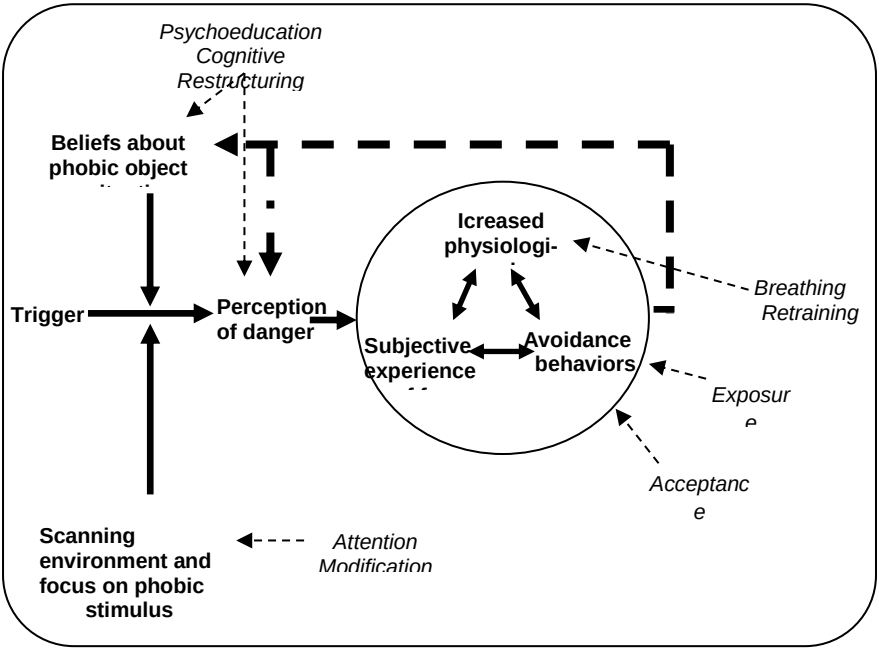
Table 2: Wagner's Model of Cognitions Associated with School Phobia

Psychological Issue	**Associated Thought**
SeparationAnxiety	*Something badwillhappen to mymomwhileI'm at school.*
GeneralizedAnxiety	*I willfail the spelling test.*
Obsessive-Compulsive Disorder	*I willget AIDS and die if myclassmatestouchmyschool supplies.*
Social Phobia	*No one will talk to me duringrecess.*
Panic Disorder	*I can'tcompete and I will die because no one can help me.*
Performance Anxiety	*I'msonervous I forgeteverything.*
Learning Difficulties	*Math istoo hard for me. I won'tanswerany question, no matterwhat.*
Medical Condition and Absenteeism	*I won't catch up withmyclassmates and willgetsick in class.*
Fear of Aggression	*Myclassmatesmock me on the school bus and tearmybackpack.*
Classroom Discipline	*The teacheralwaysverbally abuses me and makes me feelstupid.*

AdaptedfromRasha Mahmoud Hussein, 2014

Cognitive Behavioral Therapy (CBT) for school phobia is based on a set of interventions that focus primarily on the student's personal experience. These include restructuring maladaptive cognitive patterns (i.e., modifying dysfunctional beliefs), altering behavioral responses through behavioral activation and behavioral modification techniques—especially acceptance and exposure—and reducing physiological symptoms via breathing retraining and relaxation exercises.

Figure 01: Hoffman's Model of Cognitive Behavioral Therapy Strategies

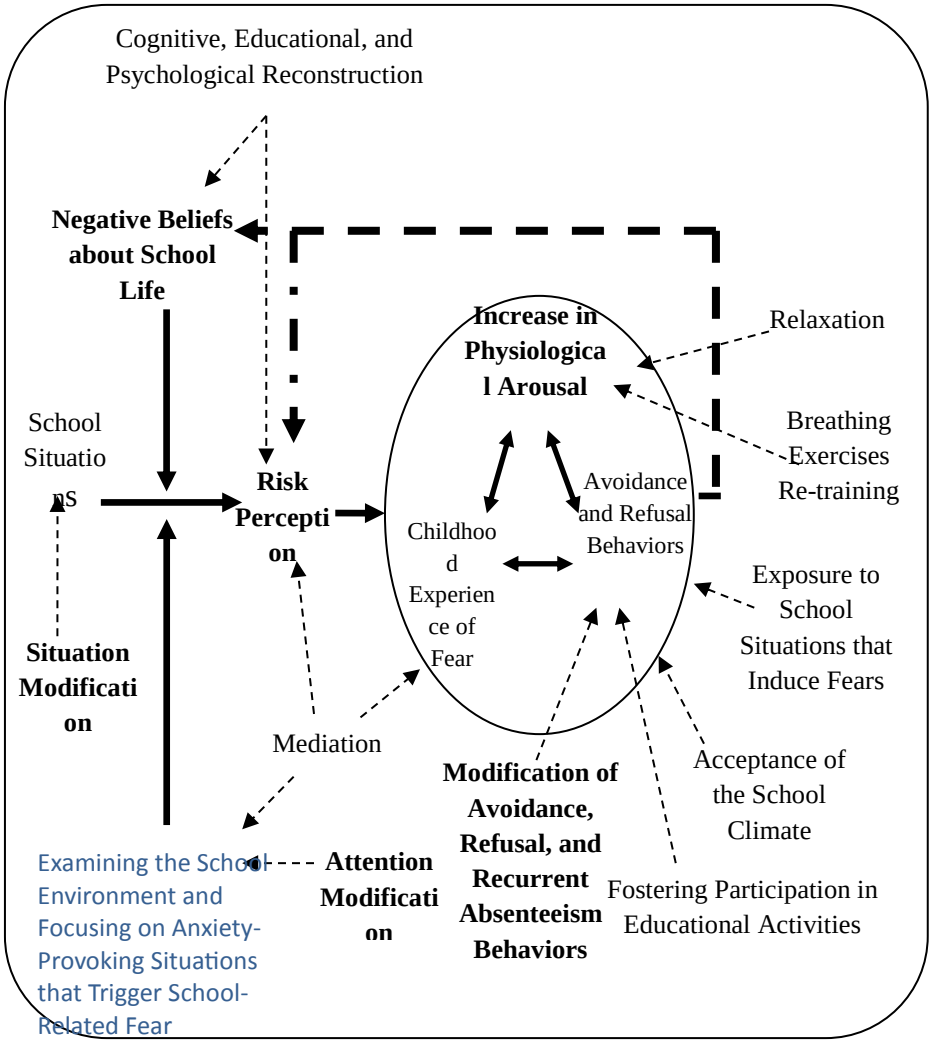


Hofmann, 2012, p. 51

According to Hofmann (2012), the strategies of Cognitive Behavioral Therapy (CBT) are based on a series of structured and clearly defined procedures aimed primarily at the cognitive restructuring of mental schemas. The process begins with attentional refocusing on the situation in order to modify the overall perception of the event or circumstance. This is followed by cognitive reappraisal, and subsequently, interventions targeting the behavioral response and the associated physiological manifestations.

In the case of children suffering from school-related phobia, this model offers a foundation for designing a set of rational steps consistent with the principles of CBT. The goal is to eliminate fears linked to the school environment by addressing the attentional processes the child engages in when faced with school-related situations. Through therapeutic mediation, the child is supported in constructing new, positive, and enjoyable personal experiences with these same situations. Maladaptive behavioral responses are modified through both imagined and real-life exposure to different school settings, while physiological regulation is achieved through continuous training in breathing and relaxation techniques. These interventions are designed to help the child confront fears without being overwhelmed by distressing physiological changes or intense emotional disturbances. These are sequential and synchronized steps that enable the child to regain proper control over their school experience. (*See Figure 02*)

Figure 02: CBT Strategies for Treating School Phobia (Researcher)



3.2. Psycho-educational Cognitive Restructuring:

School phobia is typically associated with a set of irrational beliefs about school life, often rooted in a single distressing school event that triggered fear and avoidance behaviors. This isolated incident is then generalized to the entire school environment, leading to the development of a network of fearful thoughts associated with school. The primary goal in treating such fears is to alter the cognitive schemas that perpetuate and intensify these distress sing thoughts whenever the child thinks about or is exposed to school-related stimuli.

A key therapeutic step is identifying the specific incident that led to the child's mal adaptive behaviors in the school setting. Changing these irrational beliefs involves redefining core concepts related to the school environment. Socratic dialogue with the child plays a crucial role in guiding them to realize that the school is, in fact, a safe place for them—as itis for many of their peers of the same age and background. The school may also be reframed as an enjoyable setting where engaging and pleasant activities take place.

Some of the child's negative beliefs—such as the expectation of being beaten or humiliated by peers, teachers, or administrators—can be challenged through carefully structured therapeutic interventions. These may include supportive statements from school staff, such as the principal or teacher, provided in a way that respects the therapeutic process and does not interfere with treatment sessions. These testimonial scan help change negative perceptions and create a supportive and accepting environment around the child.

Additional therapeutic and educational interventions may take the form of structured homework assignments, such as reading an illustrated story title d"*I Love My School*". The story could be designed to incorporate common school-related fears and narrated from the perspective of a protagonist who is the same age and grade level as the child. This narrative method facilitates identification with the character and encourages the child to discuss and rationalize their automatic thoughts. The story is then discussed in therapy using Socratic questioning to promote a shift in the child's negative beliefs about school.

4 Theoretical Foundations of a Proposed Program for Reducing School Phobia

4.1. Behavioral Attention Modification:

Pathological fear of school life is often linked to an initial stage in which a threatening stimulus is registered, leading to the automatic and rapid orientation of attention toward threat-related information. "Although this process is evolutionarily adaptive, it becomes problematic when it results in hypervigilance" (Hofmann, 2012, p. 76). This, in turn, increases anxiety symptoms and physiological changes that cause significant distress for the child throughout their time at school.

Therefore, the initial steps of Cognitive Behavioral Therapy (CBT) often involve redirecting attention to stimuli that are not associated with fear or anxiety. Children with school phobia tend to engage in selective attention toward specific stimuli, such as the principal's standing position, the visible ruler in the teacher's bag, the way the school janitor looks at them, or the body language of students in the courtyard—

interpreting these cues as hostile and personally directed. These perceptions reinforce the belief that school is a prison-like environment filled with unending suffering.

Therapeutic interventions may involve redirecting the child's attention to more pleasant and comforting aspects of the school environment. For instance, the child may be tasked with giving a flower to the school janitor and the principal at the beginning of the school day and encouraged to notice the smile that results. Another strategy could involve having the child plant a small flower in a pot placed near the school entrance, allowing them to focus on it each time they enter the school.

4.2. Relaxation and Breathing Retraining:

Pathological fears of school life often trigger panic and anxiety, especially in response to anxiety-inducing situations such as raising the national flag during morning assembly, being called on by a teacher during class, or writing on the board. These scenarios heighten the child's perception of being judged and scrutinized.

To address this, such situations can be reintroduced in imagination during therapy, and through suggestion techniques, the child can be taught to regulate their breathing and induce a state of relaxation. The goal is to reframe the mental representation of these situations so they are no longer perceived as threatening or anxiety-provoking.

4.3. Exposure:

Before implementing exposure therapy, itis essential to identify the specific school-related situations that most intensely trigger anxiety and panic. From a behavioral per-

spective, school phobia is considered a learned adaptive response that is conditionally linked to fear of maternal separation. A neutral stimulus such as the school environment becomes verbally associated with thoughts related to maternal loss (Ghayat, 2012, p. 44).

Thus, a list of school-related fear-inducing situations can be presented to the student, who is then asked to rate their fear intensity for each situation on a scale from 0 to 10. The situations are ranked from least to most fear-inducing. Exposure then occurs progressively in agreement with the teacher and the child's parent.

Each anxiety-inducing situation canebrake down into smaller, preparatory steps. For example, exposure might begin with the least threatening scenario—such as speaking privately with the school janitor or principal as a homework assignment—followed by raising the flag, participating in a classroom activity, writing on the board, and eventually delivering a speech during morning assembly.

It is not easy for a child with school phobia to voluntarily participate in such activities without resistance. Therefore, peer participation may foster a sense of competition and motivation. The child could also be assigned a leadership role in a school club under the supervision of a teacher or school staff member. Additionally, schools may find more acceptable formats for integrating therapeutic activities into the regular school routine, allowing the child to engage in them as part of their normal educational experience.

4.4. Acceptance:

One of the key goals of CBT in cases of school phobia is to help the child develop acceptance of school life and to en-

gage with it in a natural and comfortable manner, rather than continually experiencing fear, anxiety, and irrational thoughts.

Treatment sessions should conclude with an assessment of the child's acceptance of the school environment and the degree of progress made during their participation in school activities. Behavioral changes should be observable to both parents and teachers—for example, the student might begin arriving at school early, enthusiastically participate in class, compete to write on the board, or join educational clubs.

Even if the therapist only observes a reduction in absenteeism, resolution of attendance-related issues, and improvements in academic performance, these are considered positive treatment outcomes.

Conclusion:

CBT aims to modify maladaptive behaviors associated with school-related anxiety and adjustment difficulties. It relies on a variety of techniques, all rooted in restructuring dysfunctional cognitive schemas and correcting incompatible behaviors. Like other psychotherapeutic approaches, CBT is carried out through structured, goal-directed sessions where the client's active effort to change their own reality is central. The therapist's role is to foster a collaborative relationship and carefully plan the intervention.

Using specific techniques, CBT helps the client gain insight into their thoughts and behaviors while reducing emotional reactivity to everyday life situations. The goal is to create new, positive experiences that allow the individual to

engage in healthier, more adaptive life contexts—moving beyond rigid behavioral patterns and negative thoughts that have hindered heir psychological and social development. In this way, therapy becomes an opportunity for the client to recognize ineffective coping strategies and to develop more effective mechanisms for adapting to their environment.

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