
References

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SCHOOL PHOBIA: HOW HOME-SCHOOL COLLABORATION CAN TAME THIS FRIGHTFUL DRAGON

Children, adolescents, and their parents experience considerable suffering and educational loss from school phobia, a disorder that school counselors encounter occasionally during their professional careers. School phobia is a devastating cause of school failure and involuntary dropout. Treatment is generally believed to be difficult, and success, regardless of efforts by all parties, is not guaranteed. Common sense recommendations suggest that school phobia is a mental health emergency. Expert advice can take the following form:

Get the child back into class quickly and use whatever means available, including force. The child has too much control and the skewed power imbalance must be reduced. The source of the problem is probably the parents. Separating the child from the pathological mother-child relationship is essential to the resolution of this disorder.

Frequently, when a quick resolution is not forthcoming, referral to residential treatment seems the best alternative to a deteriorating situation. Unfortunately, these commonsense approaches serve to aggravate rather than resolve school phobia. The disorder is contagious. A well-organized, competent school with a humane approach may be thrown into an uproar when counselors, administrators, teachers, and parents struggle for a solution.

School phobia leaves everyone perplexed. Families seem to be working against the school, and schools against the family. Parents, particularly mothers, seem to overprotect the children and resist reasonable school and counselor-initiated efforts to resolve the disorder. An observer from outside the school and the family system might see mutual frustration, escalation of symptoms, and polarization or taking sides on who is right and who is wrong. The splits between involved parties--the school, the family, the child and perhaps a community psychotherapist--presage irreconcilable differences. These differences may doom a child to a

fragmented school career and eventually to dropping out of school entirely (Flakierska, Klein & Last, 1989; Lindstrom & Gillberg, 1988; Ono, 1972). However, the potential loss is preventable, using a counselor-led team approach that trusts all concerned--the child, the school and the family--to find a solution that works.

A review of contemporary perspectives on children's anxiety disorders suggests that clinicians and researchers do not speak in the unified voice that school counselors, teachers, and administrators may assume to exist. In reality, there is little agreement in these expert groups on the definition of school phobia, its source, or its treatment. The position presented in this article is systemic, that is, it includes the perspectives of all parties. It also suggests cognitive-behavioral interventions that have found considerable success in the adult population experiencing anxiety disorders. The fundamental argument presented here is that the resistance to treatment seen in school phobia is, in part, the product of the escalation of differences in the home--school system (Edwards & Foster, 1995), growing demoralization, and misconceptions of the nature of the disorder. I argue for home-school collaboration, education, patience and the use of successful treatment plans for anxious adults. Finally, it is the school counselor who can take the lead in developing a supportive team with a systematic, school-based solution to school phobia.

DEFINITIONS AND DEMOGRAPHICS OF SCHOOL PHOBIA

School refusal is a general term that applies to all children who reject school, a minority of whom have school phobia. When a child is frequently absent from school, personnel become concerned. The first step in addressing the attendance problem is to learn its source. School attendance disorders may be defined as "internalizing" or "externalizing." Those disorders that are externalizing refer to truancy--willful absence from school, usually for the purpose of engaging in alternative activities with peers. These children often exhibit antisocial behavior when attending school (Hersov, 1990). Internalizing disorders are principally indicative of school phobia--the child desperately wants to attend school but is unable to. Historically, until the onset of the disorder, these children are average to excellent students and have rarely presented serious classroom management problems. Ninety percent of attendance disorders are externalizing in nature, the remaining 10% are internalizing in nature (Hersov, 1990). The focus of this article is on the latter group, those whose longing to attend school is somehow not accomplished.

Many authors point to age-based peaks in internalizing difficulties with school attendance (Hersov, 1990; Rutter, Graham, Chadwick, & Yule, 1976). One peak in school refusal consists of those who refuse school at entry, young children, ages 5 to 7 years. This difficulty seems to be transitory and is based on normal to exaggerated, but temporary, separation issues (Rutter et al., 1976). The second age-based peak has a sudden onset in the later elementary to middle school years and is the concern of this article. A smaller, older third group is those whose attendance has historically been poor The poor attendance escalates during the high school years, relative to possible incipient mental disorders. Alternatively, some authors conceptualize attendance disorders as acute and chronic. The acute type corresponds to the second peak described above during the years between 9 and 14. The chronic type has a slow onset, no evident precipitating event, years of poor school performance, and long-term family issues (Kennedy, 1965; Paccione-Dyszlewski & Contessa-Kislus, 1987).

The focus here is school phobia of the acute type: sudden onset in a child with a recent history of loss or serious illness who was previously doing well in school. Frequently, there is a concurrent depression and growing isolation including evidence of parental distress over this change in the child's attitude toward school.

An estimate of the prevalence of school phobia depends on how it is defined, and its definition continues to be a topic of discussion. It may be surprising to note that school phobia does not occur as a Diagnostic and Statistical Manual (DSM) diagnostic category (Young, Brasic, Kisnadwala, & Leven, 1990). There is also variability in its incidence across cultures. School refusal behaviors are estimated to occur in 31% to 52% of middle school children in Japan (Honjo et al., 1987). This high level of absenteeism is thought to be related to the extraordinary pressure on academic performance in this age group in Japan. In this country, 17% of adolescents are estimated to have anxiety disorders, a level similar to that reported in adults (Kashani & Orvaschel, 1988). Various authors estimate the prevalence of acute school phobia to be about 1 in 100 to 2 in 1,000 at a given point in time (Young, Chiland, & Kaplan, 1990). In a middle school of 500 students, one may expect to find at least one and possibly five young adolescents with the disorder Though this may be a small number, the potentially devastating effects of the disorder argue for its thorough understanding and systematic management. Taylor and Adelman (1990) estimated that one quarter of mental health referrals in the Los Angeles public schools are based on school avoidance behaviors, an indication of the importance of treating the disorder.

THE ETIOLOGY OF SCHOOL PHOBIA

Freud proposed a psychoanalytic perspective for childhood neuroses based on separation anxiety experienced in the presence of threatened loss of a loved object. The threat results in destructive rage toward the love object, and the consequent anxiety regarding one's own destruction by the now angry loved object--the repressed hostility concept (Lebovici, 1990). Other explanations include developmental shifts in congitive development, learned behavior (modeling), helplessness in the face of danger, cognitive mistakes, and preexisting high levels of circulating epinephrine and nonepinephrine resulting in an over-active nervous system. Authors from varying theoretical perspectives believe that the roots of anxiety disorders, whether in childhood, adolescence, or adulthood, lie in the threatened or actual loss of an attachment object (Baker, 1989; Bowlby, 1973; Hersov, 1990; Phelps, Cox, & Bajorek, 1992). Prior to the onset of symptoms of adult panic disorder, school phobia, and adult agoraphobia, sufferers report a significant loss (Hersov, 1990; Von Korff & Eaton, 1989), such as the death or catastrophic illness of a loved one, a divorce, geographic relocation or other major threat to the sufferer's sense of security, including the sufferer's own illness or hospitalization. Some authors suggest the initial trauma may even occur at school (King & Ollendick, 1989) or is school-induced (Knox, 1989; Pilkington & Piersel, 1991). Schools are not necessarily safe, nor are all schools perceived by students as safe places (Young, Chiland, et al., 1990). It cannot be assumed that children have nothing to fear.

The following discussion of the etiology of school phobia presents a position inspired by the more extensive work on adult panic disorder Adults with anxiety disorders report their first experience of anxiety at an average age of 15 (Margraf & Ehlers, 1989), suggesting that child and adult anxiety disorders are not distinctly different conditions. The adult model serves the understanding and treatment of school phobia very well. In individuals vulnerable to anxiety

disorders, the initial loss event or external stressor is followed within a short period (though it may be up to several months) by an experience of intense anxiety. Durham (1989) provided an excellent description of the cycle of a panic attack:

The initial episode of panic is precipitated in vulnerable individuals by either psychosocial or physical stresses of an acute or chronic kind. The vulnerabilities on which life stresses impinge may be of a cognitive nature in terms of dysfunctional beliefs, a biological nature such as a labile autonomic nervous system, or some combination of the two ... the essential vulnerability in people who are prone to panic attacks is an extreme sensitivity to internal sensations that do not seem to be normal ... when a pathological explanation for these abnormal sensations seems very plausible (for example, a sign of impending death, insanity, of loss of control), and when a non-pathological explanation is unavailable, the focus of attention of such patients becomes fixated on these internal sensations ... this fixation of attention then enhances the patient's sense of imminent danger resulting in an increased activation of the autonomic nervous system ... a vicious cycle then develops between the patient's catastrophic interpretations and the consequent intensification of anxiety-related symptoms. (p. 263)

Loss events are part of living, but not everyone experiences anxiety disorders. A segment of the population may be genetically vulnerable to react to stress through the experience of various anxious states. Anxiety disorders tend to cluster in families. First order relatives of those with anxiety disorders have a higher-than-average rate of anxiety and depressive disorders (Hersov, 1990; Last, Hersen, Kazdin, Francis, & Grubb 1987). In addition, approximately one third to one half of children or adolescents with a diagnosed anxiety disorder, including school phobia, also have a concurrent or preexisting diagnosis of depression (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987; Paccione-Dyszlewski & Contessa-Kislus, 1987). Some authors have suggested that as many as 80% of school phobic children are clinically depressed (Berstein & Garfinkel, 1986; Kearney, 1993), raising the possibility that school phobia is actually masked depression. However, the direction of this correlation is not known. It is equally possible that having school phobia causes depression, or contributes to its maintenance or escalation. Regarding other characteristics, Cloninger (1987) noted that school-phobic children and adolescents seem hypervigilant, as though they have an overactive danger alarm system. This quality of hypersensitivity may predate the onset of school phobia and is noted in early childhood. This may correspond to the sensitive personality described by Kramer (1993) and Lebovici (1990).

In summary, the onset of panic disorder consists of three coexisting conditions: a genetically vulnerable predisposition; a recent, threatening loss event; and an internal, physical experience then catastrophized by the experiencing individual. The maintenance of the disorder, referred to by some as secondary anxiety and avoidance, consists of behaviors that the sufferer hopes will preclude another distressing event. These avoidance behaviors are accompanied by intense monitoring of internal physical sensations that the sufferer believes herald the onset of another attack. Central to the experience of panic is the sufferer's belief that physical symptoms are specific indicators of extreme danger and eminent catastrophe (Argyle, 1988). Physiological measurements of individuals experiencing panic attacks reveal that the physical symptoms (increased heart rate, increases in blood pressure, and rapid breathing) are real (Margraf & Ehlers, 1989). The fact that the individual attaches the interpretation of extreme peril to these physiological events is what distinguishes the experience of panic.

After the initial attack, individuals seek to control panic by increasing safety factors: having an escape strategy, avoiding the location in which the attack occurred, distracting themselves by engaging in compulsive activity, seeking the company of friends or family, and using alcohol or other drugs. These coping strategies prevent correction of the original mistaken cognition that the physical sensations signal extreme danger, and thus the disorder becomes self-maintaining (McFayden, 1989). Should another panic attack occur, this is taken as evidence that the sufferer must apply coping strategies more rigorously. Not only is panic disorder self-maintaining, it is self-escalating.

ADULT MENTAL HEALTH IMPLICATIONS OF SCHOOL PHOBIA

School counselors may have heard not only that school phobia is an emergency but also that the long-term outcomes are poor. As is often the case with outcome research on clinical syndromes, methodological concerns limit usefulness. Early work consisted of outcome studies of inpatient treatment for school phobia. Results were not good. After treatment, 50% of adolescents continued to have serious difficulties with school attendance and 70% had continuing evidence of mental disorder (Berg, Butler, & Hall, 1976). In-patients may have had more serious pre-phobic difficulties than the average child with school phobia and perhaps may have had more disturbed family situations. The effects of hospitalization and separation from attachment figures on a disorder whose origin includes attachment and security concerns may have affected these findings and is impossible to assess in the absence of alternative-treatment or no-treatment control groups.

Studies of outpatient treatment have been more encouraging. Flakierska et al. (1988), in a 15 to 20 year follow-up of adults who had school phobia, found that these individuals were indistinguishable from controls, with the exception that they used outpatient mental health services more frequently. In a study of 54 individuals who had school phobia during their youth, Klein and Last (1989) found that school phobics had an increased rate of agoraphobia (7%), but less clinical evidence of depression compared with a control group of 60 with no history of childhood mental disorders. This is interesting in view of the frequency of a dual diagnosis of depression and school phobia. In a study with a sample size of 264, researchers found that school phobia predicted a slightly increased risk of agoraphobia but did not increase the risk of other mental disorders in adulthood (Perugi et al., 1988). In summary, school phobia is slightly predictive of adult agoraphobia but is apparently not predictive of other mental disorders in adulthood. In general, anxiety disorders are less stable across the life span than other mental disorders. Anxious children have a high rate of recovery (Cantwell & Baker, 1989).

COMMON TREATMENT RECOMMENDATIONS FOR SCHOOL PHOBIA

Although there is growing agreement on treatment regarding adult anxiety disorders, clinical opinion is unclear for childhood anxiety disorders in general and for school phobia in particular. Treatment recommendations are diverse: treat the mother (Estes, Haylett, & Johnson, 1956); treat the whole system and relieve pressure on school attendance as the focus of attention (Talbot, 1957); gradually introduce the feared situation (Talbot, 1957); develop a behavioral contract (Mansdorf & Lukens, 1987); immediately use force to compel a return to school (Klein, 1945); set up a program of systematic desensitization (Eysneck & Rachman, 1965); work primarily with the mother's anxiety (Hersov, 1990); treat the family (Mansdorf & Lukens, 1987); rely initially on medication (Gittelman-Klein & Klein, 1980); medication is of no use in the treatment of school phobia (Berney et al., 1981); provide residential treatment (Hersov, 1985);

remove the child from school and provide home tutoring (Knox, 1989); and formally arrest for truancy (Knox, 1989). This list indicates a lack of treatment consensus, and dispute occurs in the following areas: the use or non-use of drugs; the physical location of treatment--residential or otherwise; the nature of the disorder--whether individual or systemic, interpersonal or intra-psychic; immediate or gradual return to the feared situation; and treat the symptoms or treat underlying issues.

Based on the adult and child literature, I argue here that (a) treatment is best conducted in vivo, that is, in the setting in which the distress initially occurred; (b) gradual reintroduction of the feared situation under the general control of the school phobic student is most effective; (c) although the whole system (school, family, community) may not be in treatment, it must be in communication and in agreement regarding treatment procedures; (d) although underlying issues may exist, the first and most important step in treatment is to resolve the school phobic behavior; and (e) except in cases of additional diagnoses, medication is questionable.

TREATMENT IN THE SCHOOL SETTING THROUGH HOME-SCHOOL COLLABORATION

The Subjective Experience of Intense Anxiety

School phobia has been thought to be intrapsychic and primarily related to pathological family interactions. In a previous section, I have argued that school phobia is a self-maintaining system based on genetic predisposition, a recent event that threatens the security system of the individual, and internal physiological hyper-reactivity interpreted by the sufferer as heralding catastrophe. Prominent among the cognitions of the afflicted person is a sense of being overwhelmed and unable to control one's reactions in the presence of a major life threat, particularly a threat to beloved others (Hussain & Kashani, 1992). In young children, the anxiety tends to be focused on explicitly separation-related concerns. In older children and adolescents, this concern shifts to generalized panic, without conscious reference to concern for the other, but with a focus on the behavior of the self during a panic episode (Kashani, Orvaschel, & Rosenberg, 1989). There is a sense of the body being out of one's control. Those afflicted experience faintness, heart palpitations, shortness of breath, dizziness, nausea, loss of control, a desperate need to escape, and a sense of impending doom that includes the belief that one is about to die or go insane.

Those readers who have not experienced a panic attack may be able to get a sense of this experience by recalling an event of claustrophobia in which escape was not possible, such as in a stalled elevator, or perhaps a childhood experience of being locked into a closet by a sibling or playmate. The inability to take charge of or change the unwanted situation is what is alarming to the sufferer, creating a growing sense of overwhelming anxiety. What is important to understand as the school counselor assists in the resolution of school phobia is that, although the student must eventually overcome the symptoms, he or she is not willfully misbehaving. The terror and sense of losing control, along with the physiological changes in the body are genuine.

School and Family Efforts to Resolve School Phobia

Regrettably, efforts made by the student, parents, and school personnel to resolve school phobia frequently serve to make it worse. Lebovici (1990) noted that

The presence of the phobia and the inability to go to school and/or stay there clashes head-on

with adult common sense ... and this clash provokes violent reactions that can only serve to reinforce the symptom and the school refusal it entails. (p. 187)

The more distressed the child, the more all parties redouble their efforts to manage the problem. The child is likely to experience escalated management efforts as loss of control, the one thing most feared by those with anxiety disorders, whether a child, an adolescent, or an adult. It is a common observation of adults working with a school-phobic child that he or she has too much control. This can be seen as the child's reaction to the subjective experience of having no control at all, and to the threat that what little he or she has will be taken away without consent, paradoxically intensifying the sense of powerlessness and thus the phobic response.

In contrast, adult treatment models ensure that the person afflicted has control over therapy decisions. The mental health professional acts as an educator and a coach. This approach is useful in the treatment of children with school phobia as well. The growing evidence that cognitive therapies are effective for adult anxiety disorders suggests their application to school phobia. However, punishment, banishment from school, blaming the family, and referral to outside experts remain common. Blagg and Yule (1984) reported a 93% success rate in school-based cognitive behavioral treatment, as compared with the 37% success rate in hospitalization and 10% success rate in home tutoring alone. Mansdorf and Lukens (1987) reported almost 100% success with a cognitive-behavioral contract that also addresses common issues such as the demoralization and hopelessness that maintain the problem.

Unfortunately, students and their families struggling with school phobia come to the attention of school personnel late in the escalating cycle. Frequently, a profound sense of shame surrounds school phobia. It is inexplicable, especially to the school-phobic student. Past professional explanations have pathologized both the child and the family, particularly the mother-child relationship, ordinarily a source of strength under stress. However, what we see in school phobia is the nature of the parent-child bond when the child is perceived to be threatened. from the outside, although the child's behavior may seem to be willful disobedience, the child is deeply in the vise of school phobia and profoundly confused by his or her behavior Some feel so hopeless, they make threats of suicide (King & Ollendick, 1989). These threats are commonly interpreted as manipulative, but the child is making a statement of demoralization relative to the disorder. It is not that he or she wants to die, but that he or she does not wish to live forever like this. Suicide threats are a measure of distress, not only in the child, but in the child's interpersonal context. With each failure at mastery and control, demoralization deepens, eventually affecting those around the child. Adult exasperation and impatience are common, further pushing the child or adolescent into profound despair.

A MODEL FOR HOME-SCHOOL COLLABORATION IN RESOLVING SCHOOL PHOBIA

An organized school-based response has considerable power to reverse the downward spiral of school phobia. A list of management techniques that have much potential to turn the spiral from down to top is provided. In addition, the multiple perspectives of teachers, parents, and student must be solicited to ensure a coordinated, planned response to the problem (Taylor & Adelman, 1990). The school counselor can provide the necessary leadership.

Specific Suggestions for the School Counselor

Depathologize the situation. School phobia seems bizarre from the outside, but it is manageable, especially if it is seen as solvable and ordinary. Resist attempts by others to see the disorder as terribly serious and lifelong.

Maintain a non-anxious presence. Listen. (Edwards & Foster, 1995). You may wish to teach the student relaxation techniques (Brulle, McIntyre, & Mills, 1985). This may help you relax as well and assist to create a bond with the student that is pressure free.

Expect an initial negative attitude from the student. The student with school phobia is unlikely to approach its planned resolution positively. The student may be hostile and must come to see the school as supportive and helpful.

Be patient and be willing to allow the disorder time to resolve. Adult studies suggest that anxiety disorders may conclude after active treatment for several months or longer (Durham, 1989; Hussain & Kashani, 1992; McFayden, 1989; Rapee & Barlow, 1989).

Believe that the school is the best place to resolve school phobia. Resist suggestions that residential treatment or non-school-based treatment by an outside professional is best. Encourage the family to hire a knowledgeable mental health consultant only when this person is known to work well as a school team member.

Actively address efforts to construe school phobia as a discipline problem. It is a mental disorder that limits the child's access to an education. It may require accommodations, such as seating the child near the classroom door, allowing the child to exit to certain agreed-upon locations on school grounds or to return home on especially difficult days. School phobia is a condition affecting the child's access to an equal education. Because of federal mandates regarding equal access to education, districts or schools will have a person whose assignment includes ensuring such access, sometimes called the "504 coordinator," though other terms may be used. The school counselor may wish to consult with this person regarding reasonable accommodations for the school-phobic student.

Temporarily suspend a focus on the child's immediate academic progress. With the long-term goal of school attendance paramount, curriculum-based education may become secondary. Some teachers will require explanation and support because this asks them to put their usual priorities in second place with this particular student.

Remember that children and adolescents with school phobia are humiliated by their disorder and are quite self-conscious. Assist school personnel to understand that calling attention to the student, even by welcoming him or her into the classroom, may focus unwanted attention. Ask the student about greetings and invitations to come to class.

Remember that students with school phobia desperately want to attend school. They are known to bargain with God, willing to give up every possession they hold dear for one day of feeling normal and attending school. Whatever is suggested by their overt behavior, align yourself with their inner wishes.

Make the parent(s) a genuine part of the planning team. They will have a different perspective, but it must be respected and included. The parents did not cause the child to have panic

disorder, although once it is present, all those involved with the student must look at how they may be contributing to maintaining the problem.

Before a plan is developed, have one or several meetings with all concerned. This is a collaborative effort. The child's abilities set the pace, and until the child has some sustained success with school attendance, the pace will be slow. Be sure the child has a sense of control and reward accomplishments, however tentative and gradual. During meetings, you are the coach and provider of information. The student may feel overwhelmed by the large number of concerned, assembled adults. Allowing the child to decide who sits where may convey the message that the group is truly collaborative. It may be necessary to have meetings before or after school when the student will have less difficulty entering the school building.

Avoid being drawn into conflicted triangles and coalitions. One goal of the team is to avoid polarization and good-bad splits. The school counselor is a model here.

Take charge of educating classroom teachers and building administrators. Because this is your area of expertise, other school personnel need access to your knowledge and skills.

Be sure that students remain in contact with friends. Isolation is a sure way to exacerbate school phobia. This may mean allowing a child who is not attending, or not fully attending, school to participate in school sports and other activities. Resist the temptation to withhold these social contacts pending resolution of school phobia. This may violate school policy, so the school counselor should address concerns about special treatment.

Keep track of progress made, or have the child do this. It is easy to miss the small steps that indicate substantial progress.

Develop graduated steps for return (exposure) to school. Overwhelming (flooding) the student is not justified (Strauss, 1990). Step one may be driving by without entering the building. Step two may be entering the building when school is not in session and when accompanied by the parent(s). Step three may be entering the building without the parent late in the day, to stay only as long as is comfortable. Step four may be entering the building early in the morning staying only as long as is comfortable. Step five may be attending one class, identified by the child as the easiest class to attend. Active classes such as art or physical education are easiest because activity distracts the student from the physical symptoms of anxiety. Each step works up to full-day attendance at the child's pace. Make sure the child has assisted in drawing up the program and allow him or her to remain at each step as long as desired. Paradoxically, encouraging the child to go slowly may inspire the child to escalate the pace, once trust is established.

If and when relapse occurs, keep faith so that the child does not lose his or hers. This is exactly when your coaching duties will get intense. Be there. Expect relapse on Mondays, after the child has been ill, after vacations, or during schedule changes. Interpret relapses as temporary setbacks. "Depathologize" them.

If there is a change in the school schedule, give the child warning. You may wish to put the parent or child in charge of keeping track of events through telephone contact with the building secretary. Students just recovering from school phobia or who are attending partial days may

have trouble with field trips. Keep the child informed about these events and respect his or her decisions.

If you see evidence of disagreements, however slight, between home, school, and others, consult with the individuals involved to be sure you have the correct information. If necessary, get the team together to resolve these disagreements. Incipient disagreements pop up and blindside weeks of effort.

Remember that school personnel may need coaching and encouragement along the way. The plan to assist the child's reentry into school and eventually to full-day attendance may require substantial alterations in how the school does business. It is normal for teachers and administrators to feel uncomfortable with a process that is new and unusual. Ask the family's permission to provide information on the treatment plan to clerical and other school staff.

SUMMARY

Research on resolving anxiety disorders demonstrates that graduated in vivo exposure eliminates the mistaken beliefs of catastrophe so regularly a part of panic disorder and school phobia. Based on this understanding, the school is the best place for the resolution of school phobia. The school counselor serves as the child/ home/school/community team manager and coach, making sure that the child has a sense of control over the planned resolution of the school phobia. The school counselor educates the child, the family, and school personnel, depathologizing the disorder, offering hope and conviction that school phobia can be overcome. The school counselor joins with the intention of the child whose deepest wish is to be normal and attend school without anxiety just as his or her friends and siblings do. By organizing and leading the team, the school counselor assists in forming a school-based container from which recovery can emerge. What one person cannot do alone, collective purpose can accomplish. As one commentator has noted, in the case of school refusal heterogeneity rather than homogeneity prevails; that is, the symptoms and resolution of the disorder are diverse and perplexing (King & Ollendick, 1989). The fact that there is no single path to success opens the way to creative, collaborative problem solving. The need to develop an approach that is comprehensive, flexible, and team-based is evident. Change and accommodation in the school will probably be necessary for these students (Blagg, 1987). The school counselor can provide the necessary leadership, coaching, and team building for success.

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