School-based family counseling practices: A national survey of school counselors, school psychologists, and school social workers

Karen Y. Whitmore
William & Mary - School of Education

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SCHOOL-BASED FAMILY COUNSELING PRACTICES:
A NATIONAL SURVEY OF SCHOOL COUNSELORS,
SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS

A Dissertation

Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Karen Y. Whitmore
February 2004
SCHOOL-BASED FAMILY COUNSELING PRACTICES:
A NATIONAL SURVEY OF SCHOOL COUNSELORS,
SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS

by

Karen Y. Whitmore

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Acknowledgements

Upon entering the doctoral program in counselor education, my worldview was expanded. As a result of being introduced to family systems and ecological theories and training, my paradigm shifted from that of a more traditional linear, cause and effect perspective to a more global systems perspective. The epiphany that resulted is best summed up by a quote from Oliver Wendell Holmes: “Man’s mind, once stretched by a new idea, never regains its original dimensions.”

I wish to acknowledge the following people who in their own special ways brought me through this enlightening and rewarding, but sometimes painful growth experience. First, I thank Dr. Victoria Foster, director of the counselor education program, my advisor, and committee chairperson, for providing immersion into the necessary learning experiences to make possible my worldview transformation. In addition, her knowledge of family systems counseling, ability to lead, and steadfastness helped ensure my educational goals were met from beginning to end. I would also like to thank Dr. Thomas Ward, who from the very first research and statistics class, made this subject interesting, understandable, and relevant. He gave me assurance in his own subtle way that I could undertake this research project and maneuver through its many challenges. I am thankful, too, for Dr. Lynn Pelco’s scholastic and painstaking review of my writings from beginning to end. She provided the oversight guidance (which was referred to as “the helicopter approach”) through this sometimes “feeling lost in the forest” process. And finally, because of Dr. Norma Day-Vines’ contributions and
influence in the world of school counseling, I was able to more easily obtain needed materials and information for this project.

I wish to express gratitude to Dr. Denyse Doerries for her inspiration, who because of her progressive thinking about interventions, showed that school-based family counseling could be done effectively by school psychologists, school counselors, and school social workers. As one of my motivators to enter the doctoral program, Dr. Doerries was a faithful mentor throughout this long and arduous process.

Finally, I would like to publicly thank my husband, Collins, who through his devotion and unremitting encouragement helped me believe in my abilities to complete this rewarding, yet difficult journey. He endured many inconveniences but never relinquished his support of my educational goals and interest in my new belief system.

Karen Y. Whitmore
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SCHOOL-BASED FAMILY COUNSELING PRACTICES:
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Abstract

The purpose of this study was to investigate the extent to which the systemic mental health intervention—family counseling—was being conducted in the schools by school counselors, school psychologists, and school social workers. Also investigated were the differences, if any, in the school-based family counseling practices and attitudes among these three groups. Survey research was conducted at the national level. Participants included a randomized sample of school counselors belonging to the American School Counselors Association, school psychologists belonging to the National Association of School Psychologists, and school social workers belonging to the National Association of Social Workers. An overall response rate of 73.2% was obtained with a useable response rate of 62.9%. Only 10.9% to 12.7% of the three groups of school practitioners in this survey reported providing school-based family counseling. Eighteen percent of all respondents reported that family counseling was offered as a school-based service in their school districts. Slightly more family counseling was being conducted by contracted mental health professionals than by school social workers who were doing more than either school counselors or school psychologists. Nearly one-third of all school practitioners surveyed perceived personal barriers related to role appropriateness by questioning either the role of the schools in providing family counseling or the role of their own discipline in the provision of family counseling. Additional personal and
administrative barriers to the practice of school-based family counseling were identified. Encouragers were also identified along with descriptors of the family counseling services actually being provided by school counselors, school psychologists, and school social workers.

Karen Y. Whitmore

DEPARTMENT OF COUNSELING EDUCATION
THE COLLEGE OF WILLIAM AND MARY IN VIRGINIA
SCHOOL-BASED FAMILY COUNSELING PRACTICES:
A NATIONAL SURVEY OF SCHOOL COUNSELORS,
SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS
Chapter One

Introduction

Statement of the Problem

With the education of the nation’s students becoming more complex, the critical role of the family is illuminated (Batsche, 1992; Crepsi, 1997; Kraus, 1998). Due to families being one of the most underutilized educational resources, “The success of the schooling process in the 21st century may well rely on our ability to link schools and families as effective partners in the education of children” (Batsche, 1992, p. xv). Because public schools historically reflect and image societal trends, the student population is becoming progressively diverse in background experiences, family configurations, cultural values, and learning styles (Murphy, DeEsch, & Strein, 1998). What implications do the changing needs of today’s students have for school-based mental health professionals?

The journal literature is clear that families who are involved with their children’s schooling improve their children’s academic success (Carter & Evans, 1997; Gandara, 1989; Scott-Jones 1995). The home and the school are considered the two most influential factors in a child’s life (Woody & Woody, 1994). In addition, the family is widely acknowledged as a crucial factor in the development of a child’s competence in school (Carlson & Sincavage, 1987; Maeroff, 1990; Nicoll, 1992/1997). A growing body of research on parent-school involvement concludes that measurable gains in student performance can be achieved with many types of parent participation in the schools (Christenson, Rounds, & Franklin, 1992; Epstein, 1995; Henderson & Berla, 1995).
In the new millennium, the complexities of our society have created a need for school reform. Instead of focusing primarily on the intellectual development of the child, the new vision commits to the development of the whole child (Walsh, Howard & Buckley, 1999). Students exhibiting internal and external stress can experience school failure, both academically and behaviorally (Policy Leadership Cadre for Mental Health in Schools, 2001). This has created the need for a paradigm shift from the intrapsychic to the systemic, resulting in the need to develop new ways of promoting school success.

With recognition that schools and families share mutual goals in the education and socialization of their children, family counseling is now considered part of school reform and a new frontier in meeting the needs of today's students (Woody & Woody, 1994). Family counseling provides an innovative change in the provision of school-based mental health services.

As clearly acknowledged, schools can no longer just address the academic needs of the students. In order to address the student's academic and social-emotional needs, schools are challenged to restructure to meet the needs of the "whole" child by linking all contextual influences on that child. A paradigm shift is required of all mental health professionals currently practicing in the schools. Not only are school counselors challenged to make this shift (Fine & Gardner, 1991/1997), but also school social workers (Millard, 1990/1997) and school psychologists (Crespi, 1997). In the past, when these three groups were surveyed individually about their family intervention practices, which also addressed parent/family counseling (Beck, 1984; Carlson & Sincavage, 1987; Prout, Alexander, Fletcher, Memis, & Miller, 1993; Spencer, 1989; Staudt, 1991; Telfer, 1987), a lag appeared to exist between actual family-oriented practice and the stated need.
for this type of practice. It is still unclear if a family-systems paradigm shift has occurred.

Few school districts have staff allocated to provide family counseling (Crespi, 1997; Mince, 2001; Mucher, 1996). As the three groups of school district employees assigned to address the social-emotional needs of the students, school counselors, school psychologists, and school social workers are at the forefront of the schools' mental health service provision. These three groups are often referred to as "pupil services personnel" (H. R. Rep. No. 63, 2001; Policy Leadership Cadre for Mental Health in Schools, 2001). They are mental health service professionals who are most accessible to students, families, teachers, and administrators. What are the current practices of these three professionals groups in terms of providing mental health services to both students and their families? Have these three professional groups developed the necessary skills to meet the contemporary mental health needs of today's school children? Do they practice family counseling in the schools?

Though the professional literature contains program descriptions of school-based family counseling being done by school psychologists, school counselors, and school social workers (Fausold-Mowers, 1998; Merrill, Clark, Varvil, VanSickle, & McCall, 1992), recent survey research could not be found to determine the specific family counseling practices of these pupil services personnel across the nation. Several surveys in the middle to late 1980s found that some form of parent or family counseling was being done by school psychologists (Carlson & Sincavage, 1987; Spencer, 1989) and by school counselors (Beck, 1984). However, counseling done specifically with families was reported as minimal. Noteworthy in the surveys by Spencer (1989) and Beck (1984)
was the finding that counseling with parents and/or families was viewed by these practitioners as a viable service in the schools. Also noteworthy in Beck's study (1984) was the reported desire of the school counselors to engage in more parent or family counseling than they were providing. In addition to these studies being outdated, definitions of family counseling were vague which raised questions about the reliability and validity of the findings.

Recent statistics cite increased mental health problems in school-aged children (Kelleher, McInerny, Gardner, Childs, & Wasserman, 2000). Because the traditional, "school-only" interventions do not appear to be working (Burns et al. 1995), schools must identify new ways to help students learn efficiently. The latest trends in mental health service provision have sprung from school-community collaboration efforts in the form of comprehensive school-based and school-linked programs called full-service schools or community schools (Dryfoos, 1994). Within these models, assorted services in the areas of mental health, physical health, and social services are frequently provided. Ideally, these programs represent a unification of fragmented services that aim to increase school-family collaboration and student academic success (Adelman & Taylor, 2000; Zapeda & Langenbach, 1999).

Many educators acknowledge that students' mental health status affects the school’s ability to achieve their academic mission (Policy Leadership Cadre for Mental Health in Schools, 2001). Additionally, the No Child left Behind Act of 2001 calls for “...comprehensive school reforms, based upon scientifically-based research and effective practices that include an emphasis on basic academics and parental involvement so that all children can meet challenging state content and academic achievement standards”
This Act further acknowledges that attention to academics alone might be insufficient in meeting the required standards, thus creating need for mental health services within the schools that can remove the barriers to learning.

With the schools’ mission being primarily education (Adelman & Taylor, 2000), administrators often have limited knowledge of mental health services, especially family counseling. Family counseling can be used as one way to remove the barriers to learning and/or create parent-school relationships (Crespi, 1997; Fausold-Mowers, 1998; Kraus, 1998; Merrill et al. 1992). It is unclear if administrators view family counseling as a way to achieve the school’s mission of educating its youth. Are school counselors, school psychologists, and school social workers receiving support for family counseling from their administrators and supervisors?

Though mental health professionals in the schools have paid lip-service to the fact that families who are involved with their children’s schooling improve their children’s chances for academic success (Carter & Evans, 1997), there is a remarkable lack of research related to actual family-oriented interventions specifically in the area of family counseling as practiced in the school setting. This lack of research suggests that family counseling may not be available in many schools. The professional literature on this topic contains some studies that are empirically based; however, many have methodological flaws. Often, school-based family counseling studies are similar to Donovan’s (1992) review of family systems intervention studies involving student change. These studies represent: (a) program descriptions with utilization data, (b)
clinical papers with recommended interventions and strategies, or (c) case studies that are theory driven.

Though conclusive research is still unavailable, the literature supports adoption of the systems approach for mental health professionals who are working in the schools. In addition, there is sufficient evidence that, in general, family counseling is effective (Pinsof & Wynne, 1995). These two points suggest that application of family counseling within the schools can also be effective. Fausold-Mowers (1998) studied a school-based family counseling program and found a significant correlation between the client families' satisfaction and their perceived outcomes of therapy. In addition, a significant correlation was found between the families' satisfaction and the school practitioners' internal knowledge of the schools and ability to join with the families to navigate and negotiate within the schools' structures.

Amidst the restructuring of America's schools, it is crucial that mental health services also be restructured as school-based mental health practitioners attempt to meet the present needs of the nation's school-aged children. All mental health professionals working in the schools must continually update their knowledge and practices to meet the ever-changing challenges brought to our nation's schools. Recent calls for school-based family counseling provided by school-based mental health professionals are documented in the literature (Carter & Evans, 1997; Crespi, 1997; Fausold-Mowers, 1998; Franklin, 2000; Greene, Jones, Frappier, Klein, & Culton, 1996; Hinkle & Wells, 1995; Johnston & Zemitzsch, 1997; Kamphaus, 1996; Kraus, 1998; Millard, 1997; Walsh & Williams, 1997).
The documented calls for family therapy in the schools and desire on the part of the schools' mental health practitioners to engage in family counseling highlight the need for further information about present school-based family counseling practices. Survey research is missing that describes the current school-based family counseling attitudes and practices of school counselors, school psychologists, and school social workers.

Current Social Trends and Statistics for School-Aged Children in the U.S.

Just thirty years ago, schools in the U.S. were rarely troubled by serious conduct problems (Charles, 1999). However, today, major challenges face our nation’s schools. Societal trends are greatly impacting our students and spilling into the schools and classrooms. An estimate of 20.3% of students (ages 9, 11, and 13) have a discernable mental health diagnosis, with 1 in 9 (11.1%) students having emotional disorders severe enough to cause impairment (Burns et al. 1995). In addition, only a small minority (approximately 1 in 5 students) obtains treatment through a specialty mental health sector (Burns et al. 1995). In 1996, three million children were reported to Child Protective Services as abused or maltreated (U.S. Department of Health and Human Services, Children’s Bureau, 1998). An alarming number of children have been present during domestic violence incidents (Jaffe, Wolfe, & Wilson, 1990). Of the approximate 58 youth under age 18 who committed suicide in Virginia from 1994 to 1995, the State Child Fatality Review Team (2000) of Virginia found that 34% had been physically abused, sexually abused or had witnessed domestic violence at some point in their lives. Many teens are homeless and at risk for depression, substance abuse, and emotional disorders. Frequently, they are underserved by mental health providers (Kazdin, 1993).
In addition, there has been a major restructuring of the family leaving children with less adult supervision and assistance with schoolwork. Often families are experiencing multiple stressors which result in children having to take on adult responsibilities. The 1999 U. S. Census released estimates that seven million school-aged children (ages 5 to 14) are without adult supervision on an average of six hours per week (Simpson, 2000). This statistic appears to result in part from parental employment requirements. The most at-risk time for juvenile crime is from 2:00 to 6:00 p.m., the time during weekdays when many youth are left unsupervised (National Crime Prevention Council, 1998). Cited as having the world’s highest divorce rate, the U. S. has approximately 50% of its children who have experienced divorce or are living in single parent homes (Lickona, 1991). Currently, 12.1 million children live below the poverty line (Children’s Defense Fund, 2000). According to a recent study of 21,065 children, ages 4 to 15, emotional problems increased by 18% from 1979 to 1996 (Kelleher et al. 2000). In this study, identified emotional problems were associated with poverty and higher proportions of single-parent households.

Additionally, communities are becoming more populated and by perception, less governed by a hierarchy of social mores. Youth homicide has increased with a downward trend in the age of youth who commit serious and violent crimes (Craig, 1995). According to the Federal Bureau of Investigation records, as many as 5.7% of 14-years-olds and younger were arrested in 1998 (U. S. Department of Justice, Federal Bureau of Investigation, 1998). Homicide stands as the third leading cause of death for U.S. youth ages 5 to 14 (National Center for Health Statistics, 1997, unpublished data as
cited in Snyder & Sickmund, 1999). Approximately three million crimes (11% of all existing crimes) reportedly take place annually in our nation’s schools (Craig, 1995).

These grim statistics as well as current social trends that are correlated with depressed scholastic achievement have pushed our society to call on schools to address the needs of the “whole” child including his or her academic, physical, social, and mental health needs. Unmet mental health needs can create barriers and impact on children’s ability to learn efficiently (Adelman & Taylor; 2000; Center for Mental Health in Schools, 2001; Drake & Bernard, 1994; Woody & Woody, 1994; Policy Leadership Cadre for Mental Health in Schools, 2001). It is imperative that schools become primary loci of not only educational services, but also comprehensive services that provide for the physical, social and mental health needs of students and their families (Holtzman, 1997). This approach has shown positive gains in students’ academic performance (Newman, 1995). Legislation such as the Goals 2000: Educate America Act (signed into law in 1993) further supports this model of school reform (U. S. Department of Education, 1994). More recently, the No Child left Behind Act of 2001 passed by the 107th Congress authorizes and mandates a comprehensive model of school reform (H. R. Rep. No. 63, 2001).

Importance of Family Systems Theory In Understanding the Problems of School-Aged Children

Interrelatedness of mental health and students’ performance in the schools.

A review of 52 studies shows the prevalence of psychopathology among children and adolescents to range from 1% to 51%, with a mean of 15.8% (Roberts, Attkisson, & Rosenblatt, 1998). With prevalence rates this high, psychosocial problems in childhood

The overarching vision of the Surgeon General’s National Action Agenda for Children’s Mental Health states, “Mental health is a critical component of children’s learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority” (Department of Health and Human Services, 2000, p. 3). Guided by the recognition that mental health is primary to children’s health, the Surgeon General’s group is committed to “…integrating family, child and youth-centered mental health services into all systems that serve children and youth” (p. 3). One of these systems is the school, which is the sole, but presently inadequate source of mental health interventions for a number of students (Burns et al. 1995).

Mental health needs as well as other contemporary issues have affected the nation’s schools and families to where both entities have become matters of public concern. Much of the literature supports the belief that our schools are in need of major restructuring due to the plethora of problems facing our nation’s school-aged children (Burns et al. 1995; Carter & Evans, 1997; Doll et al. 1993; Woody & Woody, 1994). Because schools interface with all children at some point in their lives, schools are the perfect arena in which to reach children with mental health problems and their families.
Importance of families and schools as systems that influence children’s development.

According to systems theory, children are part of a larger social network that influences and socializes them (Goldenberg & Goldenberg, 1996; Lickona, 1991). To understand a child’s behavior, it must be viewed within the context in which it occurs (Carlson, 1992; Hinkle, 1992). Referencing Scott-Jones (1995), “both families and schools are major contexts for children’s development” (p. 75). The family is widely acknowledged as a crucial factor in the development of a child’s competence in school (Carlson & Sincavage 1987; Carter & Evans, 1997). According to the National Educational Goals Panel (1995), its review of studies shows that parent-school involvement is associated with higher academic achievement, better attendance, and improved behavior. In this era of school accountability, the nation’s schools are being forced to find new ways to achieve their primary mission of providing optimal learning experiences and educational services to all students.

The impetus for this school-family movement was initiated by federal legislation starting in 1975 (Carlson, 1992). With the onset of the 1975 federal legislation for special education services, P.L. 94-142--when parents or guardians were encouraged to collaborate with school personnel in planning their children’s education--there has been a movement for school reform calling for more involvement of the family and the community (Peeks, 1993/1997). Additionally, parents were given further rights and responsibilities in educational decision-making through several amendments to the 1975 Education of All Handicapped Children Act, which became known in the 1990s as IDEA (Individuals with Disabilities Educational Act). Adding strength to this movement were
the publications of A Nation at Risk in 1983 which fueled school reform (Tharinger et al. 1996) and the Healthy People 2000 initiative in 1990 described by Talley and Short (1995b). The Healthy People initiative attempted to transform health care (which included mental health) for students and their families through comprehensive services in the schools. Complementary to this national movement was the more recent Goals 2000: Educate America Act which mandated that, by the year 2000, school-parent partnerships be developed in every school to promote, not only the academic growth of the students, but also their social and emotional growth (U. S. Department of Education, 1994). Further strengthening this movement for parental empowerment was the No Child Left Behind Act of 2001.

A review of the literature recommending school-family partnerships reveals that traditionally, responsibility for solving academic and behavioral problems fell either to the schools (Mascari, Danzigar, & Gross, 1992), or to the families, with a sharp division between the two (Carlson, 1992; Gandara, 1989). Nicoll (1992/1997) reviewed key studies on family-school partnerships and found a relationship between family dynamics and school performance. Despite mounting research to substantiate the significant role of family factors in students’ school performance, schools seldom work collaboratively with parents when intervening with students’ academic or behavioral problems (Nicoll, 1992/1997; Williams, 1994).

However, educators are beginning to recognize the family and the school as the major contexts for children’s education and development (Kraus, 1998; Scott-Jones, 1995; Talley & Short, 1995a). Family systems theory (Green & Fine, 1988; Scott-Jones, 1995) emphasizes the impact that these two systems have on children’s development and
ability to learn. In applying the systems paradigm, schools and families must work collaboratively and systematically to more effectively meet the needs of the students. When families are recognized as a helping resource, they can be empowered through counseling and other parent intervention programs to collaborate with the school to help identify and solve children's problems (Christenson, 1995; Kraus, 1998). If Good and Brophy's (1986) summary of the research literature still holds true, family factors appear to influence academic performance more than school related ones. However, because schools and families are linked by common goals of educating and socializing children, the solution cannot rest with the schools alone or with the families alone. Both are interdependent, making it necessary for these two systems to partner in resolving school-related problems.

Effectiveness of Family Counseling

Family counseling—as one type of family systems intervention—is now a major component of mental health services. As schools are being called upon to make a paradigm shift from treating just the educational needs to addressing the whole child including his or her contextual influences (Policy Leadership Cadre for Mental Health in Schools, 2001), family counseling is beginning to play a role in serving the needs of our nation’s students. A number of journal articles have been published describing the theories and merits of using family counseling in the schools. These articles cite it as a feasible intervention in dealing with school problems, especially those problems that are rooted in family dynamics that can create barriers to successful school performance (Carlson, 1987; Williams, Robison, & Smaby, 1988).
The goal of family therapy, in general, targets change in the system's transactional patterns that optimizes the development of its members (Minuchin, 1974). The goal of family counseling in the schools, more specifically, can target change in the family system that removes the barriers to learning and ultimately facilitates parent-school partnerships (Green & Fine, 1980/1988). In addition, school-based family counseling can provide a positive link between families and school personnel (Fausold-Mowers, 1998).

Have the three groups of school-based mental health professionals adopted family counseling as part of their mental health services to students and their families? No literature exists within the past 10 years to adequately answer this question. However, in 1987 Carlson and Sincavage reported that approximately one-quarter of the school psychologists in this nationwide survey engaged in some form of parent therapy and/or family therapy (15% provided “brief therapy with families” and 7% provided “long term family therapy,” one to five hours weekly). Spencer (1989) found that approximately 28% of school psychologists nationwide were engaged in parent and/or family therapy, with considerably less (16%) engaged in just “therapy with families.” Beck’s (1984) survey showed that only 0.9% of the responding school counselors provided some form of “family counseling” “often,” and approximately one-half provided family counseling “sometimes,” leaving the other half who never provided family counseling. Noteworthy in Beck’s (1984) study was that 57.4% expressed a desire to do more, with 81.5% expressing the necessity for this service in the schools.

Further rationale for providing family counseling in the schools comes from the research specific to family counseling. A review of the research in this field shows
sufficient evidence to substantiate its efficacy (Pinsof & Wynne, 1995). These authors summarized the empirical research included in the 1995 Special Issue of The Journal of Marital and Family Therapy (volume 21, issue 4). Of significance was the finding that marriage and family therapy produced effective outcomes with the following child or adolescent problems: adolescent conduct disorders, anorexia in young female adolescents, adolescent drug abuse, conduct disorders, autism, chronic physical illnesses in children, child obesity, cardiovascular risk factors as well as aggression and noncompliance associated with Attention Deficit /Hyperactivity Disorder. Marital and family counseling was found to be more effective than standard and/or individual treatments for childhood conditions including conduct disorders and drug abuse in adolescents, anorexic adolescent females, childhood autism, and chronic childhood illnesses.

One of the few studies to describe the effectiveness of a school-based family counseling program was conducted by Fausold-Mowers (1998). School counselors, social workers, and school psychologists provided the family counseling. Effectiveness was measured from the parents’ perspective upon using these services, identifying specific aspects of the program found to be helpful and not helpful. Overall, parents had positive views about this school-based family counseling program and found it to be helpful in addressing their concerns and attaining their goals. Additionally, there was a positive correlation between families’ satisfaction level and the knowledge these school-based mental health professionals possessed in their understanding of school procedures and familiarity with teachers and other school-level personnel.
Though mental health professionals in the schools have paid lip-service to the fact that families who are involved with their children’s schooling improve their children’s chances for academic success (Carter & Evans, 1997), there is a noticeable lack of research related to actual family-oriented interventions specifically in the area of family counseling as practiced in the school setting.

A close examination of the journal literature on school-family interventions shows that much of the literature is comprised of descriptions of recommended practices. As Donovan (1992) states,

There is a proliferation of clinical papers, case studies, and program descriptions that report the use of specific family intervention strategies. These reports are useful in suggesting areas for further research, but for obvious reasons cannot be considered for a comparative analysis of outcome. (p. 441)

Though counseling interventions based on theory is accepted practice, Donovan proceeds in saying that the practice of general family systems interventions is still “theory-only” driven. Though an emerging number of empirical studies are being reported, evidence for solid conclusions is limited.

If the results of Conti’s study published in 1971 still hold true, less than one-third (30%) of the families referred for community based counseling followed through with these referrals, and even less (8%) used these community services more than two sessions. These results and those from validation studies of full-service schools suggest that accessibility of services in the school environment increases the chances of usage and follow-through. For example, in one three-year study of adolescent usage of school based health centers, adolescent students were 10 times more likely to use the mental
health or substance abuse services provided on site than the control group that did not have access to school-based health centers (Kaplan, Calonge, Guernsey, & Hanrahan, 1998). These researchers state, “School-based health centers are particularly successful in improving access to and treatment for mental health problems and substance abuse” (p. 2).

Another recent example of usage and follow-through specifically with families receiving school-based mental health services was described by Atkins, Graczyk, Frazier, & Abdul-Adil (2003). When families living in an urban area were randomly assigned to either school-based mental health services or clinic-based mental health services, both enrollment and follow-through usage were significantly better in the school-based programs. Approximately 94% of the families assigned to the school-based programs enrolled while only 69% of the families assigned to the clinic-based programs enrolled. A three-month follow-up showed that all families who enrolled in the school-based programs were still receiving services while none of the families in the clinic-based programs were. A nine month follow-up showed that all families in the school-based services were still receiving services except for several families whose children changed schools.

School-Based Family Counseling and Mental Health Service Provision

Debate on the school’s role in mental health service provision.

According to the Policy Leadership Cadre for Mental Health in Schools (2001), the prevailing focus in schools is education, not mental health, with accountability and reform that targets instructional outcomes. Mental health is not always viewed as directly related to academic achievement. “Schools are not in the mental health business” (p. 4),
though "...a variety of psychological and physical health problems affect learning in profound ways" (p. 7). However, the Carnegie Council on Adolescent Development (1995) along with the Policy Leadership Cadre for Mental Health in Schools (2001) reference schools as not being responsible to meet all students' needs, but having responsibility to meet those needs that affect learning.

Trends in school-based family counseling and mental health services.

Many school mental health programs are supplemental, fragmented and marginalized, which calls for a comprehensive service design (Policy Leadership Cadre for Mental Health in Schools, 2001). Using a systems intervention approach to resolving children's school-related problems is being touted in both the mental health and education literature as one of the latest and most desirable approach for use in the schools (Fish & Jain, 1997; Hinkle, 1993; Mucher, 1996; Walsh & Williams, 1997). Because children's difficulties in the schools go far deeper than the traditional running in the halls or talking without permission (Mucher, 1996), an appropriate intervention response includes an eco-systemic, interdisciplinary approach to solving mental health issues.

Select school districts across the country are beginning to open their doors to mental health services with implications that ecological approaches or systems theory are being embraced. But given the experimental stage of this movement as well as the magnitude of planning and development efforts for such services, comprehensive mental health programs are slow to evolve with many school districts maintaining continued reliance on traditional services and available resources. With the potential for reform brought by these movements, schools have an unprecedented opportunity to address the
needs of children and their families using holistic, collaborative interventions (Talley & Short, 1995a, 1995b).

Five models for mental health services provision in the schools.

The Policy Leadership Cadre summarizes five current delivery formats for meeting the mental health needs in the schools (Policy Leadership Cadre for Mental Health in Schools, 2001). The first model of delivery is “school-financed student support services” (p. 14). This is the most traditional format whereby the school system employs school counselors, school psychologists, and school social workers to provide mental health services to deal with the social-emotional problems in the schools. The second model involves school-based health centers that are centralized and available to all schools. The third model involves formal links with community mental health services through means such as formal contracts with community agencies for community based services. This model can also take the form of partnerships with community agencies in providing services at local satellite clinics or family resource centers. The fourth model is classroom-based curriculum with integrated instruction and specific curricula. The fifth and final model is described as the most comprehensive approach and provides a full continuum of services to promote prevention and provide intervention. This latter model includes the integration of school and community services as well as the restructuring of student support services in order to fully support the school’s instructional efforts and the goal of creating a community school.

Full Service Schools.

As an outgrowth of the school reform and school-family partnership movements (see the second and third models described above), comprehensive programs known as
“full service schools” have developed. Full-service schools have been established experimentally in a number of states to promote the coordination of health and social service efforts in order to provide comprehensive physical and mental health care to students and their families. Numerous models exist, often in conjunction with community agencies. Most programs offer a wide array of services in school operated facilities (Dryfoos, 1994). Full service schools are also labeled school-based health clinics, family resource centers, or community schools with some programs more youth oriented and others more family oriented. Specific family-school interventions within full service schools include a myriad of services and programs such as: (a) parent training, (b) parent support groups, (c) parent-school collaboration as a part of student support teams, (d) individual parent consultation regarding a child’s academic or behavioral difficulties, and/or (e) parent and family counseling (Dryfoos, 1994; Donovan, 1992). When these programs are offered at the school, they provide convenient, coordinated services to students and their families who might not otherwise obtain them.

A description of several examples of full service schools follows. James Comer of the Yale University Child Study Center was one of the early architects of the full service school concept. His School Development Program implemented in New Haven Public Schools in 1968 offers mental health services, parent participation, and a team approach to the management of the schools (Holtzman, 1997). The School Development Program is comprised of three important components: (a) the mental health team, (b) the school management team, and (c) the parent team. According to Drake and Bernard (1994), over 600 schools in 14 states have implemented the Comer Model.
One of the most comprehensive models for children, aged birth through twelve, is Zigler’s School of the Twenty First Century (Zigler, Finn-Stevenson, & Marsland, 1995). This model offers before and after school care along with coordinated social, health, and educational services for students and their families.

In Texas, The School of the Future, a five-year experimental project described by Holtzman (1997) provides an array of on-site mental health services such as family counseling (using local university graduate students as counselors) and social services at four different schools. This program received start up funds from a mental health foundation.

Finally, California created a state supported system in an attempt to restructure education, health, mental health, and social services by linking them together through the schools in an effort to develop integrated, comprehensive services. These programs are called “Healthy-Start,” with the overarching goal of supporting students and their families (Newman, 1995).

Research on school-based centers and clinics is somewhat scarce due to the relative newness of this movement (Dryfoos, 1997). In California’s Healthy-Start program (Newman, 1995), however, outcome data were collected and analyzed with outcome goals that projected measurable improvement in student performance. Four types of programs were studied including: (a) school-site family resource centers, (b) satellite family service centers, (c) family service coordination teams (extensions of student support teams where members could follow-up with direct services), and (d) youth service programs addressing adolescent health, education, and social needs (Newman, 1995).
Pre and post records of students were studied in the areas of attendance and GPAs. Additionally, the results of teacher rating scales of students' behaviors before the start of the program and after the completion of the program were collected and analyzed. The majority of the students enrolled in the program were eligible for free lunches. When results of student behavior were analyzed, students who exhibited the poorest behaviors made the largest improvements. In the area of attendance, no significant differences emerged. In the area of grades, however, positive gains in academic achievement were found. Also, elementary students made higher GPA gains than high school students, with grades kindergarten through three making larger gains than grades four to eight.

Of the four types of programs studied in California's Healthy Start project (Newman, 1995), the family service coordination team program showed the most gains in the area of GPAs. Of importance was the finding that programs with clearly stated educational outcome goals produced greater gains than programs that did not. Though no control groups were used, the researchers suggested that comprehensive, educationally-oriented services might contribute to small gains in school performance even after short participation.

The nature of these school-family-community partnerships is based on systems ecological theory as it relates to child development (Walsh, Howard, & Buckley, 1999). The assumption of this theory links the development of children to joint functions of their ecological environments including home, school, and community (Bronfenbrenner, 1989). In the school environment, students' development must be viewed holistically. Intellectual development cannot be separated from physical, social, and emotional development. In addition, the student cannot be understood without comprehension of
his or her joint contexts and contextual influences. Not only do children profit from this approach, but also adults. By supporting the significant adults in a child’s life, the foundation for the child’s development is strengthened (Lerner, 1986; Walsh, Howard, & Buckley, 1999).

The student support services delivery model using school-based mental health service providers.

From the list of the mental health service delivery models presented by the Policy Leadership Cadre for Mental Health in Schools (2001), the school-financed student support services delivery model is the one under current investigation. According to Lockhart and Keys (1998), “...even with the movement toward school-based and school-linked services, most community mental health services remain isolated and fragmented from school initiatives and inaccessible to student and families” (p. 3). Due to factors such as managed care and downsizing, community mental health services are becoming harder to access by the general public. Lockhart and Keys (1998) proceed in saying, The rising numbers of students and families in need of mental health services, coupled with diminished public system of services and a less available system of private services, places school counselors in the critical position of being the only accessible mental health service provider for many students and families.... Current conditions suggest that the time is ripe for school “guidance” counselors to redefine themselves as school “mental health” counselors and to take a proactive stance in stimulating the changes necessary within their school systems to support this new role. (p. 4)
Limited community services paired with limited access underscore the need for school-based services provided by professionals who are easily accessed. Traditionally, the three mental health professionals serving the public schools include school counselors, school psychologists, and school social workers. Therefore, not only are school counselors accessible to students and their families, but also school psychologists and school social workers. These professionals, each with their own unique training and skills, are qualified to serve a myriad of mental health needs. They have been assigned by many school systems across the U. S. to meet the social-emotional needs of the students (Merrill et al. 1992).

With family counseling being acknowledged as an integral component in mental health services across the nation (Rait, 1988), what types of mental health services are most readily available in our nation’s schools? Historically, interventions conducted by the schools’ three designated mental health disciplines have been child focused and intrapsychically oriented (Carlson, 1987; Carlson, 1992; Donovan, 1992; Kraus, 1998). Emphasis has been on traditional individual and group counseling (Schmidt, Lanier, & Cope, 1999). Conferences between parents and school personnel have also been utilized (Telfer, 1987). However, when conferences are not effective, few alternatives have been in place other than referrals to outside resources or referrals for psychoeducational evaluations (Kraus, 1998).

Special education is used as another method of intervening with the mental health barriers to learning. As part of this process, psychoeducational diagnosis is generally approached from an individualistic medical model that tends to be viewed as “… a static, simplistic process which, in reality, is highly complex, due to the complexity of the
ecosystems of the individuals" (Wendt & Zake, 1984, p. 206). In addition, the process of psychoeducational diagnoses tends to address mental health needs that have a severe impact on learning. Lesser mental health needs are not always addressed by this method leaving many students who have mental health needs unattended (Policy Leadership Cadre for Mental Health in Schools, 2001).

In general, family oriented practice in the schools by school-based professionals has been limited. This continues to be the case despite calls in the professional literature that have encouraged systems interventions—including family counseling—already in the late 1970s and early 1980s (Friesen, 1976; Greene & Fine, 1980; Palmo, Lowry, Weldon, & Scioscia, 1984; Wendt & Zake, 1984).

An examination of the roles of school counselors shows that many are assigned to just one school. Therefore, they are in a unique position to work with families in coordinating school services. They are trained as specialists in child development, counseling, effective communication, and conflict mediation. They are also trained in behavioral change techniques in addition to possessing knowledge of the school’s curricula and operational processes (O’Rourke, 1991). Though much of their practice involves individual and group counseling (Roberts & Borders, 1994), according to Hinkle (1992), school counselors are becoming more cognizant of family counseling’s effectiveness in resolving chronic school performance problems, and as a result, are beginning to seek this training.

When examining the literature regarding school psychologists’ roles, authors such as Farley (1996), Crespi and Fischetti (1996), Walsh and Williams (1997), and Ysseldyke et al. (1997) propose that school psychology “reinvent” itself to become a broader
profession in order to provide a full range of psychological and mental health services as it relates to schools and to the psychology of learning. This range of psychological services includes counseling, family psychology, and developmental psychology in addition to educational and instructional psychology. With the reauthorization of IDEA in 1997, less emphasis is now placed on formal psycho-educational evaluations (especially re-evaluations) leaving more time for other activities such as student-family interventions. Due to the recent upsurge of massive school violence, school psychologists have an opportunity for role expansion that involve crisis prevention, crisis intervention, and other specialty areas such as family counseling (Furlong, Morrison, & Pavelski, 2000).

Of the three traditional mental health disciplines commonly found on-staff in the schools, the school social worker is best known for working as a liaison among schools, families, and community agencies. The systems approach is especially relevant in the work of school social workers because of their emphasis in dealing with the dynamic totality of the student-family-school-community environments (Haynes & Holmes, 1994). Though school social workers are generally trained in systems theory, little is known from the research literature about how much family counseling they do and how much retraining is necessitated in order to practice family counseling.

Each of the three disciplines (i.e., school counselors, school psychologists, and school social workers) share the potential to use the ecological or systems approach in analyzing all factors that can affect a child’s learning. These learning factors include: (a) the personal characteristics of the student, (b) parental support and home variables, and (c) instructional strategies and classroom variables (Zapeda & Langenbach, 1999).
Accessing and utilizing this systems or ecological information on a regular basis is a distinct advantage in improving students’ chances for success.

The Center for Mental Health in the Schools (2001) recommends that, as schools reform, these three groups of pupil services personnel restructure to better address the "...host of external and internal barriers interfering with their [students'] development and learning" (p. 1). Often these groups do not work together which can interfere with the schools’ mission of educating its youth. For those students who are not ready to learn, pupil services personnel must work collaboratively to address the needs of the whole child that potentially create barriers to learning.

The Policy Leadership Cadre for Mental Health in Schools (2001) proposed a guide outlining the issues and components for mental health services in the schools. This cadre is affiliated with the University of California in Los Angeles’ (UCLA) Center for Mental Health in Schools, operating under the School Mental Health Project. (An executive summary was also included in the National Association of School Psychologists’ Communique, September 2001 issue.) Proposed are three domains that should be addressed in serving the mental health needs of our nation’s students. These include: (a) the promotion of academic success by enhancing healthy cognitive, social, and emotional development, (b) elimination of the barriers to learning (both internal and external), and (c) provision of social-emotional services to students as well as their families.

There is a wide array of roles these school-based professionals can adopt in meeting the needs of today’s students. In the No Child Left Behind Act of 2001 (H. R. Rep. No. 63, 2001), the services of the school counselor, school psychologist, and the
school social worker (as members of the pupil services personnel team) are addressed, with funds appropriated for better access to these school-based mental health professionals. More specifically, funding is available

... to expand and improve school-based mental health services, including early identification, assessment, and direct individual or group counseling services provided to student, parents, and school personnel by qualified school-based mental health services personnel. The Committee recognizes that LEAs may find that school-based mental health services are a necessary and appropriate component of improving student learning and experiences and outcomes. (p. 337)

Authorized activities for school counseling programs include expansion of counseling services by using a team approach and parental involvement. In addition, innovative approaches to improve peer and family relationships are recommended. These recommendations are consistent with the competencies that are proposed by the Center for Mental Health in Schools (2001), which also include direct interventions with students and their families. Needed is more information about the actual roles and practices of these pupil services professionals in the implementation of systems/ecological approaches, which includes family counseling.

Role expansion and collaboration.

Confronting all mental health practitioners interfacing with the schools is the need, not only for a paradigm shift to accommodate family-oriented interventions, but also for an expansion of roles by all three school-owned mental health disciplines. In addition, there is need for collaboration and interprofessional teamwork among these three groups (Carpenter, King-Sears, & Keys, 1998; Center for Mental Health in Schools,
When collaboration of effort to ensure efficient and effective services is not addressed, fragmented services result, which further marginalizes mental health services as a useful or valuable educational support (Adelman & Taylor, 2000; Center for Mental Health in Schools, 2001). It is still unknown if these school-based mental health professionals have expanded their roles in a collaborative manner and made a paradigm shift to accommodate family-oriented interventions.

**Definition of school-based family counseling.**

Because family counseling is considered by some, as a specialty in the field of family counseling, and because schools are often considered nontraditional service delivery settings, wide acceptance of the role as a family counselor among school-based mental health professionals may still be an issue (Doherty & Peskay, 1992), even among school social workers. Though several surveys suggest that both school psychologists and school counselors endorse the practice of parent and/or family counseling (Beck, 1984; Spencer, 1989), a limited number within these groups was actually providing school-based family counseling (Carlson & Sincavage, 1987; Spencer, 1989). In a survey on family-school partnerships, NASP school psychologists were reported as "...enthusiastically supportive of the general concept of family-school partnerships and .... believed it was important for school psychologists to take an active role in such partnerships" (Pelco, Jacobson, Ries, & Melka, 2000, p. 244). Because school psychologists, school counselors, and school social workers are often involved in more traditional forms of parent-school partnerships such as parent conferencing or parent consultation (Campbell & Dahir, 1997; Telfer, 1987; Ziesemer, Marcoux, & Davis, 1991), interpretation of the terms “parent counseling” or “parent conferencing” could
easily be misconstrued as synonymous with family counseling. A distinction between the
term family counseling and other similar terms is thought necessary in order to gain a
better understanding of the practices and attitudes held by the three school-based mental
health disciplines toward school-based family counseling.

For purposes of this research, school-based family counseling is a formalized
counseling or therapy intervention that uses a family systems perspective and is delivered
on-site at a school operated or owned facility. Though sessions can involve individuals,
dyads, triads, household members, or extended family members, at least one therapy
session must be conducted conjointly with at least one parental figure and one child. This
intervention is formalized by addressing parental rights and obtaining informed consent
for services. In addition, this intervention process has the intent of more than one session
and is not parent conferencing or parent consultation. Classified as one type among
numerous types of family systems interventions, family counseling is approached from a
systemic mental health counseling model versus a more general problem solving
consultation model.

Training and supervision issues.

In order for school-based practitioners to adequately and effectively provide
family counseling in the schools, they are confronted with another concern that must be
addressed. The literature cites the need for adequate training (Palmo, Lowry, Weldon, &
Scioscia, 1984/1988) and ongoing clinical supervision in family work and family
counseling (Goldenberg & Goldenberg, 1981/1988, 1996; McComb, 1981). Because
family counseling itself is a relatively new specialty in the field of counseling, retraining
opportunities for school personnel is possibly a primary issue (Crespi, 1997; Hinkle,
The school counselor, school psychologist, and school social worker are trained in individual and group counseling; however, it is likely that not all of them have acquired training in family counseling. Regarding supervision, schools are notorious for not providing clinical supervision for the mental health professionals already on staff (Crutchfield & Borders, 1997). It is likely that administrators do not understand the merits of clinical supervision nor the differences between administrative and clinical supervision, thereby making clinical supervision a projected concern for school-based family counseling practitioners.

**Administrative support.**

There is a projected need for administrative support of school-based family counseling practitioners in the areas of time and resources (Spencer, 1989; Williams, Robison, & Smaby, 1988). In Spencer's study published in 1989, results suggested that school psychologists were more likely to engage in parent and/or family counseling with perceived support from administrators and other school level personnel. Support from administrators and supervisors, therefore, could be an issue in several areas including the endorsement of the school's mental health program as well as providing ongoing clinical supervision, time allocation, and fiscal resources. It is speculated that supervisors could be invaluable in planning and developing a family counseling program as well as facilitating the collaboration process among disciplines. In addition, fiscal support should be granted in terms of equipment and ongoing costs of clinical supervision and liability.

Without these supports, barriers can potentially erode the foundation of school-based family-oriented practice. What barriers are involved in the practice of school-
based family counseling? Clearly, there is outdated research data or information concerning these variables.

Models or characteristics of school-based family counseling practices.

Based on family systems theory and the realities of the school system, much of the literature recommends brief family counseling models (e.g., structural, solution-focused, strategic) that are focused on school performance outcomes (Carlson, 1987; Green & Fine, 1980/1988; Golden, 1983/1988; Hinkle & Wells, 1995). Little information, however, about the actual practice and effectiveness of these recommended school models is available in the professional literature.

Summary

With the education of today’s youth becoming more complex, school-based mental health professionals must expand their expertise and provide an array of mental health services that remove the barriers to learning and better meet students’ social-emotional needs. Clearly, most of the available literature is precursor information for school-based mental health practitioners as possible alternatives to their traditional, medical model approaches and child-focused forms of practice. Family counseling provides an innovative change in the provision of school-based mental health services to students and their families. In addition, it can provide a positive and direct link between school personnel and parents (Fausold-Mowers, 1998). Research in the middle to late 1980s suggested that minimal family counseling was being done by the three groups of mental health professionals working in the schools. Even less is known about today’s practices. Currently needed is descriptive research about the practice of family
counseling along with further insight into the issues and barriers regarding the practice of family counseling in the school setting.

**Purpose Statement**

The purpose of this study is to examine the practices of school counselors, school psychologists, and school social workers related to their attitudes and roles regarding school-based family counseling. Differences in family counseling practices and attitudes among or between these three groups will also be investigated. Have any of the three groups made a paradigm shift from individual intrapsychic practice to an eco-systemic family-oriented practice? How much family counseling is each of the three groups doing? Are implementation practices in school-based family counseling different among these three groups? What factors relate to these differences? What issues or barriers are noted by these school district professionals as preventing them from engaging in school-based family counseling?

**Significance of the Study**

Though all three disciplines are assigned to attend to the social-emotional needs of students in the schools, no known survey study--at the national level--has collectively examined and compared the family counseling practices of the three groups of mental health professionals traditionally hired by the school systems. Several survey studies have examined the family counseling practices of the separate disciplines, but these studies are outdated and contain vague definitions of family therapy leaving questions about the reliability and validity of this research. No collective study has addressed the service delivery model within which school-based family counseling is practiced nationwide by school counselors, school psychologists, and school social workers.
Though the literature recommends types of family counseling models for use in the schools, no known study has collectively examined the actual family counseling models or styles being practiced by school-based professionals. Once this information is gathered, empirical outcome research can then proceed to determine the efficacy of these practices in treating a broad array of problems that can affect students' performance.

Without a clear picture of current family-oriented practices and attitudes of the three school-based mental health professionals, both school-based mental health professionals and university training programs are left without knowledge of the nationwide trends in family-oriented roles and practices. Collecting this information is important to keep the targeted professions abreast of innovative and effective school-based mental health services.

**Research Questions**

Two primary research questions are: (a) to what extent is the systemic mental health intervention—family counseling—being conducted in the schools by school counselors, school psychologists, and school social workers, and (b) what, if any, differences in school-based family counseling practices and attitudes exist among these three groups. Variables to be measured include those factors that potentially affect the practice of school-based family counseling: (a) role perceptions or job role appropriateness regarding school-based family counseling held by school counselors, school psychologists, and school social workers, (b) training in family counseling, (c) ongoing clinical supervision in family counseling, (d) perceptions of appropriate family counseling practices or styles in the schools, (e) administrative and personal barriers to the practice of family counseling in the schools, and (f) perceived encouragers to the practice of school-based
family counseling. A self-constructed questionnaire addressed the following research questions.

1. What type of family-oriented work is most frequently being done by school counselors, school psychologists, and school social workers?

2. What type of training in family systems work and family counseling do school counselors, school psychologists, and school social workers typically have?

3. How much family counseling is provided by school counselors, school psychologists, and school social workers in the schools? Are there differences in school-based family counseling practices between or among these groups/disciplines?

4. What, if any, are the most frequent administrative barriers to the practice of school-based family counseling? Are there differences in administrative barriers among these three groups to the practice of school-based family counseling?

5. What, if any, are the most frequent personal barriers to the practice of school-based family counseling? Are there differences in perceptions of the personal barriers to the practice of school-based family counseling among the three groups?

6. Among the school-based mental health professionals who actually provide family counseling, what do school counselors, school psychologists, and school social workers perceive as the factors or influences that encourage the practice of school-based family counseling?

7. What are the typical practices of school counselors, school psychologists, and school social workers in their provision of school-based family counseling services?
8. How much clinical supervision in family counseling are the school counselors, school psychologists, and school social workers receiving surrounding their practice of school-based family counseling?

The answer to these questions will help provide further insight into whether these school-based professionals have adopted a paradigm shift from the traditional, intrapsychic, individual approach to a more holistic, systems approach regarding mental health services that includes the family and addresses the needs of the whole child. In addition, answers to the above questions will help determine indirectly whether these school-based mental health groups have made inroads toward role expansion that includes a broad array of mental health services in removing the barriers to learning.
Chapter Two

Review of the Literature

General Systems Theory and Ecological Theory As Related to Family Systems Theory and Family Counseling

Introduction.

In order to understand behavior in its totality, Magnusson (1995) postulates the need to develop an integrated, holistic metatheory. The systems-ecological metatheory--a combination of the general systems theory and the ecological theory--is used in this dissertation as the conceptual framework to describe and understand the family systems theory. This metaframe enlightens the pathway to “family counseling,” which falls as one intervention model within the family systems theory. The systems-ecological theory serves as a map to organize and predict family-school phenomena in a systematic and consensual manner, functions that are characteristic of a meaningful theory (Aradi & Kaslow, 1987; Lavee & Dollahite, 1991).

As “changes do not take place in single aspects isolated from totality” (Magnusson, 1995, p. 39), a systems-ecological paradigm is especially relevant to school professionals who are faced with school issues and problems carried across systems and environments (Fine, 1992). To better understand the systems-ecological framework, general systems theory and ecological theory will be examined separately before integrating them into a meaningful framework for family counseling, the family-school intervention under investigation.
General systems theory.

By exploring the origins of general systems theory within the context of the 1940s and 1950s, Bertalanffy's search for a theory of wholeness was illuminated. He was looking for a unification of the sciences in order to provide a more realistic understanding of human kind. According to Bertalanffy (1968), "American psychology in the first half of the 20th century was dominated by the concept of the reactive organism, or, more dramatically, by the model of man as a robot" (p. 205). Behavior was explained using a linear, stimulus-response scheme. Juxtapositioned against this prevailing mechanistic learning theory, Bertalanffy (1968) developed the general systems theory. This theory contained universal principles that could be applied to systems in general. "Any organism is a system, that is, a dynamic order of parts and processes standing in mutual interaction" (Bertalanffy, 1949, p. 11).

Theory rules and principles were first applied to nonliving, mechanical systems and later to living organisms. The primary tenets of the general systems theory are included in Guttman's (1991) definition of a system: "...a unified whole that consists of interrelated parts, such that the whole can be identified as being different from the sum of its parts and any change in one part affects the rest of the system" (p. 41).

General systems theory was launched as a viable theory along with the parallel movement of Norbert Weiner's cybernetics theory, a theory explaining self-regulation or corrective feedback. These regulatory schemes are governed by a circular process of interactive feedback (Bertalanffy, 1968). Further, all systems have boundaries and the components within a particular system are mutually interdependent. This leads to a circular process of causality versus a linear, one-way causality. In addition, a system is
termed closed or open based on the amount of information that is imported or exported from the outside environment. Homeostasis or “maintenance of balance” as termed by Bertalanffy (1968) is an important characteristic of a feedback arrangement and described in Weiner’s cybernetics. Cybernetics, then, is defined by Bertalanffy (1968) as a “…theory of control systems based on communication (transfer of information) between system and environment and within the system, and control (feedback) of the system’s function in regard to environment” (p. 21).

Though Bertalanffy (1968) is credited as instrumental in first postulating the general systems theory, Gregory Bateson, anthropologist, is credited with applying it more directly to the field of human communication and family therapy (Guttman, 1991). Bateson’s study of communication through his work at Palo Alto with schizophrenic patients led to his belief in systems theory and cybernetics (Bateson, 1970). He came to view the family as a system while assigning primary emphasis on communication patterns which he proposed as synonymous with the nature of the particular system (Plas, 1992).

Ecological theory.

In the 1960s, Auerswald (1968) built a case for a broader, more holistic approach to human behavior which drew from systems theory with the additional emphasis on ecology. He named this approach, “ecological systems approach” (p. 203) with its focus on the interplay of systems and the connecting interfaces. Barker (1965) postulated ecological psychology that stressed the effects of environmental input and its unique impact when combined with a person’s individualistic attributes.
In the 1970s Urie Bronfenbrenner introduced his version of the ecological systems theory, with its emphasis as an environmental, contextual model. In 1977, his ecology of human development centered on the importance of interactions between developing persons and their ever-changing, multidimensional environments. Defined more specifically, “The ecology of human development is the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives…” (Bronfenbrenner, 1977, p. 514). Bronfenbrenner’s model was further refined in 1989 and termed, “ecological systems theory” in that publication.

With his concern about the effects of the environment, Bronfenbrenner (1977) defined the ecological environment as a “nested arrangement of structures, each contained within the next” (p. 514). Bronfenbrenner referred to Brim’s (1975) terminology when he developed his taxonomy of environmental systems. This hierarchical arrangement of environments includes: (a) the microsystem defined as the interaction of the person with the immediate environment (e.g., home/family, school, job); (b) the mesosystem defined as the relationships between two or more microsystems; (c) the exosystem defined as major social structures or institutions that affect the person (e.g., government, neighborhood); and (d) the macrosystem defined as the ideologies of the culture or society that permeate its dwellers (Bronfenbrenner, 1977, 1989).

As the conceptual backdrop to Bronfenbrenner’s model is Kurt Lewin’s field theory (Lewin, 1935) which states that behavior is a function of the person and the environment “B = f (PE)” (pp. 35, 39). Lewin’s theory is based on Gestalt theory with the assumption that the whole is different from the sum of its parts. Added to Lewin’s
The formula is Bronfenbrenner’s dimension of an individual’s development over time (Bronfenbrenner, 1989). Development, according to Bronfenbrenner, involves cognition, temperament, and personality.

Bronfenbrenner then developed a biocological paradigm in his 1994 and 1995 publications (Bronfenbrenner & Ceci, 1994; Bronfenbrenner, 1995). His 1995 research model calls for not only studying the “joint interactive effects of characteristics of both the person and the environment on the individual’s development” (p. 639), but also for including the dimension across time. This later model focuses on the developmentally instigative characteristics that potentiate or negate environmental responses. These characteristics emphasized in his latest model are considered biopsychological and are determined biologically.

With the model’s emphasis on ecology, Bronfenbrenner’s work “…provides a theoretical expansion to the work in family systems theory” (Berry, 1995, p. 379).

According to Bronfenbrenner (1989),

No characteristic of the person exists or exerts influence on development in isolation and finds both its meaning and fullest expression in particular environmental settings, of which the family is a prime example. As a result, there is always an interplay between the psychological characteristics of the person and of a specific environment; the one cannot be defined without reference to the other. (p. 225)

Using this paradigm, the family can be visualized as the microsystem or the pivotal source of influence for the children and other members of the family. The mesosystem, exosystem, and macrosystem can then be viewed as hierarchical influences surrounding
the family (Berry, 1995). These larger systems support the family as a microsystem through society’s prevailing beliefs and the availability of services to meet the children’s needs.

**Family systems theory and family therapy.**

Family systems theory developed first and foremost from general systems theory. By the late 1960s, systems thinking became the theoretical underpinnings of family systems interventions (Goldenberg & Goldenberg, 1996). It was after the establishment of family systems theory that ecological theory emerged into its complementary role. Its role served to emphasize context (Fine, 1992).

From a systems perspective, the family is viewed as a “natural social system” (Goldenberg & Goldenberg, 1996, p. 3). The family is prominent in its role as the “basic unit of society” (Ackerman, 1966, p. 58). It transmits the social rules of the larger macrosystem into its separate, unique unit as a microsystem while at the same time imparting selfhood to individual members (Minuchin, 1974).

The family is not a mere assortment of its members (Plas, 1992). Family members are interdependent and bound together as a unit through shared history and deeply embedded rules governing family culture, beliefs, and transactions (Goldenberg & Goldenberg, 1996). A family is a separate microsystem and, according to Minuchin (1974), defines its members both individually and as a group. Fine (1992) states,

Families can be understood as groups of people who share some connectedness to each other and who learn how to behave and function in relation and in response to each other. There is reciprocity of behavior so that we cannot think of one person impacting on a second person without also appreciating the interplay
between the two individuals. (p. 2)

Minuchin and associates constructed a framework of the family as a system that sparked wide-spread appeal in its graphic mapping of the family’s structure (Nichols & Schwartz, 1998). As in general systems theory, every system has subsystems, or smaller components that interact and function to comprise the whole. A change in one part, then, affects a change in other parts. Though today’s society produces numerous and diverse family configurations (Bordan & Goldin, 1995), in general, family subsystems can be identified hierarchically as spousal (the marital dyad), parental (the child care role of guardians), and sibling (the children or peer group) (Minuchin, 1974). Each subsystem has its own functional roles for the benefit of its members, but all act to organize and orchestrate the whole. Subsystems are governed by boundaries that serve to maintain subsystem interdependence as well as to allow for individual autonomy.

Families are considered by Bateson (1970) and Minuchin (1974) to be open systems that constantly exchange information with the outside world. Boundaries can be open or closed with a desired balance between the two (Goldenberg & Goldenberg, 1996). When the boundaries are too closed, the family unit can become rigid (or disengaged) and risk needed growth. When the boundaries are too open, the family unit can become enmeshed and lose the identity of individual members.

Family structure is an enduring and universal concept in the field of family therapy (Nichols & Schwartz, 1998). The family’s structure and organization are characterized by rules overseeing interpersonal relationships and repeated transactions. Family rules (first introduced by Don Jackson in 1965) are often unstated and deeply woven into the fabric of the family. Family rules and homeostasis help regulate stability
through circular loopback mechanisms or intercommunication processes that ensure the
family’s internal balance (Goldenberg & Goldenberg, 1996). The principles of
cybernetics when applied to families explain both stability and change. Bateson (1970)
refers to the family as social system designed with innate feedback structure and the
ability to exchange information.

Though a family works to maintain constancy, it must also learn to adapt and
change throughout its existence (Minuchin, 1974). Families proceed through predictable
stages which Duvall and Hill described in their publication in 1948. These stages of the
family life cycle, which have been updated over the years, provide a framework in which
to assess the family’s ability to adapt to inevitable developmental phases. A balance of
morphostasis (a proclivity for sameness) and morphogenesis (a proclivity to adapt to
change) is required to provide constancy while also allowing for needed change
(Goldenberg & Goldenberg, 1996).

Symptomatic behavior is identified as representing a dysfunction within the
family system (Goldenberg & Goldenberg, 1996; Nichols & Schwartz, 1998). Symptoms
result from faulty structures or transactional rules. The goal of therapy then is to
reorganize the family’s structure and rules for the welfare of all its members. As the
family is a part of a larger network of systems (an ecological system), the therapist must
focus not only on the family as a microsystem, but also on outside societal influences
including the mesosystem, exosystem, and macrosystem.

Family therapy emerged “...when clinicians recognized that the identified
patient’s behavior is a function of the whole family” (Nichols & Schwartz, 1998). This
position is posited against the traditional medical model that views the patient’s problems
as residing within the individual. The Freudian view of psychopathology resulted in the treatment of the individual apart from his or her context. In contrast, the systemic view of dysfunction resulted in the treatment of the family. With family therapy being a relative newcomer to the counseling field (Shields, Wynne, McDaniel, & Gawinski, 1994), a major paradigm shift from an intrapsychic perspective to an interpersonal perspective was required (Goldenberg & Goldenberg, 1996).

**History of family therapy.**

Family therapy is a relatively young field with its roots in social psychiatry (Broderick & Schrader, 1991). Broderick and Schrader (1991) divide the historical period of the family therapy movement into two main eras. The “founding decade” (from 1952 to 1961) is introduced by the origins of conjoint family therapy and ends with the advent of the journal, Family Process. The second era follows from 1962 to 1977.

Due to John Bell’s report regarding the effective use of family therapy along with his handbook on family therapy in 1961, he was considered a family therapy founder (Broderick & Schrader, 1991). He was also innovative in his use of the one-way mirror, which is a training technique characteristic of family therapy supervision. Nathan Ackerman, a child psychiatrist, was also influential in pioneering the family therapy movement through his publications, professional association work, Family Mental Health Clinic (which he opened in 1957), and the Family Institute (which he opened in 1960). With Don Jackson’s assistance, Ackerman founded (in 1961) the Family Process journal, which helped establish the field of family counseling (Broderick & Schrader, 1991).

According to Minuchin (1998), Nathan Ackerman led the East Coast family therapy movement. Gregory Bateson masterminded the West Coast movement.
Gregory Bateson was influential enough in his theories on systems and
cybernetics to be considered another founder of family therapy (Broderick & Schrader, 1991). He was instrumental in the origins of the Palo Alto movement. After meeting Norbert Weiner at the Macy Conferences following World War II, Bateson introduced the concepts of cybernetics to his study of families. Bateson’s focus on feedback processes (cybernetics) prompted the paradigm shift from linear to circular causality, a hallmark of family systems theory (Nichols & Schwartz, 1998). Later, Bateson’s interests revolved around the logic of communication. Upon obtaining a grant to study paradoxical communication in 1952, he met John Weakland, Jay Haley, and Milton Erickson (Broderick & Schrader, 1991). Erickson was especially influential in establishing paradoxical communication, which characterized the Palo Alto group. When the original grant ended, work focused on schizophrenia with Don Jackson as a consultant.

As a consultant to the Bateson project, Don Jackson then published his views on family therapy in 1959 and organized the Mental Research Institute (MRI). In 1959, he also began his work with Virginia Satir, a social worker (Broderick & Schrader, 1991). Satir brought about widespread interest and acceptance of family therapy through her professional presentations and writings as well as by her more humanistic side of relationships versus the more mechanistic side (Nichols & Schwartz, 1998).

In 1960, Jackson’s MRI group and Ackerman’s Family Institute group sponsored the Family Process journal. In 1962, Jay Haley became the first editor (Broderick & Schrader, 1991).
When the Bateson project ended in 1962, Haley and Weakland joined Jackson’s MRI group (Broderick & Schrader, 1991). According to Nichols and Schwartz (1998), at the end of the Bateson project, members of the Palo Alto group (including the MRI) became less concerned about the flow and meaning of communication in context and more mechanistic in their concern about the problem and its solution. This was the origin of brief strategic family therapy with its heavy emphasis on indirect, paradoxical techniques (Nichols & Schwartz, 1998).

The following era (1962 to 1977) established by the journal, Family Process (first published in 1962) helped unify the theorists and practitioners. As identified by Broderick and Schrader (1991), this second era ended in 1977 with the development of the American Family Therapy Association (AFTA).

During the second era from 1962 to 1977, several centers on the East Coast became prominent (Broderick & Schrader, 1991). Ackerman’s Institute (formerly known as The Family Institute) continued to be active. The Albert Einstein College of Medicine was founded by leaders who had been trained and mentored by Ackerman or Jackson. The Wiltwyck School for boys under the treatment of Edgar Auerswald and Salvador Minuchin was also active in working with families. Though influenced by Ackerman who worked with middle class families, Minuchin developed his family intervention model around disorganized families. Minuchin treated families involved with poverty, immigration, and limited education. After he and his colleagues (Montalvo, Guerney, Rosman, and Schumer) published Families of the Slums in 1967, Minuchin later became the director of the Philadelphia Child Guidance Clinic. Once in Philadelphia at the Child Guidance Clinic, Montalvo, Rosman, and Haley joined Minuchin. This group refined the
live supervision process as well as developed a training program for paraprofessionals in
the local community. From this work came Structural Family Therapy (which became
popular in the 1970s) based on its simple, but innovative map of family structure,
organization, and communication (Nichols & Schwartz, 1998).

Leading to the end of the second era, marriage counselors in the 1960s began to
merge with family counselors. Though marital therapy or couples counseling originated
in the 1930s and 1940s, and the first use of the term “family therapy” did not originate
until the 1950s, marriage counselors and family counselors are currently linked and
recognized as one profession by the American Association for Marriage and Family
Therapy (AAMFT) (Shields, Wynne, McDaniel, & Gawinski, 1994). The events leading
up to the current name show that in 1970, the American Association of Marriage
Counseling became known as the American Association of Marriage and Family
Counselors. This organization also began accrediting training programs in marriage and
family therapy as early as 1974. Finally in 1978 this organization changed its name to
the American Association of Marriage and Family Therapy (AAMFT). The AAMFT has
now established marriage and family therapy as a specialty field within the counseling
profession (Shields et al. 1994).

In 1977, nearing the end of the second era of the family counseling movement, the
American Family Therapy Association (AFTA) was founded, with Murray Bowen as its
first president (Broderick & Schrader, 1991). (Murray was a child psychiatrist who
formulated the theory of differentiation and popularized the use of family genograms.)
This organization (AFTA) provided a collective identity for many of the founders and
early leaders in family therapy.
Theoretical approaches in family therapy.

Major schools of family therapy were established in the 1960s and 1970s (Minuchin, 1998). "...Competing ‘schools’ of therapy were becoming differentiated..." (Broderick & Schrader, 1991, p. 30). Approaches of family therapy became differentiated based on models such as psychoanalytic (Ackerman, 1958; Ackerman, 1966), strategic (Haley, 1976; Madanes, 1981), structural (Minuchin, 1974; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), experiential (Satir, 1964; Satir, 1971), Bowenian (Bowen, 1978), and cognitive/behavioral (Ellis, 1978; Liberman, 1970). However, Minuchin (1998) states, "...there was also a remarkable solidarity in the shared beliefs that defined the field. The pioneers were united in their rejection of psychoanalysis and embrace of systems thinking, however, much they might have differed in their therapeutic techniques" (p. xiii).

In the years following the middle 1970s to the present, a reevaluation of theoretical stances and a refinement of the issues emerged. Systems theory was challenged as a result of the expansion of family therapy across different cultures and populations (Broderick & Schrader, 1991; Guttman, 1991; Minuchin, 1998). Minuchin (1998) identified two main challenge areas. Theoretically, because of circular causality, feminists questioned the absence of gender and power especially as it related to family violence, inequalities in gender, and oppression. Therapeutically, the tendency to exclude the treatment of individual family members and intrapsychic issues was also questioned (Guttman, 1991; Minuchin, 1998; Nichols & Schwartz, 1998). Other issues such as ethics and multiculturalism arose in addition to the need for empirical validation (Broderick & Schrader, 1991). New family counseling approaches emerged as a result.
Family therapies in the twenty-first century include three major perspectives (Goldenberg & Goldenberg, 1996). The first, postmodern constructivist approach posits that, “reality exists only in the context of each person’s set of constructs for thinking about it” (p. 328). During therapy the family’s behavioral sequences or transactional patterns are given less importance than the meaning attributed to various events and construction of a more desirable family story. Example therapies include brief, solution-focused therapy and narrative therapy. The second therapy to recently arise is gender-sensitive family therapy with emphasis on equity and the ability to choose roles based on empowerment versus gender-biased stereotypes. The third new perspective is the psychoeducational approach with emphasis on coping skills instruction. This approach includes medical family therapy or models for living with family members with a mental illness.

Enduring concepts in the field of family counseling include the following elements: (a) interconnectedness whereby all individuals operate within systems, (b) change in one part reverberates throughout the system, (c) emphasis is on circular or multiple sequences versus linear sequences (except in special cases such as violence or oppression), (d) symptoms are embedded within the context of the systems with need to identify the functions of symptomatic behaviors, (e) focus is on solutions, (f) acknowledgement of the context and culture in which the family operates, and (g) client pathology that is de-emphasized (Nichols & Schwartz, 1998). Though differences continue to exist in intervention techniques, a trend towards integration has emerged in the last decade (Goldenberg & Goldenberg, 1996).
In summary, the emphasis in family systems theory and family therapy is placed on individuals in context with their primary relationships. Shields et al. (1994) state, Family therapy is primarily concerned with the relationships between persons, especially in marriages and families. Family therapy is also concerned with how these family relationships and their disruptions are linked both to the physical and mental disorders of individuals and to phenomena in larger contexts in the community, workplace, and society. (p. 118)

Systems theory emphasizes an interdependence of members within a structural unit (e.g., the family) while ecological theory involves a perspective of the child in context (Carlson, 1992).

Though family systems theory is no longer synonymous with family therapy, it remains closely associated with it. Currently, major treatment models in family systems therapy include: (a) psychoanalytic, (b) strategic, (c) structural, (d) Bowenian, (e) experiential, (f) cognitive-behavioral, and (g) the more recent brief, solution-focused model (De Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986). (Brief, solution-focused family therapy is a more recent model made popular due to its brevity, focus on solutions, and ease of learning [Nichols & Schwartz, 1998].) These models are all committed to systems thinking and family processes, but vary in the degree to which systems concepts are manifested in treatment or therapy (Nichols & Schwartz, 1998).

Though general systems theory expands to include multiple systems, and ecological theory accounts for the interactive relationships among systems, the term used by Fine (1992), “systems-ecological” magnifies the reciprocal nature of behaviors across
settings. Ecological systems theory is about “linking lives to context” (Bronfenbrenner, 1995, p. 623). Carlson (1992) affirms the “complementarity of systems theory and ecological theory” (p. 19) as useful in conceptualizing school-family relationships.

Given the nature of public schools and the recommendations in the professional literature for brief therapies (Hinkle & Wells, 1995), the well-established briefer therapies will be included in the current survey research. In addition, “Almost every survey of clinicians conducted within the past ten years shows that most clinicians are becoming increasingly eclectic and integrative” (Pinsof & Wynne, 2000, p. 3). Therefore, an eclectic/integrative approach will be added to the questionnaire form in addition to the better-known family counseling approaches.

Research Effectiveness

In 1995 the Journal of Marital and Family Therapy published a special issue on the scientific knowledge to date regarding the effectiveness of marital and family counseling. The definition of family therapy that these researchers used was as follows: “...psychotherapy that directly involves family members in addition to an index patient and/or explicitly attends to the interaction among family members” (Pinsof & Wynne, 1995, p. 586). In addition, marital counseling was defined as therapy involving partners and/or therapy focusing on their interpersonal transactions. These authors concluded that “convincing scientific evidence supports the efficacy of broadly defined marital and family therapy for the treatment of many disorders, as well as its superiority to standard and individual treatments for certain disorders and populations” (Pinsof & Wynne, 1995, p. 585).
A meta-analytic study of 163 randomized trials was conducted by Shadish, Montgomery, Wilson, Wilson, Bright, and Okwumabua (1993). Shadish and his colleagues conducted this study to determine the effects of marital and family therapy. Scientific trials that were examined took place between 1963 and 1988 with \( N = 101 \) for family therapy and \( N = 62 \) for marital therapy. All trials included a comparison group with 105 studies using comparisons to other treatment groups and 71 using control groups. Thirteen studies had both treatment and control groups. Methodology in the studies chosen was cited as adequate. Results revealed that marital and family psychotherapy had better outcomes at posttest than control groups. In addition, little statistical differences were found in the theoretical orientations, though behavioral orientations, especially in marital therapy, generally produced stronger effects than non-behavioral therapies. Effect sizes for family therapy were non-significant and lower than marital therapy effect sizes though the authors pointed out that this may have been confounded by the differences in the more complex issues often presented in family counseling.

Pinsof and Wynne (1995) described the Shadish et al. (1993) meta-analysis as the most comprehensive study to date. Family therapy models reviewed by Shadish et al. (1993) were noted as follows: (a) behavioral (cognitive-behavioral, parent training, contingency, and solution-focused, (b) systemic (structural, strategic, Milan), (c) humanistic (Satir, Rogerian), (d) psychodynamic (insight-oriented, Adlerian, psychoanalytic), and (e) eclectic (integration of various family therapies).

A review of the Shadish et al. (1993) meta analysis was conducted by Shadish, Ragsdale, Glaser, and Montgomery in 1995. Results clearly indicated that the efficacy of
marital and family therapy outcome studies was significant therapeutically, and at least as
effective as individual therapy. When compared to control groups, 71 marriage and
family therapy (MFT) studies showed significant differences with an effect size of $d = .51$. When family therapy was evaluated apart from marital therapy (MT), the effect size
of FT ($n = 44, d = .47$) was slightly smaller than MT ($n = 27, d = .60$), though both effect
sizes were statistically significant. Further, family therapy was shown to be effective
with childhood behavior problems ($n = 18, d = .53$), childhood aggression ($n = 5, d = .61$), general family functioning ($n = 4, d = .60$), and communication/problem solving ($n = 2, d = .52$). However, fewer studies were done with problems related to delinquency ($n = 8$) and school achievement ($n = 1$) with little to no findings from this limited number of studies to support efficacy. Though little evidence was found to support one orientation
over another, behavioral therapies and systemic therapies tended to perform better than
psychodynamic, eclectic, and unclassified ones depending on the type of statistical
analysis. These authors presented the view that methodologically, family therapies were
difficult to compare due to confounding variables such as standardization, sample sizes
(too small), number of outcome measures (e.g., self versus observational reports), client
attrition, or type of publication (dissertation versus journal). Recommendations were
made for researchers to establish increased standardization procedures among
themselves. It was noted that university settings produced larger effects than clinical
settings as was the case with randomized versus non-randomized samples. Though
behavioral, systemic, and eclectic therapies produced solid research, better studies were
still needed in psychodynamic therapies. Several studies showed cost effectiveness when
comparing hospitalization to family crisis intervention. Shadish et al. (1995)
summarized the 1993 meta-analysis stating that MFT “...demonstrates moderate and often clinically significant effects” (p. 358).

Estrada and Pinsof (1995) conducted a comprehensive review of the empirical studies involving family based therapies in the treatment of childhood behavioral disorders (ages 14 and younger). In general, interventions for childhood disorders were initially limited to the individual treatment of the child. More recently the treatment broadened to involve the child as well as the family and other ecological settings such as the school. Because studies involving family therapy with targeted childhood problems were limited, the study expanded to include the parent management training model (PMT) which included numerous behaviorally oriented approaches with the family (e.g., parenting techniques to improve childhood behaviors.). Childhood disorders were classified as externalizing (conduct disorders, Attention Deficit/Hyperactivity Disorder), internalizing (phobias, anxieties), and pervasive developmental disorders (autism). Definitions of all childhood disorders were based on DSM-IV diagnostic features.

When examining the research in effectiveness with conduct disorders, Estrada and Pinsof (1995) found overall support for PMT as an effective treatment model. With added strategies such as marital accord procedures, further advantages were identified. In general, many methodological difficulties such as high attrition rates were found. Only three studies existed where traditional family therapy treated conduct disorders, and these studies contained methodological flaws. In these studies PMT performed better than family therapy, in part, due to the specific nature of the behavioral interventions that revolved around targeted behaviors.
In the area of Attention Deficit/Hyperactivity Disorder (AD/HD), the parent management training (PMT) model and structural family therapy (one study) were effective in intervening with behavior problems in general (e.g., noncompliance and aggression), but were not effective in dealing with the core diagnostic features of AD/HD including inattention and overactivity (Estrada & Pinsof, 1995). Research also highlighted the need to involve the school setting in improving school performance.

Multimodal therapy plus psychostimulant medication showed long term positive effects; however, the intervention that appeared most effective with AD/HD was medication.

In Estrada’s and Pinsof’s (1995) review of family-based approaches with internalizing disorders, only tentative evidence for treatment effectiveness existed with childhood fears; however, more evidence for treatment effectiveness existed with school phobia and the overanxious disorder. Problems such as having no comparison groups or inadequate sample sizes were found in these studies.

In their study of family-based approaches with autism, Estrada and Pinsof (1995) found clear evidence--from the 12 PMT studies reviewed--to cite effectiveness. Parental interventions that were found effective stressed teaching and therapy.

In summary, Estrada and Pinsof (1995) found that parent-involved interventions were consistently effective with conduct problems and autism, with many studies showing long-term gains. By comparison, the effects of family-based treatment with AD/HD and internalizing disorders such as fear and anxiety were not as supportive. There were suggestions that PMT might be more effective with certain childhood disorders than family therapy, though too few family therapy studies were found to arrive at conclusiveness. When using an expanded definition of family therapy that entails...
family involvement, "...there is a significant body of evidence supporting the efficacy of family therapy in the treatment of childhood psychopathology" (Estrada & Pinsof, 1995, p. 434).

Chamberlain and Rosicky (1995) reviewed the studies involving family therapy and its effects on adolescents with conduct disorders and delinquency. As Shadish et al. (1993) had conducted a meta-analysis on studies from 1963 to 1988, only studies from 1989 to 1994 were included in Chamberlain's and Rosicky's (1995) review. Studies reviewed were classified as social learning family therapy (which was behavioral), structural family therapy (based on the structure of the family and patterns of transactions), and multi-target ecological treatment. (As a reflection of recent approaches to treatment, the last model was multifaceted or multi-systemic to include multiple settings and a combination of interventions with its focus on treatment of severe conduct problems.) Results from seven studies since 1988 based on three criteria (control groups, specific family interventions, and measurement of conduct or delinquency problems) showed that when viewed as a group, "...family therapy interventions appear to decrease adolescent conduct problems and delinquent behavior when compared to individual therapy, treatment as usual, or no therapy" (Chamberlain & Rosicky, 1995, p. 445). Though the studies chosen met three criteria, methodology limitations such as small sample size were noted with more research needed to be conclusive. Other studies were also cited by Chamberlain and Rosicky (1995) that validated family therapy as an effective treatment approach.

From the research articles included in the 1995 special issue of the Journal of Marital and Family Therapy, Pinsof and Wynne (1995, 2000) summarized the empirical
evidence on MFT (though not all of the articles were reviewed in this dissertation). In general, family therapy produced effective outcomes and was clinically more effective than no psychotherapy for the following child or adolescent problems: adolescent conduct disorders, anorexia in young female adolescents, adolescent drug abuse, conduct disorders, autism, chronic physical illnesses in children, child obesity, and cardiovascular risk factors as well as aggression and noncompliance in AD/HD children. MFT was not deleterious or destructive in its effects. MFT was more effective than standard and/or individual treatments for conduct disorders and drug abuse in adolescents, anorexic adolescent females, childhood autism, and chronic childhood illnesses. One theoretical orientation was not superior to another. MFT was shown to be more cost effective than residential treatment or inpatient treatment for schizophrenia and adolescent conduct disorders and delinquency. Finally, in more severe disorders such as adolescent drug abuse or chronic mental disorders, MFT was not sufficient alone to successfully treat them. “The research on these problems suggests that family involvement is a critical and necessary component in the treatment of these problems but is not sufficient in itself” (Pinsof & Wynne, 1995, p. 605). For most severe disorders, family involvement potentiated other treatment. These researchers made the point that more “gold standard” replication studies were needed to be conclusive (Pinsof & Wynne, 2000).

Introduction to School-Based Family Therapy

This introduction provides an overview of school-based family counseling. It includes major issues surrounding this practice followed by an in-depth review of the research based literature.
As a result of the expansive family therapy movement and its paradigm shift from the individual psychopathology model to the family systems model, systems ecological theories are beginning to permeate school-based interventions. These interventions recognize the interrelatedness of the family and the school in addressing school problems (Carlson, 1992; Fine, 1992; Fine & Carlson, 1992; Fine & Holt, 1983). In addition, the establishment of the major models of family therapy and influential work of their originators have given rise to the use of family counseling in nontraditional settings such as the public schools (Hinkle & Wells, 1995). This paradigm helps explain the complexities of family-school interactions as well as provides alternative types of innovative family-school interventions (Doherty & Peskay, 1992).

A systems ecological approach should not be confused as synonymous with family counseling (Fine, 1992). Home-school interventions such as parent education, parent consultation, parent conferencing, family interviewing, support groups, and parent volunteerism also fall under this paradigm. In their review of the research on parent involvement, Christenson, Rounds, and Franklin (1992) state that, "...there is a substantial body of literature that documents the positive effects of parent involvement in schooling" (p. 32). These authors proceed in saying that, "...benefits include improved achievement, attitudes, and better relationships between teachers and parents" (p. 32). The systems ecological approach is a way of thinking that is holistic and contextual. Subsequently, the systemic ecological approach requires that the student be viewed not only as an individual within the school, but also as an individual within a larger context. This includes the family and the community.
A fully functioning parent program should include more than just family counseling (Palmo, Lowry, Weldon, & Scioscia, 1984/1988). No single intervention is sufficiently effective to preclude all others (Beck, 1984; Kazdin, 1993). Helpful in understanding where parent or family counseling falls relative to other parenting programs, several models of family involvement have been proposed for use in the schools (Doherty & Peskay, 1992; Fine & Carlson, 1992; Lombana, 1983). These models identify parent or family counseling as the highest, most demanding, and most interactive level of parent and family intervention when compared to other parent-school interventions. Fine and Carlson (1992) view parent or family counseling as a direct service in comparison to both parent education and parent consultation. Doherty and Peskay (1992) view parent or family counseling as more interactive in bringing about attitudinal changes than either conferencing or consultation. Lombana's (1983) hierarchy of parent involvement highlights the number of parents reached by a particular type of activity and the amount of time and expertise required on the part of school personnel. Proceeding up Lombana's (1983) pyramid, general school activities take the least amount of expertise and time, but reach more parents. Parent education and conferencing take more time and expertise but begin to reach fewer parents. At the top of the pyramid, parent or family counseling reaches fewer parents, with more time and expertise required of the mental health educator.

According to Swap (1992), the conventional method of interacting with the home has been the "school to home transmission philosophy" which provides support to the families for school assignments and activities using one-way communication. The "school to home transmission philosophy" includes the family minimally and only as
necessary. As proposed by Swap (1992), home-school partnerships are identified as the highest level of the parent involvement model. "Positive family-school connections are not automatic; however they are essential to children's optimal success in school and must become a major focus within educational restructuring efforts" (Christenson, 1995, p. 253). In order to engage in partnerships with families, they must be empowered. One way this can be accomplished is through parenting programs such as school-based family counseling. This last tier of family involvement was investigated in the current study.

Though the professional literature and even legislation recommend school-family partnerships, Epstein (1992) states that few schools have actually developed comprehensive programs. In the wake of such shortcomings, school-based mental health professionals are called upon to expand their skills in order to have the greatest impact on our nation's school children. Part of this expansion includes adopting a paradigm shift from intrapsychic to contextual.

When assessing and intervening with student problems, school professionals have traditionally applied the medical model which uses individual labels and diagnostic terminology (Howard, 1980; Kraus, 1998; Mince, 2001). This model is more individual or intrapsychically oriented than systemic or interactionally oriented (McDaniel, 1981).

For example, [the traditional] model would dictate that we describe a child who acts sad and cries everyday in school as a depressed child. This child contains that depression as a trait within him or her. If the depression is chronic or "core depression," it is viewed as the result of some very early loss that stunted the child's psychosexual development....The systems model, on the other hand, ...looks at the primary interactions in the child's life and how the child's
symptoms affect those around him or her. (McDaniel, 1981, p. 215)

“Adoption of a family systems orientation dramatically changes our perspective on the etiology of school-related problems” (Fine & Carlson, 1992, p. xi). It also dramatically changes the perspective on interventions. No longer are the child’s problems based intrapsychically, but they are “based contextually in the immediate and extended sets of relationships in which the child is embedded” (p. xi). With the professional literature recommending family systems interventions for school related problems (Fine & Carlson, 1992; Goldenberg & Goldenberg, 1981/1988; Hinkle & Wells, 1995; Paget, 1987; Sawatzky, Eckert, & Ryan, 1993; Walsh & Williams, 1997; Woody, Yeager, & Woody, 1990), a paradigm shift is required of many school-based mental health professionals as well as teachers and administrators (Malone, Manders, & Stewart, 1997).

In the midst of school reform and its attempt to deal with the growing complexity of our society (Paget, 1987), school counseling programs must also reform (Cecil & Cobia, 1990; Kraus, 1998). It is tempting to grapple with these changes by hanging onto the old, especially with limited understanding of systems and ecological theory to guide one into a new framework of thinking and interacting. However, mental health professionals (including those professionals working in the schools) are confronted regularly with: (a) family crises (child and adult suicidal ideation, emotional disorders, health, substance abuse, family violence), (b) family issues related to diversity (cultural, ethnic, racial, gender), and (c) family law (custody/divorce, abuse) (Goldenberg & Goldenberg, 1996). These issues call for job role expansion of the three groups of school-based mental health professionals who are hired to provide school counseling services. School counselors, school psychologists, and school social workers must view
a student's behavior and performance from a larger perspective. No longer can the school system compartmentalize education into strictly an intellectual endeavor. Children also develop and learn in a family system and a community system, thus creating mutual interplays and interactions among these experiences (Bronfenbrenner, 1977, 1979; Christenson, Rounds, & Franklin, 1992). School-based mental health professionals must become more cognizant of the reciprocal influences of students' major contexts (Paget, 1987). This belief argues for an expanded role among school-based mental health professionals to include or improve their school-family relationships (Green & Fine, 1988). In order to keep pace with changing demographics, changing family configurations, and the growing complexity of society, school-based mental health professionals must adopt family systems thinking and interventions (Donovan, 1992; Hackney, 1990; Nicoll, 1992/1997; Paget, 1987; Sawatzky, Eckert, & Ryan, 1993; Walsh & Giblin, 1988a, 1988b; Walsh & Williams, 1997; Worden, 1981).

A research study by Figley and Nelson (1990) identified the skills required of a novice therapist using Structural Family Therapy, and supported the need for therapists to first conceptualize family issues in a systemic or structural manner. Using the Delphi method, Figley and Nelson (1990) identified varied Structural Family Therapy skills that were required of novice therapists. With the use of a Likert-type scale, one hundred skills were ranked according to their importance as rated by experienced therapists as well as by trainees. From this ranking, the ability to conceptualize family issues in a systemic manner fell in the top ten skills that were necessary for beginning therapists.

A qualitative study was conducted by Sawatzky, Eckert and Ryan (1993) to answer the concern about school mental health practitioners' ability to conceptualize and
apply systemic interventions in light of their work with students using a traditional, intrapsychic or behavioral approach. School counselors who were not family therapists but possessed family systems knowledge were asked to combine family systems interventions with their traditional individual, child centered approaches. Five school counselors met with researchers in three focus group sessions to introduce the project and review systems theory and interventions. Individual interviews followed using critical incident questioning involving a critical moment when family systems strategies appeared effective with a student. Interviews took place over two months and were recorded and transcribed. Fifteen cases were reviewed. From a total of 123 interventions, six major intervention categories were identified: (a) joining, (b) reframing, (c) restructuring of family and reinforcing the parenting role, (d) using paradoxical strategies, (e) teaching parenting and communication skills, and (f) using behavior modification within a systems framework. Counselors then answered four questions regarding their perceptions of the family systems interventions.

Findings of the study by Sawatzky et al. (1993) revealed that school counselors were able to conceptualize their cases in both a systemic and nonsystemic framework without reported conflict and without having to relinquish their previous, more traditional intrapsychic approaches. The researchers suggested that these two approaches were complementary. Additional findings included beliefs that school personnel developed positive relationships with families, that working with families took less time to effect change than individual interventions (three sessions versus longer periods for individual strategies), and finally that counselors found it more rewarding to work with families versus individual students due to longer lasting effects. Though organizing a systemic
approach with families initially took more time and energy, change happened more quickly resulting in fewer sessions. Several counselors had administrators who wanted family cases referred elsewhere, but their initial resistance resulted in eventual support when these supervisors were enlightened by actual intervention effectiveness.

According to professional literature recommendations, counseling programs within the schools need restructuring to include family counseling. Instead of solely offering traditional services, which generally involve individual or small group counseling with students, family counseling provides another alternative to improving school performance (Minke, 2001). Though individual and group counseling will always be necessary (Edwards & Foster, 1995), in the past, the missing intervention piece was the family unit (Kraus, 1998). As a major tenet of family counseling, an individual’s behavior is viewed contextually with the assumption that the impact of one system on the child is not isolated from the impact of other systems.

The primary rationale for school-based family counseling is clearly exposed upon examining the advantages of these two systems joining in order to provide a team approach to problem solving (Fine & Holt, 1983). This advantage is based on the premise that “...the family is ecologically the most crucial unit in society largely determining the development and functions of the individual...” (Friesen, 1976, p. 182). Additional reasons for school-based family counseling are noted in the literature. These reasons include noncompliance of families when referred for outside counseling (Conti, 1971; Hinkle & Wells, 1995), travel convenience or ease of access especially when mental health services are located in neighborhood schools (Atkins et al. 2003), and less costs if done by school-based professionals (Fausold-Mowers, 1998). With the
likelihood of reduced negativism as a result of school-based family counseling, families can build positive school relationships and improve the student's school performance, thereby creating a higher probability that the family will obtain the needed mental health services.

When referring families to counseling resources in the community, disadvantages to using community resources result when families do not comply with the referral request or when family therapists treat families with school-related problems without activating schools as part of the treatment plans (Lusterman, 1985). When family counseling is provided in the schools, the goal of family therapy is often to improve students' school performance. This goal can more easily be defined and achieved in the school where there is better access to teachers, administrators, and other support personnel (Hinkle & Wells, 1995).

The question remains as to what extent family counseling is being done in the schools and who is assigned to do it. Though the professional literature recommends school-based family interventions, Crespi (1997) notes that few school districts have mental health professionals specifically assigned to provide family therapy. Some authors have recommended external providers or consultants (Aponte, 1976; Malone, Manders, & Stewart, 1997; Mince, 2001) while other authors have recommended school-based (or school-owned) providers. Though controversy exists as to who should provide this family counseling service, enough support is given in the professional literature to pursue examination of the practice in family counseling being done by the three groups of school-based mental health professionals employed by school systems. These potential providers of family counseling include: (a) school counselors (Friesen, 1976; Hinkle &
Wells, 1995; Kraus, 1998; Walsh & Giblin, 1988a, 1988b; Wilcoxon & Comas, 1987),
(b) school psychologists (Conoley, 1987a, 1987b; Crespi, 1997; Green & Fine, 1988;
Kamphaus, 1996), and (c) school social workers (Greene, Jones, Frappier, Klein, &
Culton, 1996; Millard, 1990/1997). In addition, Johnston and Zemitzsch (1997) state that
all three groups of designated pupil services personnel should be trained to provide
school-based family counseling.

Due to the research linking school and family issues, families can profit from
being offered direct services in the schools (Clancy, 1995; Mince, 2001). By providing
school-based family counseling, the ultimate goal is to activate the positive and
reciprocal nature of both the family and school system in a balanced and complementary
manner. When these system ties are strengthened, they become the foundation for
strengthening children (Paget, 1987).

In general, efficacy research in school-based family counseling is limited.
However, Donovan (1992) conducted a review of 13 empirical studies to determine if
family systems interventions were effective in treating school-aged problems of children
and adolescents. Though family therapy included at least one parent and one child,
therapy was not necessarily school-based. It was noted that at least one student outcome
variable was required for inclusion in the review, with treatment applied to five
categories of student problems often confronted by school mental health professionals.
This author’s summary of the research on family systems interventions based on five
different child and adolescent referral problems generally supported the use of short-term
family systems interventions. Though not all of these family therapy services were
school-based, Donovan’s (1992) findings suggested that family systems interventions
might be more effective in ameliorating school-related problems than the traditional, child-centered approaches.

In summary, as school-doors are opening to school-based family counseling, more information is needed to determine the extent to which the three groups of school based mental health professionals are providing this service. The roles of each school-based mental health discipline will be examined separately followed by a review of the research-based issues and barriers connected with the practice of school-based family counseling.

School-Based Mental Health Professionals as Family Therapists

School counselors.

In regards to student services, school counselors are often considered the heart of student services programs (Zapeda & Langenbach, 1999). Generally, they are assigned to one school with easy access by school personnel and families. Though the services of school counselors vary from region to region (Campbell & Dahir, 1997), they frequently provide individual and small group counseling, crisis counseling, academic and career counseling, classroom guidance programs, work with school-wide testing programs and academic scheduling as well as work with teachers, administrators and support staff in response to students at risk behaviorally or academically (Campbell & Dahir, 1997; Mince, 2001). It is noted that, generally, classroom guidance is more prevalent at the elementary level while testing activities, academic scheduling, and career counseling are more prevalent at the middle and high school levels (Roberts & Borders, 1994). Though elementary, middle, and high school services fluctuate across levels, core services tend to exist.
Upon development of the guidance counseling field in the early 1900s, three phases were evident based on both legislation and historical events. The first phase was known as the trait and factor period. During this time from 1900 to 1920, vocational guidance was prominent. The second phase was known as the mental hygiene period. During this time from 1930 to 1960, social-emotional adjustment was prominent. The third phase was known as the developmental period. During this time from 1960 to the present, developmental elements of students' need took precedence (Gysbers & Henderson, 1988; Zepeda & Langenbach, 1999).

The American School Counselors Association (ASCA) was established in 1952 as a distinct and separate association representing the school counseling profession (Campbell & Dahir, 1997). A national model for school counselors was created by ASCA in 2002 (Bowers, Hatch & Schwallie-Giddis, 2001). According to ASCA, the current focus of the school counseling program is to promote student learning through three interconnected areas of student development. These three areas of student development are: (a) academic, (b) career, and (c) personal/social (ASCA, 2003; Campbell & Dahir, 1997). The definition formulated by the ASCA's governing board in 1997 follows:

Counseling is a process of helping people by assisting them in making decisions and changing behavior. School counselors work with all students, school staff, families, and members of the community as an integral part of the education program. School counseling programs promote school success through a focus on academic achievement, prevention and intervention activities, advocacy, and social/emotional and career development. (Campbell & Dahir, 1997, p. 8)
Hence, in a comprehensive school counseling program from grades kindergarten through 12, the following roles are identified: (a) counseling (individual and small group), (b) consultation (with parents and teachers), (c) coordination (liaison between parents, instructional staff, resource staff, and the community), (d) case management, (monitoring progress), (e) guidance curriculum (prevention, classroom activities on academic, career and social/emotional topics), and (f) program development and evaluation (evaluation of programs) (Campbell & Dahir, 1997).

As a part of the educational reform movement, ASCA also adopted the eight objectives outlined in Goals 2000. Both ASCA’s school counseling model and Goals 2000 commit to parental involvement. As just noted, ASCA interprets parent involvement as parent consultation through individual or group conferences, parent education, or liaison and coordination of needed school and community services (Campbell & Dahir, 1997).

The term “guidance counseling” has been replaced in many states by the term “school counseling” to more accurately reflect the field’s “...expanded counseling functions” (Campbell & Dahir, 1997, p. 8). Counseling became a prominent part of the guidance counselor’s role after the introduction of Carl Roger’s nondirective approach in the 1940s which expanded the definition of guidance counseling and paved the way for nonmedically trained professionals to practice counseling (Aubrey, 1977). The emphasis in this approach was the treatment of individuals. Though the latest school counseling model has expanded to acknowledge the need for work with parents, this model is closely aligned with the academic program of the school and appears somewhat narrow in its definition of counseling and mental health. Further examination is warranted given the
recommendations in the professional literature already in the early 1980s for expansion of
the school counseling role to include families and family counseling.

As early as 1976, family counseling was described as a viable role for school
counselors (Friesen, 1976). Since that time numerous authors and leaders in the field of
school counseling have reviewed and recommended its merits. Goldenberg and
Goldenberg stated in 1981, “Family therapy could be considered an idea whose time has
come” (p. 165).

In 1981, two school counseling journals devoted special issues to family
counseling: The School Counselor and Elementary School Guidance and Counseling.
Elementary School Guidance and Counseling prefaced its special issue (volume 15, issue
3, 1981) by stipulating the conditions under which family counseling in the schools are
appropriate (McComb, 1981). In regards to counselors, they must have appropriate
family counseling training, work under the supervision of family therapists, and obtain
support from school administrators. In regards to specific procedures with the families,
attempts should be made to conference with them before engaging in family counseling.
Families with less severe issues who are merely “stuck” are better school counseling
candidates than families with severe disorders who should be referred to community
resources.

“Historically school counseling has been viewed from an individual model”
(Kraus, 1998, p. 13). School counselors have traditionally addressed the child’s problems
apart from the family’s (Palmo, Lowry, Weldon, & Scioscia, 1984/1988). However, by
being called upon to provide comprehensive services to meet the developmental learning
needs of all children, “A school counselor who delivers only one or two types of
counseling services will only be able to help a limited number of students” (Brotherton & Clarke, 1997, p. 44).

Because of the changing demographics and the changing needs of students, vital or essential questions must be posed about whether the services offered at present by school counselors are sufficient for the task at hand (Lockhart & Keys, 1998). With community mental health services becoming harder to access by the general public due to factors such as managed care and downsizing, school counselors are challenged to redefine themselves as mental health counselors and take the necessary steps to obtain the school system’s support for this role. School counselors must develop expanded resources to meet the contemporary needs that are becoming less available in the community. These mental health services incorporate family systems interventions (Lockhart & Keys, 1998), which ultimately can include family counseling.

Though school counselors traditionally do not provide family counseling services, this intervention is recommended for school counselors who are trained in this type of counseling (Hinkle & Wells, 1995; Palmo et al. 1984/1988; Wilcoxon & Comas, 1987). These authors proceed in saying that the contemporary school practitioner cannot ignore the mental health trends in family counseling or the mental health needs of today’s students. To better address contemporary needs, Hackney (1990) supports the mental health role of the school counselor and holistic family systems interventions. Other authors who voice their support of school counselors updating their training and roles as family counselors include Kraus (1998), Keys and Bemak (1997), Goodman and Kjonaas (1988), Amatea and Fabrick (1981), and Beck (1984).
Several books have been written on the subject with Hinkle and Wells (1995) proposing in their book, *Family Counseling in the Schools: Effective Strategies and Interventions for Counselors, Psychologists and Therapists*, that family counseling be school-based and conducted by school counselors versus external practitioners. In Walsh and Giblin's edited book in 1988, *Family Counseling in School Settings*, school counselors and other school professionals in the helping profession are encouraged to adopt a systems approach in their assessment and treatment of students with school related problems. This includes family counseling. In the edited book by Walsh and Williams (1997), *Schools and Family Therapy: Using Systems Theory and Family Therapy in the Resolution of School Problems*, school mental health professionals are challenged to make the paradigm shift from the individual, medical model to the family systems model, with descriptions of how to apply family counseling interventions.

School counselors are inimitably and unquestionably positioned to participate in this therapeutic approach (Goldenberg & Goldenberg, 1981/1988). In their daily work with individual students, school counselors are confronted with the family’s influence. In addition, school counselors generally have access to the systems that most influence the child. Pressing issues encountered regularly by many counselors include suicidal threats or ideation, substance abuse, physical aggression, threats of school-wide violence, apathy, or mental health disorders. When intervening with these issues (which frequently affect school performance), the school counselor must have knowledge of the school system, the family system, and the larger community system. These problems are best addressed, not by counselors applying traditional individual interventions alone, but also
by counselors using an eco-systemic perspective that involves the family, other school personnel, and community services as appropriate (Hackney, 1990).

Barriers for school counselors engaging in family therapy appear in the literature. In order to engage in family counseling, school counselors must be adequately trained, receive regular clinical supervision, and obtain administrative support such as flexible scheduling, physical resources, and fiscal resources (Kraus, 1998; Goldenberg & Goldenberg, 1981/1988; McComb, 1981; Palmo et al. 1984/1988).

Debate exists in the professional school counseling literature regarding the role of school counselors as school-based family counselors. According to Paisley and Borders (1995), proponents of school counselors taking on the role of family counselors in the schools contend that family variables play a prominent role in a student’s school performance with scientific evidence to support family counseling as an effective school intervention. Opponents cite school counselors’ lack of time in light of an overwhelming number of tasks and responsibilities that are already expected.

Though elements of the professional school counseling literature declare family counseling as a service “...whose time has come” (Goldenberg & Goldenberg, 1988, p. 26), to what extent are school counselors currently engaging in this practice? Cecil and Cobia (1990) suggest in their review of studies regarding school counselors’ roles that little has changed in the last 20 years despite the more pluralistic nature of the nation’s schools. The profession is at a crossroads with recommendations for a shift from the more individual approach to the systemic approach. Family counseling in the schools is often supported in theory, but converting theory into reality can be difficult (Palmo et al. 1984/1988). How much progress has been made in turning this theoretical ideal into
reality? Have school counselors stayed current in meeting the contemporary needs of today's students?

The role of school counselors as family counselors is viewed in the literature as compatible and a natural extension of their school responsibilities (Beck, 1984; Goldenberg & Goldenberg, 1981/1988; Hinkle & Wells, 1995). As reform is necessitated in public education, concomitant reform is necessitated in school counseling programs to include a more holistic view and treatment of students (Cecil & Cobia, 1990; Kraus, 1998). How much change in school counselors' roles has been achieved? How prevalent is the practice of family counseling among school counselors?

School psychologists.

With the advent of The Education for All Handicapped Children Act in 1975, provision of psychological services in the schools emerged as a requirement. These services were provided in most school divisions by school psychologists (Talley & Short, 1995a). These authors state,

As the specialists credentialed to provide psychological services in the schools, school psychologists have flourished in numbers and influence over the last twenty years. However, the services that school psychologists provide typically have centered around psychoeducational assessment, often to the exclusion of other services for which they may have been prepared to deliver. (p. 3)

From the beginning, school psychologists' roles revolved around the assessment of individual students with learning characteristics that were different from the average student. Though the first psychologist was hired in Connecticut schools in 1915, it was not until the late 1940s through the 1980s that school psychologists' roles were more
clearly established and defined. After the enactment of the federal legislation for
disabled students in 1975, school psychologists became closely identified with “testing”
and special education. Through milestone conferences and symposia, roles and functions
expanded from evaluation to involvement in indirect interventions (e.g., consultation) as
well as direct interventions (e.g., conducting individual counseling and implementing
behavior modification programs) (Zapeda & Langenbach, 1999). Despite this expansion,
Fagan and Wise (1994) cited results of several surveys conducted from the mid 1980s to
the early 1990s which suggested that, although school psychologists were clearly
involved in consultation activities and direct interventions, assessment-related duties still
occupied much of their time. In addition, one survey conducted by Reschly and Wilson
(1995) showed that most school psychologists were involved predominantly in
psychoeducational assessment, though their preferred role included less testing and more
direct interventions and problem solving.

Traditionally, psychoeducational assessments, consultation, and interventions
were conducted from an individual, intrapsychic perspective versus a systems perspective
(Doherty & Peskay, 1992; Wendt & Zake, 1984). As early as 1972, Minor (1972)
contrasted an ecological, systems approach with the traditional intrapsychic medical
model to show how school psychologists could solve student problems systemically.
Smith (1978) as well as Green and Fine (1980) followed suit calling for an expansion of
the role of the school psychologist to include the family systems approach. According to
Epstein (1992), the 1980s brought a glimmer of change in school psychologists’ practice
to a broader contextual and systemic perspective that included family counseling
strategies with services to parents of children with disabilities. In 1987 the School
Psychology Review (volume 16, issue 4) published a mini series on “Family Systems Assessment and Interventions.” This issue espoused the merits of the ecological and family systems approaches due to the field’s increased interest in family interventions (Erchul, 1987). More currently, Best Practices in School Psychology, III (Thomas & Grimes, 1995) contains several sections on systems interventions.

The National Association of School Psychologists (NASP) is presently the most influential organization in establishing standards and credentials for school psychologists. In the early 1950s, school psychologists were part of the American Psychological Association, Division 16. NASP was founded in 1969 with the mission of “…promoting educationally and psychologically healthy environments for all children and youth by implementing research-based, effective programs that prevent problems, enhance independence, and promote optimal learning” (NASP, 2000, p. 3). Current NASP recommended job roles (NASP, 1999) include: (a) assessment, (b) consultation with teachers, parents, and administrators, (c) prevention (behavior problems, learning problems, violence), (d) education (substance abuse, crisis management, classroom strategies), (e) health care provision (linking children and families to needed services), (f) research and planning, and (g) intervention. Intervention more specifically includes mental health services such as social skills training, conflict mediation, crisis intervention with students and families, and psychological counseling with children and families.

Currently, the mental health role is a recommended part of the school psychologist’s training and job functions (NASP, 2000, 2001a, 2001b). (NASP standards [2000] are described as the expanded version of school psychology roles and functions, adapted from the work of Ysseldyke, Dawson, Lehr, Reschly, Reynolds, and Telzrow.
In order to carry out this mental health role, school psychologists must have knowledge about societal and family stressors that influence school performance and the child's ability to learn. Using family systems knowledge and an ecological approach are both recommended as ways to provide comprehensive services to students and their families (NASP, 2000).

In Ysseldyke's and his colleagues' (1997) blueprint for the field of school psychology, 2 of the 10 recommended job role domains include home-school-community collaboration and promotion of wellness. With less emphasis in the field on psychometric testing, school psychologists are called upon to redefine their roles. Changes in the field call for an expanded role in order to work with the needs of all students (including special education and general education students) in their readiness to learn. An expanded role is also needed for intersystem and interprofessional collaboration to capitalize on available resources. These changes require knowledge of family systems and ecological theories with accompanying interventions to promote the well being of children in both academic and social-emotional areas.

Given the research that supports family-school involvement, school psychologists "...are in an ideal position to help bridge the gap that continues to exist between parents and educators" (Telfer, 1987, p. 7). One such bridge is family counseling. "All school psychologists would benefit from knowledge about basic system and family theory and an overview of family interventions, including family therapy" (Wendt & Zake, 1984, p. 208). Though, historically, therapy has not been a primary role of the school psychologist, identification with this role is beginning to change (Green & Fine, 1980/1988; Prout, Alexander, Fletcher, Memis & Miller, 1993). In the Prout et al. survey
published in 1993, family issues were rated by school psychologists as the most frequently encountered problem in school psychologists’ work with elementary and middle school students. This finding appears to underscore the need for family-school interventions, including family counseling.

With the expansion of roles and the growing interest in family-school interventions, family therapy has become a viable option for school psychologists. Within NASP, a special interest group in family-school psychology was formed already in the 1980s (Carlson & Sincavage, 1987). From the results of the Carlson and Sincavage survey in 1987, school psychologists (especially those with doctoral degrees) engaged in some form of parent or family therapy though, in general, school psychologists spent relatively more time in parent consultation and educational activities than in family therapy. Of the NASP school psychologists surveyed by Spencer (1989), the majority strongly agreed that parent and/or family therapy services were needed in the schools, and that school psychologists should be providing these services. Barton and Garbark (1985) found that school psychologists were desirous of doing more parent and family counseling than they were currently providing. Fausold-Mower’s (1998) reported results of one school-based family counseling program that used school psychologists, school counselors, and school social workers in the provision of family counseling. Results of this outcome study revealed that the majority of families served were satisfied with the services received, and were especially satisfied with the school practitioners’ knowledge of the school system.

Due to the possibility of the profession losing its usefulness, Bardon (1994) strongly opposed being identified solely with a “particularized task” (p. 586) such as
testing. To survive as a profession, school psychologists have been encouraged to broaden their roles in working with both students and their families. Jacob-Timm (2000) predicted that future school psychologists would work in a variety of specialty roles including family interventions such as parent/family counseling. Wendt and Zake (1984) also supported family therapy as a specialty role especially for doctoral level school psychologists. Crepsi (1997) encouraged school psychologists to obtain marriage and family licensure. Due to recent trends in school and health care reform, Talley and Short (1994) stated that school psychologists should be licensed and able to provide a broad array of health and mental health services to schools, students, and their families. School psychologists should be able to work within and among systems and environments in order to provide comprehensive services to all children.

In summary, though family systems interventions have not been a part of the traditional role of school psychologists, engaging in this role is clearly promoted in the current literature (NASP, 2000, 2001a, 2001b; Talley & Short, 1994). Wide ranges of services are delivered by school psychologists with an increasing number of school systems advocating for a full array of services (Talley & Short, 1994). A wide array of services is also advocated by NASP. Part of this extension of services can include family counseling. Because the relationship between schools and families has shown a dramatic shift in recent years, new approaches in school psychology are needed (Donovan, 1992). “When most school psychologists, school counselors, and school social workers are trained in family therapy skills, schools and special education programs will profit greatly” (Johnston & Zemitzsch, 1997, p. 35). Given this
recommended role change and expansion, how much family counseling is being done by school psychologists?

**School social workers.**

Of the three groups of mental health professionals in the schools, school social workers are the most closely associated with systems and ecological theories. The predominant role of a school social worker has been that of a school-home-community liaison for the purpose of educating the whole child (Allen-Meares, Washington, & Welsh, 2000). From the groups’ inception, school social workers have been well grounded in working with parents and linking various environments.

The mission of the school is to educate all children. The mission of the school social worker is to reduce or eliminate barriers that would interfere with the schools’ teaching and the pupils’ learning. Involving parents in the educational process always has been an essential function of school social practice.

(Ziesemer, Marcoux, & Davis, 1991, p. 31)

The field of school social work originated in the early 1900s with its goal of being a liaison between and among the school, the home, and the community (Allen-Meares, Washington, & Welsh, 2000; Costin, 1969). The first school social workers were known as visiting teachers. The field of school social work evolved from an awareness of the external environment’s impact on students’ school performance (Zapeda & Langenbach, 1999). From the mental hygiene movement in the 1920s, to the social casework movement in the 1930s, to the clinical approach in the 1940s to 1960s, to the systems approach in the 1970s, and, finally, to the special education focus in the 1980s, school social work has always had an ecological approach to practice (Allen-Meares,
According to Clancy (1995), ecological theory is the "unifying theoretical perspective" (p. 40) for school social workers.

According to the 1992 standards set forth by the National Association of Social Workers (NASW), knowledge of both systems theory and ecological theory is clearly endorsed by this governing organization (NASW Education Commission Task Force, 1992). NASW was created in 1955 when the American Association of School Social Workers merged with six other social work organizations. In 1978 specific regulatory guidelines were established for school social workers with updated standards approved and adopted in 1992. In January 1995, NASW developed an official section specifically for school social workers (NASW, 1995).

Training and certification requirements are also established by NASW. In NASW accredited programs, preparation generally requires a two-year master’s degree in social work along with an internship. Coursework normally includes counseling in the individual, group, and family formats, along with other areas such as sociology and anthropology (Zepeda & Langenbach, 1999; Jonson-Reid & Wood, 1999).

School social workers are often assigned to more than one school. They can provide clinical or counseling interventions with students and parents, crisis intervention, parent education, family consultation in the home, and school-based family counseling (Ziesemer, Marcoux, & Davis, 1991). They also connect student and families with community resources or other school-based resources (Franklin, 2000). School social workers hold a prominent role as mental health providers in the schools, not only to ensure students’ social-emotional well being, but also to ensure the well being of their parents and families. Schools and families alike are affected by societal trends,
demographic trends, economic trends, and health care trends (Ziesemer, Marcoux, & Davis, 1991). The school social work field was founded on the knowledge of how these environmental factors can potentially create barriers to a child's performance in school.

"Tomorrow's social work practitioners must be ecological thinkers and doers who are comfortable with diverse populations, committed to family empowerment, and competent in work at all levels of human functioning: individual, interactional, familial, group, and neighborhood, and societal" (Pinderhughes, 1995, p. 131). Current trends in school reform include mental health clinics that are school-based and part of health clinics that also provide or coordinate physical and social services to students. This approach is integrative and comprehensive with implications that school social workers can work systemically and more holistically in meeting the diverse needs of today's students and their families (Allen-Meares, Washington, & Welsh, 2000).

With systems theory and ecological concepts being used as a framework to guide the work of school social workers, the school, the family, and the community are all viewed as major systems in which a student functions. Paralleled with the enlargement of school duties and obligations in the 1960s came the expansion of school social workers' services to include interventions "...within any system, or combination of systems, that negatively impinge upon the pupil's functioning" (Allen-Meares, Washington, & Welsh, 2000, p. 61). These services can also entail family therapy.

Millard (1990) provides a theoretical rationale for school-based family therapy and views it as a desirable approach with students who are exhibiting problematic behaviors. "Because relationships constitute the essence of the human experience, the nature, extent, and etiology of symptomatic behavior can be understood only within the
family relational system" (p. 405). This author further describes the tradition of focusing on the child as the "symptom-bearer" (p. 404) and relegating the family’s contribution to a "peripheral role" (p. 404).

...The more we study troubled children, the more we recognize that the symptom-bearer can no longer be considered in isolation, but as symptomatic of a family system in trouble. Thus, family therapy should be the prescribed treatment approach in school-based intervention. (Millard, 1990, p. 408)

Though Millard (1990/1997) recommends adoption of the systems approach to better assess and treat students, he cautions using it at the expense of individual casework that can still be helpful at times.

With the field’s emphasis on the systems and ecological approach to assessing and intervening with the barriers to learning, school-based parent and family counseling is a predicted role for school social workers. Brief forms of school-based family counseling are recommended (Franklin, 2000; Greene, Jones, Frappier, Klein, & Culton, 1996; Millard, 1990/1997; Ziesemer, Marcoux, & Davis, 1991). Franklin (2000) recommends intervention models that are aligned with the newer, briefer models such as cognitive-behavioral or solution-focused. Millard (1990/1997) recommends brief forms of family therapy such as strategic, structural, or behavioral especially when relationships between and among systems are involved. Greene et al. (1996) recommends an integrative model of family therapy that meets once a month and provides choices and novelty in change options. Family therapy is considered by Greene et al. (1996) as an alternative for school social workers when other interventions have been unsuccessful.
In summary, to eliminate barriers to learning, school social workers focus on the whole child using an ecological framework, assessing and intervening across systems and environments (Ziesemer, Marcoux, & Davis, 1991). Family counseling is a natural component of their role. “Since problems of the family and its members cannot be compartmentalized, a family framework for understanding factors within the family unit that affect children’s development allows for a more enlightened and meaningful social work intervention” (Millard, 1997, p. 15). With such an emphasis on the family and the ecological approach, to what extent are school social workers practicing school-based family counseling?

School-Based Family Therapy: Issues and Research

Effectiveness of family counseling in the schools: literature review.

As schools are being called upon to make a paradigm shift from treating just the educational needs to addressing the whole child including his or her contextual influences, what role does family counseling play in serving the needs of our nation’s students? As noted above, a number of journal articles have been published describing the merits of using family counseling in the schools, citing it as a feasible intervention in dealing with school problems, especially those that are rooted in family dynamics or have an etiology in the family (Carlson, 1987; Williams, Robison, & Smaby, 1988).

Though sufficient research has accumulated to substantiate the efficacy of family counseling in general (Pinsof & Wynne, 1995), little has been done to verify the effectiveness of family counseling in the school setting. In addition, little has been done to determine the types of family therapy that work best with particular populations.
Counseling services are mandated by federal legislation for disabled students who need them. These services include parent training and parent counseling. But how much counseling is being done in the public schools for both special education students and at-risk students in regular education? How effective is family counseling when used in the school settings? Much of the literature recommends the necessity for identifying the most useful methods of family interventions with children who are risk for mental health and school-related problems. Though it is understood that one type of treatment alone cannot eliminate all mental health problems (Kazdin, 1993), is family counseling a viable treatment option that facilitates family-school involvement? Can it be used effectively with an array of complex academic and behavioral problems within the schools?

A close examination of the journal literature on school-family interventions shows that much of the literature is a description of recommended practices. As Donovan (1992) states, “There is a proliferation of clinical papers, case studies, and program descriptions that report the use of specific family intervention strategies. These reports are useful in suggesting areas for further research, but for obvious reasons cannot be considered for a comparative analysis of outcome” (p. 441). Donovan goes on to say that the practice of family systems interventions is still “theory-only” driven. Though an emerging number of studies are being conducted, too little evidence exists for solid conclusions. Despite few outcome studies, discussion in the literature suggests a change in educational practice leaning toward systems and ecological theory. Clearly, most of this literature is precursor information for school-based mental health practitioners as possible alternatives to their medical model approaches and child-focused forms of practice.
To better determine the status of counseling services in the schools, a national survey of ASCA school counselors was conducted (O'Rourke, 1991). Though counseling was considered by ASCA as a primary role of the school counselor, this survey found that many school systems were developing partnerships with community mental health agencies to provide counseling services in the schools. Though the author was concerned about the number of non-school certified professionals who were providing these services, this survey points to the perception of many school officials that counseling is warranted with needs greater than the existing school mental health professionals can handle.

Conti provides a rationale for school-based family counseling already in 1971. Though this simple descriptive study is outdated, more recent research specific to family counseling referrals was limited due to the general way in family service referrals were often described in recent school-based mental health studies. School families in Conti’s study were referred to outside agencies for counseling services. Of the 23 families referred for outside counseling services, 15 families never acted on the referral leaving only 7 (or approximately 30%) who complied with the recommended referral services. (Follow up information with one of the 23 families was unobtainable.) In the end, 30% of the families complied with the recommended referral, while only 8% used the community counseling services for more than two sessions (Conti, 1971). If this study reflects the current state of affairs, it underscores the need for school-based family counseling services. “When family counseling is based at the school, parents will show up” (Hinkle & Wells, 1995, p. xii). Recent research on utilization of school-based mental health centers suggests that student attitudes toward these services are supportive
(Santelli, Kouzis, & Newcomer, 1996) and that ease of access improves students’ usage of needed mental health services (Adelman, Barker, & Nelson, 1993; Kaplan, Calonge, Guernsey, & Hanrahan, 1998). In addition, Atkins, Graczyk, Frazier, and Abdul-Adil (2003) found in their study that with special recruiting techniques, families used school-based mental health services with far greater frequency than families who used clinic-based services.

Donovan (1992) reviewed 13 empirical studies using family systems interventions with child and adolescent school-related problems. Though family therapy with at least one parent and child present was required for inclusion of the study, therapy was broadly defined and not necessarily school-based. At least one student outcome variable was necessitated. Five categories of student problems frequently confronted in the schools included: adolescent substance abusers, juvenile offenders and delinquents, adolescents with reported family problems, special education students classified as emotionally disturbed, and general education students with behavior or academic problems. Severe psychiatric or neurological disorders of parents or students were excluded from the study. Studies chosen met four inclusionary criteria: (a) an empirical basis, (b) at least one outcome measure that focused on student improvement, (c) conjoint family therapy with at least one parent and child involved during therapy, and (d) the exclusion of special needs students with brain damage, psychosis, or frequent hospitalizations. Donovan (1992) concluded that, “The family systems intervention research analyzed generally supports the use of short-term family systems intervention” (p. 449). Further, family interventions based on systemic orientations were more effective in reducing recidivism than traditional court programs such as probation. The families themselves perceived
improved functioning with results that were stable in six month follow-up studies. Not all family members had to be present to be effective, adding versatility to this intervention.

In the area of school performance, Donovan’s (1992) findings showed that students with behavior problems responded better to family systems interventions than students with poor academic performance. Not only did many student behaviors improve, but also family functioning and family communication. However, severe behaviors such students with bizarre thinking or anxiety did not improve. Donovan (1992) noted methodological problems such as no control groups in approximately half of the studies, limited use of pretest measures, and few longitudinal or follow-up studies. Though Donovan cited a number of methodology limitations, this researcher concluded that “…family systems may indeed be a more productive and economical intervention for some school-related problems of students than many of the intensive child-focused interventions presently employed” (p. 457).

According to the literature, school intervention programs can generally produce utilization data that have implications about treatment effects; however, they do not substitute for outcome or process studies (Dryfoos, 1994). An example of a service producing utilization data was The Topeka Public School Family Therapy Program, which was described by Merrill, Clark, Varvil, Van Sickle, and McCall (1992) as a model program for family therapy in the schools. This school-based family service took place in a Midwest, urban school district of 15,000 students. This program utilized the structural approach and Haley’s life sequences that were both consistent with the systems orientation. School counselors, school psychologists, and school social workers were
trained by an experienced supervisor in family counseling. Training occurred in the school setting for two hours on a bi-monthly basis with the use of seminars, videotapes, and readings. The school district provided the resources for this training. During counseling, trainees worked as a co-therapy team, with their sessions taped for review by their supervisor during group and individual supervision. From 1982 to 1987, family counselors saw 137 families with each therapist treating two to three families each year. Each family was seen on the average of 11 times ($M = 10.9$, $SD = 7.1$). The most common problems that were referred were parent-child conflicts (27%), poor school performance (22%), oppositional behavior (13%), family communication difficulties (13%), step-family formation adjustment (5%), drug/alcohol (4%), and antisocial behaviors (4%).

At the end of the fifth year, a survey was sent to all counselors who had participated in the program. A return rate of 79% was secured ($n = 19$). Clinical supervision was cited as crucial to the program though scheduling of supervision sessions remained an ongoing problem. Co-therapists were used 90% of the time and thought to be an important learning aid to the therapist trainees, but not necessarily to the families. When peer supervision was increased and professional clinical supervision was decreased, the group tended to become less cohesive. Attempts were made to survey families who had participated in the program, but too few people responded. Inadequate data keeping was identified as a culprit in not obtaining complete research data that resulted in a strong recommendation for improved record keeping. Though utilization data and counselor effects were reported, student and family outcomes were not reported (Merrill et al. 1992).
One of the few school-based family counseling studies to view effectiveness from the parents’ perspective was conducted by Fausold-Mowers (1998). This study attempted to measure the efficacy of a school-based family counseling program viewed by the families who used this service. Family counseling was conducted by the school district’s full time mental health professionals who were trained in structural and strategic family counseling approaches: school psychologists, school social workers, and school counselors. One hundred and eleven families who used the Family Life Education and Counseling Services (FLECS) Program from September 1990 to September 1996 were surveyed using a 15 page Likert-type survey form, part of which was constructed from The Client Satisfaction Questionnaire. To help determine the research questions, a pilot study was done with 11 families. Effectiveness (dependent variable) was defined by whether the families found the school-based family counseling program to be helpful. Independent variables included: (a) whether or not the goals of individual families were met, (b) the time taken to initiate services, (c) the counselor’s knowledge of educational resources and procedures related to the students’ educational needs, and (d) the counselors’ advocacy with school staff. Descriptive statistics and correlations were used in analyzing the data. Correlations were made between the family’s overall satisfaction and the independent variables. Because only 34/111 families returned the survey, random sampling was not used.

In general, the FLECS school-based family counseling program was perceived as positive, with at least 85% of the families who were satisfied on all composite scales surveyed except for the “overall structure” composite. (These items were then viewed individually.) Composite measures included: (a) overall satisfaction (helpful in
improving families' circumstances), (b) overall structure of the family counseling
program (availability of time slots, costs, flexible schedules), (c) counselors' knowledge
of the school system (e.g., knowledge of resources, disabilities, and school programs), (d)
counselors' access to school staff, (e) interacting with counselors in a school versus
community setting, and (f) engaging in family versus individual therapy.

The following positive correlations were reported: (a) the families' satisfaction
with the FLECS program and the school-based family counselors' knowledge of the
educational field, (b) the families' satisfaction with the counselors' ability to interact with
other school personnel, (c) the families' satisfaction in working with the counselors in the
school setting, and (d) the families' general satisfaction in doing family counseling versus
individual counseling.

Other aspects that were highly desirable for families were reported as the
availability of both day and evening hours, the counselors' familiarity with school staff,
and no financial costs to the families. Approximately 30% of the families who responded
participated in more than 21 school-based family counseling sessions with 35.3% using
these services for at least 12 months in duration. In some cases, families did not like the
lack of follow-up once counseling services were terminated nor did they like the travel
time if the counseling site was not near their own neighborhood. “Clearly, families in
this study found having a family counselor who understood and was part of the
educational system to be a major factor in their satisfaction with the FLECS Program”
(Fausold-Mowers, 1998, p. 84).

Generalizability of this study was limited due to the low response rate (30.6%).
In addition, 88% of the families were Caucasian with middle to high income levels and
62% participated from two parent homes. Many had a disabled child. Given the fact that this was a school-based counseling program, studying the teachers or administrators satisfaction with the effectiveness of the program or studying the direct effects of the counseling program on students' school performance would have been enlightening. Of interest would have been a comparative analysis with families referred to community-based family counseling services versus school-based family counseling. Despite noted limitations, this study contributes understanding about the link school-based family counseling provides between parents and school personnel when family counseling is conducted by pupil services personnel. It suggests that school-based family counseling allows the counselor to join with the family and school system in a cooperative, unique manner and move between the two systems as needs arise. This result was viewed by the researcher (Fausold-Mowers) as a clear advantage to other types of counseling programs.

In California, the effectiveness of a Mini Attendance and Review Board (SARB) was studied by Morrison, Olivos, Dominquez, Gomez, and Lena (1997) in a school of 725 students, 85% of whom were Hispanic. The mini SARB was a family-school consultation model designed to deal with chronic behavioral problems that did not respond to traditional interventions. Behavior difficulties were of six months or more duration and severe enough for the student to be considered for school expulsion. This interdisciplinary team was designed to meet with the family and school personnel to collaborate and problem solve. The school psychologist was used as the family systems consultant because of this person's familiarity with the systems approach in dealing with families, teachers, students, and administrators. Meetings had six stages: (a) social-rapport, (b) problem identification, (c) goal setting, (d) direct intervention using one of
three family systems models, (e) resolution with agreement on interventions, and (f) monitoring of progress and re-assessment. The following three family systems approaches were utilized based on the presenting issues or problems: (a) structural-communication – used when parents needed to rise to the top of the family hierarchy and make assertive demands of the children, (b) strategic – used to avoid power struggles and used when a history of hostility between the home and school was present, and (c) solution-focused – used when it was appropriate to find exceptions to the problems and build around those more successful circumstances.

According to utilization data, this program served 30 families providing an average of one to seven sessions that lasted 30 to 40 minutes. Descriptive data showed that 67% of the students served achieved their objectives. Resolution of problems was maintained one to two years later as indicated by teacher reports and a low 7% re-referral rate. According to their final analysis, results appeared to indicate that the mini SARB approach was effective toward improving students’ behaviors and increasing parent-school collaboration. Students who were not successful in meeting their goals came from more dysfunctional families and were referred in the later stages of crises or dysfunction. Results from this program suggested that the stage in which a student and their family was referred might help predict the success of this family-school consultation model that included parent counseling (Morrison et al. 1997). In this study, though a family systems approach was utilized, parent or family counseling was done more from a consultation model than from a traditional family therapy model.

In summary, though outcome research in general substantiates family counseling as an effective intervention, use of family counseling in the schools has been limited.
Few research studies exist that contain clear evaluation criteria and proof of the
effectiveness of family counseling in educational settings. Vague statements regarding
the effectiveness of family counseling in resolving school problems are common (Hinkle,
1992) with little more to substantiate this belief than theory and recommended practice.
Though counseling interventions based on theory is accepted practice, outcome research
as well as process research must be undertaken to strengthen existing studies and to
promote the use of family counseling within the schools.

The studies that are available suggest that family counseling is effective with
school related problems, though the family counseling services rendered in some of these
studies were not school-based (e.g., Donovan, 1992). Two school-based family
counseling studies were found using the three groups of pupil services personnel
employed by the schools: (a) the FLECS Program (Fausold-Mower, 1998) and (b) The
Topeka Public School Family Therapy Program (Merrill et al. 1992). Though the Topeka
program reported utilization data and served as a model in establishing school-based
family counseling, it did not report student and family outcome data. Fausold-Mowers’
(1998) study found positive correlations between parental satisfaction and school-based
family counseling conducted by school psychologists, school social workers, and school
counselors who were familiar with school resources and operating procedures. These
studies suggest that family counseling is feasible when done by school-based mental
health professionals, and that school-based family counseling has the potential to produce
desirable outcomes.
Issues or factors related to school-based family counseling.

Due to major societal transitions including the dramatic changes in the stability of the family as well as the persistent problems of our school children despite the traditional, “school-only” interventions, more recognition is being given to the role that social contexts play in students’ school performance (Carlson & Sincavage, 1987; Kraus, 1998; Scott-Jones, 1995). This recognition has translated into a nationwide movement of providing school-based or school-linked mental health services. Now that mental health services—more specifically family counseling—has begun to permeate our schools, what are the issues related to this practice? From the professional literature, major issues for school counselors, school psychologists, and school social workers are identified as training, ongoing clinical supervision, job role appropriateness, and barriers such as time and administrative support. The type of family counseling practices best suited for the schools is also an identified issue. These issues will be reviewed.

ROLES, PRACTICES, AND ATTITUDES

Numerous articles have been written advocating that school psychologists move beyond the psychoeducational model to an interventions model that includes counseling and other family interventions (Adelman & Taylor, 2000; Bradley-Johnson & Dean, 2000). Few, if any, research studies on a nationwide level could be found since the late 1980s to determine the family counseling interventions being done by school counselors, school psychologists, and school social workers.

Carlson and Sincavage completed a family intervention survey of school psychologists who were members of the National Association of School Psychologists.
(NASP). It was published in 1987. Specifically, these researchers were looking for answers to the assessment practices, intervention practices, attitudes, training and practice satisfaction levels, and perceived competence in working with families. Results of this survey may not have been representative given a return response of only 39% (n = 115).

Keeping the limited strength of this study in mind, the findings of this survey indicated that the majority of school psychologists (67%) reported performing some kind of child and/or family intervention ranging from making referrals for outside resources to actual family therapy. Of this group, only 22% conducted parent or family therapy including brief and/or long-term family therapy. Fifteen percent spent one to five hours per week engaged in brief family therapy while 6% of the remaining 7% spent one to five hours per week in long-term family therapy. Definitions of family therapy versus other family interventions such as family conferencing or consultation were unclear creating uncertainty about the reliability and validity of reported findings.

General findings reported from the Carlson and Sincavage study in 1987 (when compared to previous surveys) indicated an increased level of perceived competence in family-oriented interventions with signs of growth towards a more family oriented approach to practice. However, results also indicated that current practices continued to focus more heavily on intervening with the individual student than treating the family system. This result is surprising given that school psychologists rated family variables as greatly impacting on children’s school performance, even implicating families in the etiology of students’ behavioral problems. Most school psychologists utilized family related information in their assessment practices, though fewer were responsible to

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collect this information, and even fewer actually applied this information using a systemic, family systems intervention approach.

Carlson and Sincavage (1987) found that most psychologists in the schools practiced some form of indirect services to the families such as consultation and referrals. However, direct services with the families (e.g., family therapy and clinical interviews with the entire family) were related to a child's behavioral versus learning difficulties, and were most often conducted by doctoral versus masters level people. Forty-four percent of doctoral level practitioners compared to twenty percent of masters level practitioners engaged in either brief or long-term family therapy.

In addition, Carlson and Sincavage (1987) found that satisfaction with personal levels of family assessment and intervention training among school psychologists was moderate (64%). Perceived support from administrators was low (51% dissatisfied), along with having sufficient time to work with families (72% dissatisfied, n = 82). Of those who reported receiving formal family intervention and assessment training, most reported receiving it through their university coursework. Of the 52% who indicated that they had obtained formalized parent and family training, 72% did so through coursework at the graduate level while 60% did so through workshops and seminars, and 42% did so during internships (Carlson & Sincavage, 1987).

Spencer (1989) conducted a follow up survey of school psychologists who were members of NASP to determine the factors influencing their decisions to provide direct counseling or therapy with parents and families. Though family therapy was included on the questionnaire as one type of counseling service, the definition of psychotherapy or counseling was general, and except for one theoretical approach, counseling applied to
individual or group therapy versus family therapy. Given a response rate of only 36.7% (n = 191), results must be treated with caution due to issues of generalizability. Only 28.4% of the respondents reported engaging in therapy with parents (mother or father) and families, and even fewer (16%) reported engaging in therapy with families. This finding was contrasted with 58.6% who strongly agreed that these services were needed in the schools and that school psychologists should provide them. Only 14% disagreed that school psychologists should provide therapy to parents and families. Several factors were influential in the decision to practice parent or family counseling including support from parents, teachers, and administrators as well as the time allotted to practice this type of counseling, citation of this duty in their job descriptions, and perceptions of personal control of job role functions. The overall student/psychologist ratio was not a significant factor. A significant relationship was found between school psychologists who cited the family systems approach as “useful” and those who conducted actual therapy with families. (The behavioral/learning model was given the highest rating as the most useful counseling approach.) Beliefs regarding etiological referral factors and providing parent or family therapy were generally not related. Doctoral level practitioners (37.2%) engaged in more parent and family counseling than masters (28.3%) or specialist level practitioners, with some citing their training with parents and families as inadequate. At the time of Spencer’s study (1989), the vast majority of school psychologist respondents were not engaged in school-based parent or family therapy though the majority agreed that these services by school psychologists should be provided.

Telfer (1987) conducted a survey of Ohio school psychologists to determine the types of interventions employed with parents of special and general education students.
Six types of parenting interventions were investigated: (a) family systems interventions, (b) consultation, (c) parent conferences, (d) parent education, (e) parent training, and (f) parent counseling/therapy. Parent counseling was defined as "services provided to parents who have serious problems within the family" (p. 109). Definitions, though vague, were provided on the survey form. In reality it is speculated that it would be difficult to distinguish between “family systems interventions/family therapy” and “parent counseling.” The same holds true for the terms “parent education” and “parent training” or the terms “parent consultation” and “parent conferencing.” Surveys were sent to a total 1,047 school psychologists with a response rate of 22.3% (n = 234). A random sample (n = 80) was taken from the first and larger sample to investigate whether the smaller sample was similar.

Findings showed that school psychologists expressed being moderately prepared in working with parents. Only 55.3% had received pre-service level preparation, with the amount of training varying within school psychology training programs.

Statistically significant differences were found in the type of parent interventions performed by school psychologists. Parent conferencing was the most frequent type of parent intervention provided. Consultation and family systems interventions were second and third in frequency. The remaining categories—parent education, parent training and parent counseling—showed little differences in frequency rates, and as a group, happened far less frequently than the top three. This rank ordering fell about the same for both special and regular education student groups. The main effect in this regional study showed conferencing as the most common type of parent intervention provided by responding school psychologists. Though conferencing was the most frequent type of
parent intervention, family systems interventions was one of the top three categories of
parent interventions.

In the early 1990s, school psychologists were surveyed regarding their views and
practices of school-based counseling services (Prout, Alexander, Fletcher, Memis, &
Miller, 1993). Of the 476 nationally certified NASP members surveyed, 35.6% (n = 178)
responded. All of the school psychologists who responded reported engaging in some
form of counseling activity with an average of 17% of their time was spent in various
types of counseling. The majority (70%) noted counseling as a part of their job
descriptions. Over half (53.9%) desired more time doing counseling. The theoretical
orientations identified as most useful were behaviorally oriented. Family systems was
ranked 5th out of 14 theoretical orientations with the psychoanalytic approach found least
useful. Individual counseling was found to be the most frequent modality, with parent
counseling ranking 5th and family counseling ranking 15th out of a list of 20 modalities.
Family problems were ranked first in regards to the types of problems seen in counseling,
followed by underachievement (ranking second) and motivation (ranking third). These
researchers stated that the sample was probably not representative of all school
psychologists due to its low response rate, though it was a random sample. On average,
school psychologists provided individual and/or group counseling services approximately
one day per week to both general and special education students (including students with
counseling mandated on their Individual Educational Plans).

While not a dominant role for most practitioners, it [counseling] does appear to
be a significant one. School psychologists deal with a range of students and a
variety of problems, and favor brief, behavior theory-oriented interventions, yet
they recognize the importance of relationship considerations in their interventions. Family concerns and issues related to motivation/learning are paramount in these interventions. (Prout et al. 1993, p. 316)

Of interest in the Prout et al. (1993) study was the identity of family problems as the major reason or need for counseling, but individual counseling topping parent or family counseling as the most frequent counseling modality.

In the field of school counseling, no recent studies could be found to determine school counselors’ family counseling roles or attitudes. However, in the mid 1980s, Beck (1984) conducted a regional in-state survey of school counselors and counselor educators to determine their perceptions of the appropriateness of family counseling as a part of school counselors’ roles. Also studied were actual time versus desired time spent in family counseling as well as the barriers to practicing school-based family counseling. Surveyed were school counselors working in elementary and middle schools in a four county metropolitan area near Milwaukee. Also surveyed were counselor educators in neighboring colleges and universities. Surveys were sent to 144 school counselors and 38 counselor educators. The return rate for counselors was 79.2% (n = 114) and 76.3% (n = 29) for counselor educators.

Results from Beck’s survey in 1984 showed that 81.5% of school counselors and 78.3% of the counselor educators thought family counseling was needed in the schools. A great majority of school counselors (90.4%) and counselor educators (92.3%) agreed that the role of family counseling was appropriate for school counselors. Approximately half (49.5%) of the counselors surveyed said they did family counseling “sometimes” with the majority (57.4%) expressing a desire to do more. Only 0.9% reported doing
family counseling “often.” Forty-three percent reported having family counseling provided in their schools with 49.0% indicating that it was done by the school social workers. Barriers to practicing family counseling as identified by counselors included: (a) workload (81.6%), (b) lack of training (71.1%), and (c) lack of meeting time with families (64.0%). Administrative attitude was perceived as a barrier by only 20.2% of the school counselors while the majority (65.4%) of counselor educators believed it would be. When lack of training was indicated by counselors as a barrier, 84% specified interest in obtaining family counseling training. Of interest was that 55.2% of counselor educators never took a course in family counseling and 21.4% reported that their training programs offered no coursework in family counseling. Generalization of these findings was limited because of the regional population sample and lack of random sampling. In addition, even in the family therapy literature, family counseling can be defined differently, with some authors or researchers defining it more broadly than others.

Because family counseling was not clearly defined on the survey, it is uncertain whether all respondents defined it consistently, which could impair the validity and reliability of this study. Given these limitations, results of this survey suggested that both respondent groups viewed family counseling as compatible with school counselors’ role functions.

Schmidt, Lanier, and Cope published a study in 1999 of the topics covered in the last 20 years in the Elementary School Guidance and Counseling Journal (which terminated its publication in 1997 and merged into a new journal, Professional School Counseling). The top five interventions covered during that period (to 1997) were noted by the authors as reflecting school counselors’ roles and practices at the elementary and middle school levels. These roles included group counseling, group guidance, parent
education, individual counseling, and teacher consultation. Special topics such as family issues, multicultural counseling and computer technology were reflected as some of the current issues. Though family counseling was addressed in two special issues in the earlier years of publication, no articles on that topic were published in this journal from 1992 to 1997 (Schmidt, Lanier, & Cope, 1999).

Regarding school social workers' perceptions of their job roles, Staudt (1991) conducted a survey of school social workers' perceptions of their roles compared to the perceptions of principals and special educators. Desired frequency of various social worker job roles was compared to actual frequency of job roles. This study took place in an intermediary educational agency in Iowa, which included public and private schools. Of the 222 questionnaires sent out, 63% responded. Specific response rates were obtained as follows: (a) principals = 58% (n = 32), (b) special education teachers = 61% (n = 98), and (c) school social workers = 100% (n = 9). Because of the localized, nonrandomized sample, results may have pertained to just this sample and possibly not have been representative of the total population.

Results showed that principals, special education teachers, and school social workers were in agreement as to the following top four services they thought were actually provided most frequently by school social workers. These included special education assessments, staffings for special education placements, liaison services, and individual student conferencing. The following roles were reported as rarely provided by school social workers: research, classroom guidance, inservice training for school personnel, and parent groups (though conducting parent groups was not strongly ranked as an ideal service by teachers and administrators). Though all three groups rated
counseling as one of the top three interventions in meeting students' needs, principals and teachers expressed a desire for more of both parent and family counseling than were presently being provided. Despite the finding that parent counseling was highly desired by both principals and teachers, and school social work was the one designated discipline in the schools to work with parents, this study found limited frequency of both parenting group work and parent counseling. The actual services provided by school social workers in this school district were labeled by this researcher (Staudt, 1991) as traditional versus systems oriented.

To summarize, results of these studies suggested a growing interest among school counselors, school psychologists, and school social workers in the practice of family counseling. The limited research that was available indicated that within all three professional groups a discrepancy existed between the actual practice of family counseling and the desired practice of family counseling.

Studies reviewed above showed that the majority of school psychologists spent little time engaged in parent or family counseling though they desired more time in this activity. In addition, individual counseling was the most frequent mode of counseling interventions. Regarding school counselors, only about 1% in Beck's (1984) survey did family counseling "often." Approximately half of the group reported doing family counseling "sometimes," with the majority expressing a desire to do more. Approximately half of these counselors reported that school social workers conducted family therapy in their districts. Barriers to doing family counseling included workload, lack of training, and lack of meeting time with families. Administrative support was not perceived by the counselors as a significant barrier. These school counselors viewed
family counseling as compatible with their job roles. In Staudt’s (1991) survey of school social workers’ functions, school social workers, teachers, and principals all perceived counseling as important in meeting students’ needs. In addition, teachers and principals both desired more parent and family counseling services than were actually being provided by the school social workers in their schools.

TRAINING

Though family therapy is recommended as an important service to the schools, it is unknown how many school-based mental health professionals have the requisite training (Crespi, 1997). Quirk, Fine, and Roberts (1992) state,

The application of family systems orientation requires some subtleties of thinking and a high level of skills. It is doubtful if very many training programs for school psychologists or counselors give serious attention to training and supervised practices in this area. The experienced practitioner needs to be willing to seek out additional training opportunities before taking on this kind of role.

(pp. 421, 422)

Given the complexities of family therapy combined with conducting it in a nonconventional setting such as the public schools, how much training is required? A review of the literature follows to determine the recommended preparation and training.

In each professional discipline, accreditation standards to govern training and practice are established by national organizations. In the field of counseling and related disciplines, Corey, Corey and Callanan (1993) list four pathways to the accreditation of training programs and licensure of practitioners most relevant to the current study. The Council for Accreditation of Counseling and Related Educational Programs (CACREP)
generally accredits counselor education programs, which includes marriage and family
counseling. The Commission on Accreditation for Marriage and Family Therapy
Education (COAMFTE) accredits marriage and family therapy training programs as well.
The American Psychological Association (APA) accredits school psychology programs
at the doctorate level while the National Association of School Psychologists accredits
school psychology programs at the specialist level. In addition to the four methods stated
above, The National Association of Social Workers (NASW) accredits school social
work training programs (Corey, Corey, & Callanan, 1993). In addition, many state
departments of education grant certifications to work in the schools as school counselors,
school psychologists, or school social workers. According to Gurman and Kniskern
(1992),

In the past, most family therapists have been trained in the disciplines of social
work, psychology and psychiatry. Following this basic training, an individual
might have attended a post-degree training program or may have developed
expertise through attendance at clinical workshops and/or in supervised practice.
When enough of this family training was acquired to satisfy the American
Association for Marriage and Family Therapy (AAMFT) Membership Committee
or a state licensure/certification board, the individual was granted the status of
family therapist. The combination of prior mental health training with a specified
number of additional family therapy experiences was deemed as equivalent to a
family therapy degree. (pp. 68, 69)
In the future, however, these authors predicted that obtaining an AAMFT certification through pathways other than directly obtaining a degree from an accredited AAMFT training program would become impossible.

Currently, marriage and family therapy is considered by AAMFT to be a distinct, independent discipline. The American Association of Marriage and Family Therapy (AAMFT) stands alone in viewing marriage and family therapy as a separate profession. In 1978, AAMFT’s Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) received official recognition by the U. S. Department of Education as a national accreditation organization for MFT training programs (AAMFT, 2001a). For AAMFT licensure, minimum standards are set by this organization in three areas: educational achievement, amount of therapy experience, and approved supervision (Nichols, 1992). In order to use the title of marital and family counselor, a professional counselor must take marriage and family coursework and receive the experience and supervision required by AAMFT.

To become a marriage and family therapist licensed by the AAMFT Regulatory Board, a therapist must graduate from an accredited program. This is followed by a period of approximately two years of supervised clinical experience before being offered the state licensing exam or the AAMFT’s national licensing exam (AAMFT, 2001c). Training options include a master’s degree, doctoral degree, or postgraduate clinical training program. According to AAMFT website (2001c), most state regulatory requirements are similar to AAMFT’s requirements. Those professionals in related fields such as counselor education, psychology, or social work must also meet the minimum educational requirements for their particular field, obtain a minimum amount of
experience (often the equivalent of two years), and receive a minimum number of hours of approved supervision. It is possible to practice family therapy in some states without specifically being licensed in marriage and family therapy. Goldenberg and Goldenberg (1996) state, "...many practitioners not specifically schooled in marital/family therapy take the position that their professional background plus additional specialized training is sufficient for helping clients experiencing problems in their marriage or family as a whole" (p. 374).

In contrast to AAMFT, all other organizations mentioned above view marriage and family therapy as a specialty area within their particular professions. For example, the American Association for Counseling Development (affiliated with CACREP) views family counseling as a subspecialty within the counseling field which includes other specialties such as individual or group therapy (Nichols, 1992; Stevens-Smith, Hinkle, & Shahmann, 1993). In the field of psychology, family psychology is now one of the recognized specialties (Goldenberg & Goldenberg, 1996). Many of the above disciplines practice family therapy as a subspecialty and have obtained training in related programs that include family therapy coursework and supervision. This allows them to practice family therapy using the title of their academic profession (Goldenberg & Goldenberg, 1996), but not title themselves specifically as marriage and family therapists unless allowed by state licensure standards (Nichols & Schwartz, 1998). These fields include clinical psychology, community and mental health counseling, and pastoral counseling (Goldenberg & Goldenberg, 1996) in addition to other related fields such as school psychology, school social work, and school counseling.
CACREP accredits training programs in nine areas including marital, couple, and family counseling/therapy (American Counseling Association, 2001). To graduate from a CACREP approved program, a graduate must meet minimum educational coursework requirements and obtain a minimum amount of therapy or direct service experience under clinical supervision. More specifically, a graduate must have 600 internship hours within a counseling setting under the watch of an approved clinical supervisor. A minimum of 240 direct service hours is required working primarily with couples and family units using a systems interventions approach.

Goldenberg and Goldenberg (1996) contend, “There continues to be great diversity with respect to entrance requirements, degrees or certificates awarded on completion, types and forms of supervision and clinical experiences, clinical affiliations, levels of accreditation, and so forth between existing training facilities” (p. 373). However, Gurman and Kniskern (1992) argue that exposure and training in family systems and ecological approaches is becoming more commonplace. Already a part of psychiatry, psychology, and social work training, these authors predict that training in family systems and family therapy will receive at least equal attention with other counseling approaches in the clinical preparation of counselors and pastors. This would predict that related professions such as school psychology and school counseling would also be included.

Several authors support broadening school-based mental health professionals’ coursework and training to include family work. Included are counselor education programs (Goldenberg & Goldenberg, 1988; Hinkle, 1993/1997) as well as school psychology programs (Green & Fine, 1988; Wendt & Zake, 1984). As the field of social
work has interfaced with families since its inception, the majority of social work training programs include family coursework and experiences (Bardill, 1984; Bardill & Saunders, 1988). In addition, most social work programs have coursework related to family therapy, though sometimes "family therapy" has a broader interpretation than its purist form dictates. For school counselors, training in family counseling is generally negligible at the university graduate level, which serves to limit the amount of family counseling done by school counselors (Hinkle, 1997; Hinkle & Wells, 1995). Even at the doctoral level in school psychology, specialization in family work is scarce (Fagan, 1985).

Traditionally, school-based mental health professionals receive little training in family systems theory, family processes, and family interventions (Doherty & Peskay, 1992; Fine & Holt, 1983). However, this is likely to change given the establishment of family psychology at the doctoral level in school psychology, and the establishment of marriage and family counseling as a specialty by CACREP, the latter directly affecting counselor education programs (Stevens-Smith, Hinkle, & Stahmann, 1993).

To become a qualified family therapist, the school-based mental health professional must have received the appropriate training or be willing to pursue the appropriate training. Having already obtained the proper coursework, a time investment of several years of supervised experience is recommended (Palmo, Lowry, Weldon & Scioscia, 1984/1988). These authors propose several methods for obtaining effective training if school mental health practitioners have not received this preparation in their university training programs. Though seminars and workshops are viewed as useful, they recommend a more time-intensive approach to acquiring competency in family therapy techniques. Both family therapy coursework and supervised experiences are deemed
training from an accredited university training program or from a freestanding training
institute. If the mental health professional takes a sabbatical from employment to obtain
this degree or licensure, upon returning, he or she can assist in training other colleagues.
Additional methods of training school professionals include learning under the
supervision of local family therapists or hiring outside training consultants to provide
supervised training in the schools.

School counselors, school psychologists, and school social workers all possess at
least a master’s level degree with a supervised internship in the school setting. It is now
commonplace for school psychologists to have a Master’s Degree plus a minimum of 30
hours or an Educational Specialist Degree, and for school social workers to have a Master
of Social Work (MSW) degree which consists of a Master’s Degree plus a minimum of
30 hours. All school professionals practicing family therapy techniques must have
adequate training and supervision (Fish & Jain, 1992).

Earlier authors recommend family therapy training as a specialty at the doctoral
level for school psychologists (Wendt & Zake, 1984) and school counselors (Friesen,

It is our position that family therapy is a complex therapeutic approach that can
directly benefit a child’s functioning in school. Further, its complexity
necessitates that it should be viewed as a specialty option or part of a doctoral
program, rather than a standard curricular offering in school psychology training
programs. (p. 208)
Though the assessment role is the cornerstone role associated with school psychologists, Kamphaus (1996) states that school psychologists, especially those with postdoctoral training, continue to provide an expanded repertoire of specialty services including family therapy.

If appropriately trained, school mental health professionals can provide school-based family therapy in an effective and efficient manner (Johnston & Zemitzsch, 1997). This includes school counselors (Hinkle, 1993/1997; Hinkle & Wells, 1995; Kraus, 1998; Palmo et al. 1984/1988), school psychologists (Crespi, 1997; Green & Fine, 1988), and school social workers (Millard, 1990/1997).

The literature is clear that school mental health professionals should be thoroughly trained to do family counseling. Some authors recommend family counseling as a doctoral level specialty, though Gurman and Kniskern (1992) predict that the practitioner's degree will stay at the master's level, while the academician's degree will remain at the doctorate level. “High quality, responsible training, regardless of professional discipline is what produces skilled family-oriented practitioners” (Goldenberg & Goldenberg, 1988, p. 38). These authors proceed in saying that … “Probably the single best way to learn family therapy, once having acquired a theoretical background, is in firsthand therapeutic contact with actual families, under supervision” (p. 37).

SUPERVISION

With the schools' mission being education, administrators often have limited knowledge of mental health services, especially family counseling. School systems generally provide administrative supervision, but little clinical supervision (Crutchfield &
Traditionally, school administrators exhibit a definitional confusion between administrative supervision and clinical supervision, the latter of which is highly recommended for counseling best practices (Bernard & Goodyear, 1998). Both kinds of supervision are necessary along with a required understanding of the application and merits of each type. Supervision is defined by Bernard and Goodyear (1998) as,

> An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the client(s) she, he or they see(s), and serving as a gatekeeper of those who are to enter the particular profession. (p. 6)

Supervision is not considered by these authors as training, counseling, or consultation, but an evaluative intervention adapted to the circumstances of both the supervisee and his or her clients. Because the supervisor is a senior member of the same profession, the supervisee develops a sense of professional identity. Goals include monitoring or safeguarding the welfare of the client(s) as well as continued, professional development and learning on the part of the supervisee. Supervision is not just training (which is often associated with a degree program or a workshop), but an intervention that can extend over time throughout the career of the counseling professional (Bernard & Goodyear, 1998).

Most licensing and credentialing groups dictate the type and amount of supervision necessary for clinical competency (Bernard & Goodyear, 1998). State licensure laws generally require supervision beyond the formalized degree program.
The American Counseling Association (ACA) and the American Association for Marriage and Family Therapists (AAMFT) emphasize the need for trained supervisors in the family counseling field, and reason would follow that when family counselors are practicing in the schools, and serving special needs populations, that sufficient supervision be provided to allow counselors to work within the school setting and legal structure. (Quinn & Cowie, 1995, p. 49)

Supervision is recommended by the National Association of School Psychologists (NASP) as integral practice throughout the careers of school psychologists (NASP, 1997; Zins, Murphy & Wess, 1989). NASP standards also dictate the qualifications of the supervisor which includes credentialing by NASP, at least three years supervised experience as a school psychologist, and designation to be a supervisor by a local educational agency. School social workers must have qualified supervision that ensures competency (NASW Education Commission Task Force, 1992). Many times, school mental health professionals, especially school counselors, are supervised by school principals, a practice that is not always appropriate in the clinical counseling domain (Zapeda & Langenbach, 1999). “...Most school counselors are employees of the school district and, as such, they are bound by contractual agreement to receive supervision and to be evaluated by the school principal” (p. 111). Though larger school systems have directors of school counseling, many school counselors are housed in the schools directly under the principal’s direction, making receipt of administrative supervision more probable than clinical supervision. As editor of the special journal issue on family counseling, McComb (1981) stipulated (in Elementary School Guidance and Counseling) the conditions in which family counseling is appropriate in the schools.
Not only must school counselors have the support from their school administrators, but they also must have training in family counseling as well as supervision under a family therapist.

Supervision can occur at the formal degree program level, internship level, post degree level (approximately two to three years upon graduation), and throughout the career of the established professional. According to Goldenberg and Goldenberg (1996) “...clinical contact with families is of limited value without regularly scheduled, attentive supervision, especially crucial during the early stages of training” (p. 382). Once the formal coursework has been undertaken, current forms or methods of supervision include live supervision through the use of closed circuit television and one-way mirrors, review of videotapes, review of audiotapes and transcripts, and self-report (Goldenberg & Goldenberg, 1996). Introduction of the one-way mirror and videotaping in the 1950s furthered the advancement of family therapy by teaching and exposing family therapy techniques in a direct manner to students without interrupting the family therapy process.

In family therapy, these two methods (use of the one-way mirror and videotaping) are primary teaching and learning tools. One study of school counselors (Roberts & Borders, 1994) found that the use of self-reports and/or reviews of process notes and logs during a conference were reported as more common than either videotaping or live supervision.

When designing their statewide survey of school counselors, Roberts and Borders (1994) distinguished among three types of desirable supervision in the schools. The first category, administrative supervision, focused on clerical duties and following the rules and structure of the organization. The second category, clinical/counseling supervision, focused on skills, ethics, and relationships involved in counseling with students and
parents. The third category was program supervision. This category addressed the
development and implementation of programs such as classroom guidance and conflict
mediation.

In May 1990, 450 surveys in the Robert’s and Border’s (1994) study were sent to
a random sample of school counselors belonging to the North Carolina School
Counselor’s Association. A response rate of 37.3% (n = 168) was obtained. (Given the
small sample size limited to one region of the country, results could not be considered
reflective of the total population, although types of supervision and persons providing
this supervision were cited in this study as similar to results from other surveys.) This
survey included demographic information about the school counselors, types and
amounts of supervision received, and types and amounts of supervision desired. Results
showed that 85% (n = 117) of the responding school counselors received administrative
supervision with most (n = 67) provided by the school principal. In contrast only 59%
indicated a desire for this type of administrative supervision; however, most counselors
preferred that this type of administrative supervision be provided by the school principal.
The majority of responding school counselors also reported receiving program
supervision (70%, n = 96). The principal most often provided this service (n = 23)
followed by the director of counseling (n = 19) and the assistant principal (n = 9). This
compared to 86% who preferred this type of program supervision, with the director of
counseling identified as the most preferred program supervisor.

In the area of clinical/counseling supervision, only 37% (n = 51) reported
receiving this type of supervision (Roberts & Borders, 1994). The director of counseling

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(n = 12) sometimes provided this service as well as the principal (n = 9). This compared to 79% (n = 120) who stated a desire for this type of supervision.

As results showed, the majority specified a preference for clinical supervision being provided by supervisory personnel with counseling background and training. In this study, apprentice counselors and elementary school counselors (versus middle and high school counselors) most often received counseling supervision. For 24 respondents, clinical counseling took place at least once a month with 93 respondents expressing a desire for this amount of counseling supervision. Supervisory methods varied from self-report (n = 35), to annual review conferencing (n = 27), to review of written logs (n = 24), and finally to classroom observation (n = 22). Live observation (n = 15) was the least frequent method. The preferred method of clinical supervision was self-report (n = 89) with live supervision identified as a less preferred method except with novice counselors.

The two most frequent goals for clinical supervision were cited as professional support (80%) and increasing professional development (80%). The priority goal for both novice counselors and elementary school counselors was skill development.

The majority of school counselors’ time was spent engaged in individual and group counseling (31.6%), classroom guidance (15.4%), consultation (12.5%), and administrative duties (11.2%). Relatively speaking, more of the elementary level counselors engaged in classroom guidance while more of the high school level counselors engaged in testing activities and administrative duties. The leading counseling approach was cited as person-centered (38.3%) followed by eclectic (28.4%), behavioral (11.1%), cognitive (3.1%), family systems (1.2%), and psychodynamic (0.6%).
Though school counselors in Robert’s and Border’s (1994) study spent more time doing individual and group counseling than other duties, they received less counseling or clinical supervision than either administrative or program supervision. In contrast, they desired more clinical and program supervision and less administrative supervision. Direct methods of supervision such as review of audio/video tapes or live supervision of counseling sessions were rarely reported. The supervision they did receive generally consisted of conferencing during annual administrative reviews. A noted barrier to a more desirable type of supervision (i.e., clinical) pointed to having supervisory administrators without counseling education or experience. In order to increase their professional skills, school counselors expressed interest in clinical supervision provided regularly.

The family counseling program described by Merrill et al. (1992) was conducted by school counselors, school psychologists, and school social workers who were trained by an experienced supervisor in family therapy. Training occurred in the school setting for two hours on a bi-monthly basis with the use of seminars, videotapes, and readings. The school district provided the resources for this training. During counseling, trainees worked as a co-therapy team, with their sessions taped. Tapes were then reviewed by their supervisor during group or individual supervision. Clinical supervision was deemed crucial to the program though scheduling of supervision was cited as an ongoing problem. Co-therapists were used and thought to be an important learning aid to the trainees, but not necessarily to the families. When peer supervision was increased and professional clinical supervision was decreased, the group tended to become less
cohesive. Regular and ongoing clinical supervision was highly recommended for the professional development of these school-based professionals conducting family therapy.

Zins, Murphy, and Wess (1989) conducted a nationwide survey to identify the prevalence of clinical supervision in the field of school psychology. Clinical supervision was defined on the survey instrument as "...direct, one-to-one efforts on the part of your supervisor designed to help you improve your professional skills as a school psychologist. It does not include administrative supervision" (p. 57). In 1986, a randomized sample of NASP members was surveyed about the amount and type of clinical supervision received and the congruence of these practices with NASP standards. A response rate of 82.3% (N = 399) was obtained which was adequate to support generalizability of results. Results showed that only a quarter of respondents (22.9%) reported being clinically supervised (individually or as a group), with the majority being supervised through review of psychoeducational reports and individual cases. Only 45.1% received direct observation of their job performance and a mere 5.5% reported review of performance using audio or videotapes. The majority (52.4%) reported receiving supervision as needed, while only 23.8% reported regularly scheduled supervision. Most supervisors (70.3%) were trained in school psychology, but only 38.9% currently held that title. Over 95% cited the need for clinical supervision, but approximately one-third who received supervision found it helpful, suggesting the need for better quality supervision. Reasons for not receiving clinical supervision included being the single professional in that position, working in states that did not require supervision, not viewing it as necessary, and supervision being too time consuming. These researchers stated, "These findings suggested that many performance evaluations
were conducted by someone who may have been only minimally familiar with the clinical skills necessary for effective school psychology practice" (p. 62).

Ross and Goh (1993) surveyed a random sample of school psychologists belonging to NASP to determine the status of clinical supervision within the field. Clinical supervision was defined using a similar definition in the study just cited by Zins, Murphy, and Wess (1989). Out of 500 randomly selected NASP members, 331 useable surveys were returned with a response rate of 67.6%. Results showed that only 31.1% were being supervised, with 69.1% not receiving regular, but only as needed supervision. When compared to 31.1% who were actually receiving supervision, 58.8% desired this activity. Receiving supervision during internship and the first three years of practice was rated as desirable. From the total sample, approximately 18% either did not find clinical supervision useful or did not view it as necessary. Of those school psychologists supervising other school psychologists, few reported having formal training and preparation for this activity at the university level.

McIntosh and Phelps (2000) summarized the two studies above (i.e., Ross & Goh, 1993 and Zins, Murphy, & Wess, 1989) by stating that both studies suggested that school psychologists received little supervision and that current practices did not meet APA or NASP standards. Since the 1980s when supervision was prioritized as a recommended practice, and an entire issue of School Psychology Review was dedicated to this subject, little was accomplished in establishing supervision as essential practice in the professional development of school psychology practitioners (McIntosh & Phelps, 2000).

In the midst of school reform, schools are interfacing with a greater number of mental health professionals than ever before. When mental health practitioners fall under
the direction of the schools, school administrators are confronted with the issue of providing the appropriate clinical supervision (Talley & Short, 1995a). The professional literature cites the need for administrative support in the provision of clinical supervision. This service includes regular supervision by a qualified counseling professional who monitors the interventions provided to the client and promotes the growth and professional development of the mental health professional. Limited clinical supervision as well as supervision provided by professionals without the appropriate training or background are both commonly reported in the schools. Because of the specialty nature of family therapy, qualified, on-going supervision is highly recommended.

RECOMMENDED MODELS AND STYLES OF SCHOOL-BASED FAMILY COUNSELING

Given the fact that the American Association of Marriage and Family Therapists (AAMFT) is one of the premier organizations setting the standards for family therapy practice, its definition of family therapy will be presented and reviewed. In addition, the literature on recommended models or types for the schools will be reviewed. Given the current state of affairs, family therapy in the schools is still in the formative stage, with more information in the literature about general family systems interventions than actual family therapy.

Due to the holistic paradigm within which a family therapist functions, treatment targets the individual as well as the family (AAMFT, 2001b, 2001d). In family therapy’s purist form, the unit of treatment is generally considered the family (Gurman & Kniskern, 1992), though at times it can be the individual (AAMFT, 2001b, 2001d), dyads, and/or triads (Goldenberg & Goldenberg, 1981/1988). However, true to the family systems
perspective, the family therapist must always be mindful or cognizant of the interrelationships formed as a family unit. Marriage and family therapy is considered by AAMFT to be brief, with 12 sessions cited as average. Family therapy is also solution-focused with therapeutic goals that are clear and achievable (AAMFT, 2001d). Walsh & Giblin (1988b) state,

> Family therapy in the schools can take on various forms depending upon the counselor’s training, flexibility, and personality. Theoretically, school family counseling can range from seeing the entire immediate family for several sessions with on-site supervision to maintaining a systems point of view without necessarily having family therapy sessions. (p. 3)

Theoretical perspectives recommended for the schools can also vary from behavioral to psychodynamic (Walsh & Giblin, 1988b). The most frequently recommended theoretical approaches to family therapy for use in the schools are reported as: (a) structural (Hinkle & Wells, 1995; Kraus, 1998; Millard, 1990/1997), (b) strategic (Conoley, 1987b; Hinkle & Wells, 1995; Kraus, 1998; Millard, 1990/1997), and (c) solution-focused (Franklin, 2000; Kral, 1992; Kraus, 1998). In addition, behavioral and/or cognitive-behavioral approaches are deemed appropriate by Goldenberg and Goldenberg (1988), Millard (1990/1997), and Franklin (2000). Communication and psychodynamic models are also identified as appropriate by Goldenberg and Goldenberg (1988). Additionally, both Cerio (1997) and Davis (2001) recommend a combination of structural and strategic family therapy assumptions and interventions. It is noted that, though counseling practitioners generally identify with a primary theoretical approach
(Aradi & Kaslow, 1987; Rait, 1988), many are more integrative or eclectic than purists (Pinsof & Wynne, 2000; Rait, 1988).

The rationale given for using the structural approach in the schools is that it is brief and action-oriented (Carlson, 1987) and addresses present symptoms as well as system organization and competencies (Fish & Jain, 1992). The rationale given for use of the solution-focused approach is that the family’s strengths are highlighted and that the interventions are brief and practical and can be used in a variety of school formats such as consultation or conferences with parents and other school personnel (Kral, 1992). The rationale given for use of the strategic approach is that problems can be addressed indirectly thereby reducing resistance (Stone & Peeks, 1986). Power struggles can also be reduced, especially when a history of conflict exists between the home and the school (Morrison et al. 1997).

The type of family therapy recommended for school psychologists, which is also applicable to school counselors and school social workers, is short-term and specific to families having children with school-related problems (Green & Fine, 1980/1988). Centering on the school problem is also supported by Hinkle and Wells (1995). Golden (1983/1988) recommends brief therapy with all family members present, for a duration of no more than five sessions. Green and Fine (1980/1988) recommend that when marital issues emerge after the school problems improve, the parents or couple should be referred to community services.

“Whenever possible, the school counselor should try to see the family together as a group in order to gain a fuller understanding of overall function and areas of conflict and dysfunction” (Goldenberg & Goldenberg, 1988, p. 29). Meeting as a group is also
encouraged by Hinkle and Wells (1995). However, family therapy need not always involve the entire unit. Sometimes dyads or triads can meet, but always in the mindframe of the entire family (Goldenberg & Goldenberg, 1988). Though family counseling sessions do not always include the entire family unit, applying the systems perspective is considered integral to the process of family counseling.

In regards to specific procedures with families, attempts should be made to conference with them before engaging in family counseling. Families with less severe issues who are merely “stuck” are better school counseling candidates than families with severe disorders who should be referred to community resources (McComb, 1981).

Golden (1983) developed a simple checklist to determine what types of families that school counselors could best serve with interventions that would not “...carry the school counselor into the ‘forbidden’ realm of psychotherapy and would not impinge unduly on time” (p. 288). Three family assessment areas were included to make this determination. First, the time frame of the student’s problems or chronicity of identifiable psychosocial stressors can help discriminate between dysfunctional families and families who are considered more functional. According to the family-consultation model designed by Morrison et al. (1997), the stage (chronicity of psychosocial stressors) in which a student and their family are referred helps predict the success of therapy. Second, the family’s structure—characterized by a clear hierarchy of parental authority and discipline and relatively open communication—is also an indicator of a more workable family. Third, the family’s problem solving skills characterized by their willingness to identify problems and agree on solutions often point to a more workable family. In sum, chronic psychosocial stressors, limited parental authority, poor
communication patterns, and resistance to problem solving all tend to limit the application of brief family therapy in the schools.

In summary, the type of family therapy most often recommended in the schools is brief and focused on school performance issues. The literature identifies three theoretical approaches that are especially appropriate in the schools: structural, strategic, and solution-focused. Though family therapy in the truest form constitutes meeting with the entire family unit, other combinations are acceptable as long as the family systems framework is conceptualized and applied.

BARRIERS

Since family counseling is a nontraditional service in the schools and a nontraditional role for school-based mental health professionals, barriers to this practice will be reviewed and addressed. Drawing from Fish’s (1990) categories regarding family-school relationships, barriers can be categorized as philosophical, attitudinal, or logistical.

Though parent involvement in the schools has been applauded, change and action have come mainly from legislation and judicial rulings starting in the 1970s with the special education acts that encouraged parental decision making and assured parental rights (Fish, 1990). With parental involvement in the area of special education secured and protected legally, by comparison, other areas of parental involvement in the schools are tenuous at best. Included as part of the latter concern is the provision of comprehensive mental health services especially in the area of family counseling. In the No Child Left Behind Act of 2001 (H. R. Rep. No. 63, 2001), the recommendations for expanded school-based mental health services to remove the barriers to learning creates a
timely need to assess the current attitudes and practices regarding the various types of mental health services in the schools.

Philosophically, public school systems have traditionally believed that school personnel have sole responsibility and even exclusive rights to educate students (Fish, 1990). With education as the mandated mission (Adelman & Taylor, 2000), the school system has not customarily viewed itself as a provisional source of mental health services (Quirk, Fine, & Roberts, 1992). School systems are often considered bureaucracies built on tradition and uniformity (Lincoln, 1992). Traditionally, school administrators have limited experience in developing family policy and including families as active decision-makers (Malone, Manders, & Stewart, 1997). In addition, schools have operated using the linear versus systemic theoretical model, which greatly impinges on views toward more comprehensive special services (Lincoln, 1992; O’Callaghan, 1994). If the role of the schools is to educate, mental health services could be viewed as possibly detracting from the schools’ educational mission (Policy Leadership Cadre for Mental Health in Schools, 2001). Based on recent legislation, the current national educational goals are “...ensuring (a) all children are ready to learn, (b) safe schools, and (c) partnerships to increase parent involvement and participation in promoting the social, emotional and academic growth of children” (Center for Mental Health in Schools, 2001, p. 29). If schools are still operating by using the historical mission or theoretical orientation, both appear to constitute philosophical barriers. In addition, pupil services personnel in the schools could possibly possess similar theoretical orientations that do not support the family systems paradigm.
Attitudinally, Cerio (1995) cites a lack of consensus among administrators about whether school-based professionals versus community professionals should be doing family counseling. This is likely a result of the traditional view of academics being the predominant function of all school professionals working in the schools. It could also stem from lack of training in family systems orientation (O'Callaghan, 1994). Some administrators may view family issues as too sensitive or too time consuming to be addressed appropriately in the schools (Quirk, Fine, & Roberts, 1992). In addition, mental health practitioners in the schools may hold perceptions of their roles that support work with families, but not family counseling. In a survey of NASP school psychologists (Pelco, Jacobson, Ries, & Melka, 2000), all respondents “…endorsed the importance of parent involvement” (p. 246). In this study, though lack of time was a common barrier to working with parents, interventions with parents involved consultation rather than counseling.

Families, too, may show reluctance to using mental health services in the schools due to fears such as lack of confidentiality or too close an alignment with the values of the school for school personnel to be perceived as empathic and fair (Quirk, Fine, & Roberts, 1992). Families might also possess limited knowledge of school operations (Fish, 1990), thereby creating additional reluctance to utilize mental health resources in the schools. However, several studies (Fausold-Mowers, 1998; Goodman & Kjonaas, 1984/1988) found minimal parental concern about using mental health services with school sponsorship. In fact, in Fausold-Mower’s (1998) study, joining with school-based family counselors who were knowledgeable in helping the families with school-related
concerns was identified as a clear benefit by the families who used this school-site family counseling program.


Currently, it is unclear how these issues or possible barriers actually affect school-based mental health professionals assuming the role of family counselor. In the area of family systems interventions provided by school psychologists, Donovan (1992) addresses the issues of time constraints and inadequate training by stating, "The literature suggests that neither of these concerns is necessarily an insurmountable barrier to the practice of family systems interventions" (pp. 456, 457). According to Hinkle (1997) (in reference to school-based family counseling), "With appropriate training, administrative
support, and flexible work hours, school counselors can provide an effective and efficient service to children, their families, and the schools” (p. 206). Under investigation in the current study is the identification of the issues perceived by the three groups of school-based mental health professionals as barriers to the practice of school-based family counseling.
Chapter Three

Procedures

Research Design

Survey research was used to collect the desired data. In general, the purpose of survey research is to collect data from a representative sample of the population through use of a questionnaire in order to answer research hypotheses or questions (Nelson, 1996). In the current study, the survey research was comprised of a mailed, written questionnaire chosen because of the ease and efficiency of reaching a cross-sectional sample of school-based mental health professionals. Data were collected using a self-designed questionnaire that surveyed school counselors, school psychologists, and school social workers working in schools across the nation. Surveyed was a random sample of these three groups of pupil services personnel who were members of their national professional organizations.

Subjects, Sample and Population

Subjects included a randomized sample of school counselors belonging to the American School Counselors Association (ASCA), school psychologists belonging to the National Association of School Psychologists (NASP), and school social workers belonging to the National Association of Social Workers (NASW). There were approximately 5,180 members of ASCA making it necessary to survey approximately 361 members to obtain a representative sample. NASP had approximately 21,500 members requiring a sample of about 377, while NASW’s membership was nearly 2,750 requiring a sample of approximately 343 members.
Instrumentation

Data collection consisted of a 41 item, self-designed questionnaire that answered the research questions. Though survey questions were similar across the three disciplines, three separate instruments and cover letters were used. Each practitioner group was sent the questionnaire with a cover letter addressed specifically to its particular professional group. Questions were kept simple and straightforward to avoid misinterpretation. In addition, the definition of family counseling was stated on the questionnaire. Instructions were clear and brief.

The survey consisted mainly of forced-choice versus open-ended questions. Most questions required that respondents choose just one answer from a list of several options. These questions generally required a “most often” or “most typical” answer choice. Simple yes or no questions were also asked in addition to several fill-in-the-blanks.

Field-testing was done to ensure clarity and face validity. Questionnaires were field-tested, first by using a total of 15 local practitioners working in an urban school setting. Included were 5 school counselors, 5 school psychologists, and 5 school social workers. The piloted questionnaire invited comments or criticisms. Questions and/or formatting were re-designed as necessary. Before finalizing, the revised questionnaire was reviewed by members of the dissertation committee in order to increase the instrument’s face validity and reliability.

To obtain the desired return rate of 80% for generalizability purposes, a four-step mailing program was used. General guidelines established in Gall, Borg, and Gall (1996) were followed. The first mailing consisted of a postcard informing subjects of their being chosen to participate in a survey that would be sent in approximately one to two weeks.
As scheduled, a complete survey packet (second step) followed that included the cover letter, the questionnaire, and a stamped, self-addressed return envelope. A pen with the colors and logo of The College of William and Mary was included in the second mailing both as an enticement to complete and return the document and as a token of appreciation. Scheduled as the first follow-up was a post card (third step) that expressed thanks to those individuals who responded, with a pledge of the results should they desire them. This post card also served as a reminder to those individuals who did not respond. Approximately two weeks after the post card, a second complete mailing (fourth step) was sent to those who failed to respond previously. For each full mailing, a different, personalized cover letter accompanied the materials with a message that captured non-respondents' attention and stressed the importance of their responses. For the convenience of respondents, both full mailings included a stamped, self-addressed return envelope along with the questionnaire. The second full mailing included a bookmark (versus the pen) with the colors and logo of The College of William and Mary.

To ensure confidentiality and preclude duplication of mailings, a master list of participants was maintained. This method utilized a number code for each individual, which was recorded on both the questionnaire and the return envelope.

Using a four step procedure, the initial mailing (the postcard) was sent on October 28, 2002. The final mailing was sent on December 2, 2002. Most of the respondents returned their questionnaires before the winter holidays.
Research Questions and Variables in the Study

The two primary research questions were: (a) to what extent was the systemic mental health intervention--family counseling--being conducted in the schools by school counselors, school psychologists, and school social workers, and (b) what, if any, differences in school-based family counseling practices and attitudes existed among or between these three groups. Variables that were measured included factors that could possibly affect the practice of school-based family counseling: (a) role perceptions or job role appropriateness regarding school-based family counseling held by school counselors, school psychologists, and school social workers, (b) training in family counseling, (c) ongoing clinical supervision in family counseling, (d) perceptions of appropriate school-based family counseling styles or practices in the schools, (e) administrative and personal barriers to the practice of family counseling in the schools, and (f) perceived encouragers to the practice of school-based family counseling.

More specifically, the research questions were as follows:

1. What type of family-oriented work was most frequently being done by school counselors, school psychologists, and school social workers?

2. What type of training in family systems work and family counseling did school counselors, school psychologists, and school social workers typically have?

3. How much school-based family counseling was provided by school counselors, school psychologists, and school social workers? Were the proportions of the provision of school-based family counseling the same among these three groups?

4. What, if any, were the most frequent administrative barriers or factors to the practice of school-based family counseling? Were the proportions of the administrative
barriers to the provision of school-based family counseling the same among the three
groups?

5. What, if any, were the most frequent personal barriers or factors to the practice of
school-based family counseling? Were the proportions of the personal barriers to the
practice of family counseling the same among the three groups?

6. Among the school-based mental health professionals who actually provided family
counseling, what did school counselors, school psychologists, and school social
workers perceive as the influences or factors that encouraged the practice of school-
based family counseling?

7. What were the typical practices of school counselors, school psychologists, and
school social workers in their provision of school-based family counseling services?

8. How much ongoing clinical supervision in family counseling did the school
counselors, school psychologists, and school social workers receive surrounding their
practice of school-based family counseling?

Data Analyses

Depending on the question, the data collected were analyzed at two levels. First,
results were described in simple descriptive terms. Analyses included the percentages,
means, and standard deviations for each question. Tables were included to show
graphically the analyses and comparisons among samples.

Second, when differences among the three groups of practitioners were
hypothesized, a two-way contingency table analysis (Chi-square test) was applied to test
the differences in proportions among groups. The Holm’s Sequential Bonferroni or the
Least Squares Difference (LSD) methods were used as follow-up comparison tests. Tables with results of these follow-up tests were included.

The Statistical Package for Social Sciences (SPSS), Version 10.0 was used to analyze all data. In addition, Green, Salkind, and Akey (2000) was used as a reference for statistical analyses information related to two-way contingency table analysis (chi-square), follow-up tests, and American Psychological Association (APA) formatting in writing the results.

Ethical Safeguards

This survey research proposal was submitted for review to the Institutional Review Board of The College of William and Mary and approved. It fell under the exemption category due to being a survey that ensured disclosure of information in a confidential manner through the use of group results. Written consent was not needed due to the voluntary nature of responses; however, the cover letter contained informed consent information and the rights afforded to all research participants. These rights included assurance of confidentiality, voluntary participation, withdrawal as a research participant at any time without penalty, and provision of the final results of this survey research, if so desired. Several methods of contact were provided to ensure that follow up contacts could be made, including the mailing addresses, telephone numbers, and e-mail addresses of the researcher and the research supervisor.
Chapter Four

Analysis of Results

Introduction

This chapter describes the results of the survey research. It includes response rates and demographic information of the sample well as results of the analyses specific to the research questions.

In the fall of 2002, three national surveys were conducted using randomized samples of school psychologists, school social workers, and school counselors. All persons surveyed were members of their discipline’s professional organization at the national level. Randomized samples were obtained from The National Association of School Psychologists (NASP) and The National Association of Social Workers (NASW). A randomized sample was performed by the current investigator from the total list of members belonging to The American School Counselors Association (ASCA). The combined samples equaled to 1,079 professionals working in the field of school psychology, school social work, and school counseling. This number included randomized samples of 375 members of NASP, 343 members of NASW, and 361 members of ASCA.

A total of 1,079 questionnaires were mailed with an overall response rate of 73.2% (N = 790). Of these respondents, 62.9% were useable (N = 679). Broken down by discipline: (a) the ASCA useable response rate was 71.5% (N = 361, useable n = 258, non-useable n = 7); (b) the NASP useable response rate was 58.9% (N = 375, useable n = 221, non-useable n = 51); and (c) the NASW useable response rate was 58.3% (N =
343, useable \( n = 200 \), non-useable \( n = 53 \). Only professionals currently in practice or those who retired or stopped working within the past school year were included in the useable response rate.

**Demographic Information Obtained from the Sample of Respondents**

Descriptive statistics were used to describe respondents. In this section, results of the three professional groups were presented and described separately, along with results of the total sample when appropriate.

Demographics regarding the work setting found that the highest number of respondents (45.8%, \( n = 282 \)) reported working in public schools located in a suburban setting. This was followed by 27.4% (\( n = 169 \)) who worked in public schools located in an urban setting and 19.3% (\( n = 119 \)) who worked in a public school setting located in a rural setting. This trend held true for each of the three professional groups studied.

When asked the number of schools to which participants were assigned, school psychologists reported serving the highest number with a mean of 3.48 schools (\( SD = 4.46, n = 207 \)). School social workers reported having a mean of 2.20 schools (\( SD = 2.20, n = 193 \)) and school counselors reported a mean of 1.27 schools (\( SD = 2.08, n = 257 \)). School psychologists’ range included 35 schools, school counselors’ range included 33, and school social workers’ range included 15. (See Table 1 below.)

Groups surveyed were asked to report the number of students for which they were totally responsible. School psychologists reported not only being assigned to the highest number of schools, but also to the highest number of students (\( M = 1364.38, SD = 1222.28, n = 192 \)). School social workers reported the next highest number (\( M = 717.49, \)
School counselors reported being assigned to the fewest number of schools ($M = 1.27$ as cited previously) and being responsible for the fewest number of students ($M = 458.44$, $SD = 279.63$, $n = 249$). Table 1 shows both the mean number of schools and mean number of students of each group surveyed.

Table 1

By Profession, Mean Number of Schools and Mean Number of Students

<table>
<thead>
<tr>
<th>Assignment/ Responsibility:</th>
<th>Frequency</th>
<th>School Psychologists</th>
<th>School Social Workers</th>
<th>School Counselors</th>
<th>School Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of schools</td>
<td>$f$</td>
<td>207</td>
<td>193</td>
<td>257</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$M$</td>
<td>3.48</td>
<td>2.20</td>
<td>1.27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>4.46</td>
<td>2.20</td>
<td>2.08</td>
<td></td>
</tr>
<tr>
<td>Number of Students</td>
<td>$f$</td>
<td>192</td>
<td>162</td>
<td>249</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$M$</td>
<td>1364.38</td>
<td>717.49</td>
<td>458.44</td>
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</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>1222.28</td>
<td>1324.48</td>
<td>279.63</td>
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</tr>
</tbody>
</table>

When asked the grade levels to which they were assigned, school psychologists reported being assigned to multi-grade levels. Most school psychologists reported being
assigned to the elementary grade level (79.0%, \( n = 173 \)). Over half of the school psychologists (58.4%, \( n = 128 \)) were also assigned to the middle school level, 52.5% (\( n = 115 \)) to the high school level, 38.8% (\( n = 85 \)) to the preschool level, and 4.1% (\( n = 9 \)) to the post-secondary level.

School social workers also reported being assigned to multi-grade levels. The largest majority of school social workers were assigned to the elementary grade level (59.5%, \( n = 119 \)) with 51.5% (\( n = 103 \)) assigned to the high school level, 46.5% (\( n = 93 \)) assigned to the middle school level, 26.5% (\( n = 53 \)) assigned to the preschool level, and 2.0% (\( n = 4 \)) assigned to the post secondary school level.

Grade level assignments were fairly evenly distributed among the school counselors with 39.1% (\( n = 101 \)) assigned to the high school level, 38.8% (\( n = 100 \)) assigned to the elementary level, and 31.0% (\( n = 80 \)) assigned to the middle school level. In addition 7.4% (\( n = 19 \)) school counselors were assigned to the preschool level and 0.4% (\( n = 1 \)) were assigned to the post secondary school level. As previously cited, most school counselors were assigned to one school and therefore to one grade level.

Almost all (97.7%, \( n = 252 \)) school counselors reported having an office housed in the school in which they worked opposed to having an office centrally located in a building other than the school(s) in which they worked. This trend held true for the school social workers (85.7%, \( n = 168 \)) but less so for the school psychologists (61.8%, \( n = 134 \)) though the majority reported having an office housed in the schools.

All participants were asked about their highest level of training. Approximately twenty-five percent (25.2%, \( n = 55 \)) of the school psychologists reported having a doctorate degree while only 1.9% (\( n = 5 \)) of the school counselors and 1.6% (\( n = 3 \)) of the
school social workers reported obtaining a doctorate. The highest percentage of school psychologists (35.3%, n = 77) reported obtaining a Master’s Degree plus 30 while 22.9% (n = 50) obtained an Educational Specialist Degree. The highest percentage of school social workers (75.4%, n = 141) obtained a Master of Social Work (MSW) while the next highest percentage (13.4%, n = 25) earned a Master’s Degree plus 30. The highest percentage of school counselors (47.1%, n = 121) reported earning a Master’s Degree plus 30 while 37.4% (n = 96) earned a Master’s Degree. Table 2 contains the highest degrees obtained by the entire group and each subgroup.

Table 2

<table>
<thead>
<tr>
<th>Highest Degree:</th>
<th>Frequency</th>
<th>Entire</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
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<td>121</td>
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<td>%</td>
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Table 2 con’t.

<table>
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<tr>
<th>Highest Degree</th>
<th>Frequency</th>
<th>Entire</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
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<tr>
<td></td>
<td>f</td>
<td>63</td>
<td>55</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>9.5</td>
<td>25.2</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>36</td>
<td>21</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.4</td>
<td>9.6</td>
<td>3.9</td>
<td>2.7</td>
</tr>
</tbody>
</table>


When asked how recent the highest level of training was obtained, school counselors (n = 253) reported that they had obtained their highest degree most recently with a mean year of 1992 (M = 1992.33, SD = 8.37). School psychologists (n = 213) cited their highest level of training as 1988 (M = 1988.88, SD = 8.83) while the school social workers (n = 196) obtained their highest level of training in 1982 (M = 1982.53, SD = 8.51). (See Table 3.)

Collapsing the years that the highest level of training was obtained based on quarters, 42.1% (n = 106) of school counselors obtained their highest level of training between 1997 and 2002. School psychologists were more evenly distributed among the years from 1981 to 1989 at 28.6% (n = 61), 1997 to 2002 at 26.8% (n = 57), and 1990 to
1996 at 24.9% (n = 53). The highest percentage of school social workers (43.9%, n = 86) obtained their highest level of training between 1962 and 1980 while 35.7% (n = 70) (the second highest percentage) obtained their highest level of training from 1981 to 1989. (Refer to Table 3 for highest level of training by group and years obtained.)

Table 3

Mean Year of Highest Level of Training Obtained by the Three Mental Health Groups, Along with Collapsed Years Based on Quarters

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Co.</td>
<td>%</td>
<td>42.1</td>
<td>28.6</td>
<td>17.1</td>
<td>12.3</td>
<td>1992</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>106</td>
<td>72</td>
<td>43</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Sch. Psy.</td>
<td>%</td>
<td>26.8</td>
<td>24.9</td>
<td>28.6</td>
<td>19.7</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>57</td>
<td>53</td>
<td>61</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Sch. S.W.</td>
<td>%</td>
<td>5.1</td>
<td>15.3</td>
<td>35.7</td>
<td>43.9</td>
<td>1982</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>10</td>
<td>30</td>
<td>70</td>
<td>86</td>
<td></td>
</tr>
</tbody>
</table>

When analyzing the results of those respondents who answered the second half of the questionnaire, which was strictly reserved for individuals practicing school-based
family counseling, a total of 74 persons from the three school-based mental health professions completed this portion of the survey. Of this group, 27 reported holding a MSW (37.5%) as their highest level of training. The next highest frequency rate was at 27.8% (n = 20) for individuals holding a Master’s Degree plus 30. Approximately 11% (11.1%) held a Master’s Degree, 9.7% held a doctorate, and 8.3% held an Educational Specialist Degree. Approximately 6% (5.6%) held training other than listed degrees or certifications.

When years employed in the total group’s current job were collapsed into four categories based on quarterly outcome percentages, 34.4% (n = 76) of all school psychologists surveyed reported working more than 19 years, 24.0% (n = 53) worked 0 to 7 years, 23.1% (n = 51) worked 7 to 13 years, and the remaining 18.6% (n = 41) worked 13 to 19 years. The highest percentage of all school social workers (34.2%, n = 68) indicated working 13 to 19 years followed closely by 33.7% (n = 67) who indicated that they worked more than 19 years, 29.1% (n = 58) who indicated that they worked 7 to 13 years, and only 3.0% (n = 6) who indicated that they worked just 0 to 7 years. The school counselor group reported working the fewest number of years with 44.6% (n = 115) reporting they worked 0 to 7 years. Approximately one quarter of the school counselors (24.8%, n = 64) indicated working 7 to 13 years followed by 16.7% (n = 43) who indicated working 13 to 19 years, and 14.0% (n = 36) who indicated working more than 19 years.

As a total group, the mean hours worked was cited as approximately 38 hours (M = 38.37, SD = 8.80). The mean hours per week worked by school counselors was
reported as 40 (M = 40.46, SD = 9.05), the mean for school psychologists was reported as 37.60 (SD = 9.01), and the mean for school social workers was 36.51 (SD = 7.63).

When the ages of the participants were collapsed into ten-year categories, the highest percentage of school social workers (47.9%, n = 90) fell into the 51-to 60-year-old range along with the highest percentage of school counselors (38.0%, n = 97). Thirty-one percent (31.0%, n = 79) of the school counselors fell into the 41- to 50-year-old range. The highest percentage of school psychologists (34.7%, n = 75) fell into the 41- to 50-year-old range with 30.1% (n = 65) falling into the 51- to 60-year-old range.

The great majority of the respondents in all three groups were female. The highest percentage of females was found in the school social worker group (82.7%, n = 163) followed by the school counselor group (81.3%, n = 208). The lowest percentage of females was found in the school psychologist group (68.8%, n = 150) with 31.2% (n = 68) of school psychologists being male.

Groups surveyed represented a total of fifty-three states, territories or commonwealths. When the participants’ states of residence were broken into five regions, the Northeast region was most heavily represented by the total group of respondents (34.8%, n = 236). Forty-three percent (43.0%, n = 86) of school social workers, 33.9% (n = 75) of school psychologists, and 29.1% (n = 75) of school counselors worked in the Northeast. As a total group, the Southeast (23.9% n = 162) was the next most represented region followed closely by the Midwest (22.2%, n = 151). Approximately 29% (29.5%, n = 76) of the school counselors, 21.7% (n = 48) of the school psychologists, and 19.0% (n = 38) of the school social workers worked in the Southeast. The Midwest was represented by 25.5% (n = 51) of school social workers,
24.0% (n = 53) of school psychologists, and 18.2% (n = 47) of school counselors. The West comprised 14.3% (n = 97) of the total group which broke down into 17.4% (n = 45) of the school counselors, 13.6% (n = 30) of the school psychologists, and 11.0% (n = 22) of the school social workers. The Southwest was represented by only 3.8% (n = 26) of the total group. By profession, this result included 5.9% (n = 13) of the school psychologists, 4.3% (n = 11) of the school counselors, and 1.0% (n = 2) of the school social workers. Other geographical regions of the world represented 1.0% (n = 7) of the entire group. (See Table 4.)

Table 4

Geographic Regions of Respondent Groups

<table>
<thead>
<tr>
<th>Group:</th>
<th>f</th>
<th>North-east</th>
<th>South-east</th>
<th>Mid-west</th>
<th>West</th>
<th>South-west</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>School psychologist</td>
<td>f</td>
<td>75</td>
<td>48</td>
<td>53</td>
<td>30</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>33.9</td>
<td>21.7</td>
<td>24.0</td>
<td>13.6</td>
<td>5.9</td>
<td>0.9</td>
</tr>
<tr>
<td>School counselor</td>
<td>f</td>
<td>75</td>
<td>76</td>
<td>47</td>
<td>45</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>29.1</td>
<td>29.5</td>
<td>18.2</td>
<td>17.4</td>
<td>4.3</td>
<td>1.6</td>
</tr>
<tr>
<td>School social worker</td>
<td>f</td>
<td>86</td>
<td>38</td>
<td>51</td>
<td>22</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>43.0</td>
<td>19.0</td>
<td>25.5</td>
<td>11.0</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Total Group</td>
<td>f</td>
<td>236</td>
<td>162</td>
<td>151</td>
<td>97</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>34.8</td>
<td>23.9</td>
<td>22.2</td>
<td>14.3</td>
<td>3.8</td>
<td>1.0</td>
</tr>
</tbody>
</table>
An overwhelming majority of respondents in all three groups reported being white/Caucasian (90.5%, n = 613), which broke down to 94.1% (n = 208) of the school psychologists, 90.7% (n = 233) of the school counselors, and 86.4% (n = 172) of the school social workers. The next most frequently represented group was black/African American (5.2%, n = 35). Approximately 8% (8.5%, n = 17) of the social workers were black/African American while 4.7% (n = 12) of the school counselors and 2.7% (n = 6) of the school psychologists reported being black/African American. See Table 5 for the frequencies and percentages of each ethnic or racial group represented by profession.

Table 5
Ethnic or Racial Group Represented by Profession

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Total</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>f</td>
<td>613</td>
<td>208</td>
<td>233</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>90.5%</td>
<td>94.1%</td>
<td>90.7%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>f</td>
<td>35</td>
<td>6</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.2%</td>
<td>2.7%</td>
<td>4.7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Other Ethnic Designation</td>
<td>f</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.6%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Table 5 con’t.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Total</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>f</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>f</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Other Hispanic/Latino</td>
<td>f</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Latino American Indian/Alaska Native</td>
<td>f</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Chicano/Mexican American</td>
<td>f</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>American</td>
<td>%</td>
<td>0.3</td>
<td>0.5</td>
<td></td>
<td>0.5</td>
</tr>
</tbody>
</table>

Data Analyses Specific to Research Questions

Research Question 1: What type of family-oriented work was most frequently being done by school counselors, school psychologists, and school social workers?
Q-16A TYPE OF FAMILY WORK MOST OFTEN PROVIDED BY SCHOOL PSYCHOLOGISTS, SCHOOL COUNSELORS, AND SCHOOL SOCIAL WORKERS

When school psychologists, school counselors, and school social workers were asked what type of family work in which they were most often engaged, results did not include family counseling as the top selection. (Refer to Table 6 for all answer options.) In fact, only 0.3% (n = 2) of the entire group reported doing family counseling more than other types of family work in their schools. The two individuals who reported providing this service more than other types of family interventions were school social workers (1.1%, n = 2).

As the most frequently provided type of family work, the group in its entirety (42.1%, n = 259) reported parent conferencing or consultation apart from student support team meetings or special education evaluations. The second most frequent selection by the entire group was parent conferencing or consultation during special education evaluations (23.4%, n = 144).

When results were analyzed by separate groups, the majority of school counselors (63.6%, n = 152) reported most often providing parent conferencing apart from student support team meetings or special education evaluations. This type of family work was also reported with the highest frequency by 39.0% of the school social workers. This result was followed by 24.9% (n = 44) of the school social workers who reported parent conferencing or consultation during special education evaluations. School psychologists (45.2%, n = 90) reported with greatest frequency providing parent conferencing or consultation during special education evaluations. Of note is that 2.9% (n = 18) of the entire group reported doing none of the family work mentioned, with the highest
percentage of this group (6.0%, n = 12) being school psychologists. See Table 6 for comparative results.

Table 6

Type of Family Work Most Often Provided by School-Based Mental Health Professionals

<table>
<thead>
<tr>
<th>Type of Family Work:</th>
<th>f</th>
<th>Total</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Group</td>
<td>% Psy.</td>
<td>% Co.</td>
<td>% S.W.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent conferencing apart from team meetings or special ed evaluations</td>
<td>f</td>
<td>259</td>
<td>38</td>
<td>152</td>
<td>69</td>
</tr>
<tr>
<td>%</td>
<td>42.1</td>
<td>19.1</td>
<td>63.6</td>
<td>39.0</td>
<td></td>
</tr>
<tr>
<td>Parent conferencing during special education evaluations</td>
<td>f</td>
<td>144</td>
<td>90</td>
<td>10</td>
<td>44</td>
</tr>
<tr>
<td>%</td>
<td>23.4</td>
<td>45.2</td>
<td>4.2</td>
<td>24.9</td>
<td></td>
</tr>
<tr>
<td>Parent conferencing during student support team meetings</td>
<td>f</td>
<td>79</td>
<td>38</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>%</td>
<td>12.8</td>
<td>19.1</td>
<td>11.7</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Referral services for parents or families</td>
<td>f</td>
<td>67</td>
<td>11</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>%</td>
<td>10.9</td>
<td>5.5</td>
<td>15.1</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Crisis counseling with students that required parent involvement</td>
<td>f</td>
<td>34</td>
<td>8</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>%</td>
<td>5.5</td>
<td>4.0</td>
<td>2.9</td>
<td>10.7</td>
<td></td>
</tr>
</tbody>
</table>
Table 6 con’t.

<table>
<thead>
<tr>
<th>Type of Family Work:</th>
<th>f</th>
<th>Total</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, did not provide designated family interventions or services</td>
<td>18</td>
<td>12</td>
<td>1</td>
<td>5</td>
<td>2.9</td>
</tr>
<tr>
<td>Parent education, training or support groups</td>
<td>12</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>2.0</td>
</tr>
<tr>
<td>Family counseling</td>
<td>2</td>
<td>2</td>
<td>0.3</td>
<td>1.1</td>
<td></td>
</tr>
</tbody>
</table>

**Q-16B HOURS PER WEEK SPENT DOING MOST OFTEN ENGAGED IN FAMILY WORK**

The hours per week spent doing the most often engaged in family work was also analyzed. School social workers reported providing parent conferencing apart from student support team meetings or special education evaluations approximately 9 hours per week (M = 9.00, SD = 8.23, n = 163). School counselors reported providing parent conferencing or consultation apart from student support team meetings or special education evaluations approximately 6 hours per week (M = 6.27, SD = 5.57, n = 222). School psychologists reported providing parent conferencing or consultation during
special education evaluations approximately 5 hours per week (M = 5.36, SD = 4.55, n = 172).

Q-13 TYPE OF COUNSELING MOST OFTEN PROVIDED BY SCHOOL COUNSELORS, SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS

Participants were asked the type of school counseling they most often provided. Answer choices included: (a) individual (student), (b) group (students), (c) crisis, (d) family, (e) do not provide counseling. Individual counseling with students was reported most often by all three groups (total group = 50.2%, n = 329). The majority of school counselors (66.1%, n = 168) reported that they provided this type of counseling most often followed by 48.4% (n = 91) of the school social workers and 32.7% (n = 70) of the school psychologists.

Group counseling with students was reported with the next highest frequency by school counselors (15.4%, n = 39) and school social workers (14.9%, n = 28). School psychologists reported providing approximately the same amount of group counseling (10.7%, n = 23) as crisis counseling (11.2%, n = 24). Though school psychologists reported doing less individual and group counseling than the other two groups, results showed that on a frequency basis, most often they provided more crisis counseling than either the school social workers (9.6%, n = 18) or the school counselors (3.1%, n = 8).

School social workers (3.7%, n = 7) reported providing family counseling more often than either the school psychologists or the school counselors. Less than one percent of the school psychologists (0.9%, n = 2) and school counselors (0.4%, n = 1) reported providing family counseling most often.
Of note was that over a quarter of the school psychologists (29.0%, n = 62) claimed that they did not provide counseling as a service to their schools. Though participants were asked to give one answer (the type of counseling they provided most often), 17.0% (n = 32) of the school social workers, 15.0% (n = 32) of the school psychologists, and 14.6% (n = 37) of the school counselors gave multiple responses that included family counseling.

**Research Question 2: What type of training in family systems work and family counseling did school counselors, school psychologists, and school social workers typically have?**

**Q-17 FORMAL TRAINING AT THE UNIVERSITY LEVEL RELATED TO FAMILY SYSTEMS THEORY AND FAMILY COUNSELING OBTAINED BY THE THREE GROUPS OF MENTAL HEALTH PROFESSIONALS WHO DID AND DID NOT PROVIDE SCHOOL-BASED FAMILY COUNSELING**

Respondents were asked to indicate whether or not they had received university level training in five topics related to family work and family counseling. The following options were included: (a) general systems theory and/or ecological theory, (b) family systems interventions, (c) family counseling/family therapy survey course, (d) advanced coursework in counseling, and (e) supervised practica in family counseling.

When asked if school psychologists, school counselors, and school social workers had received university training in general systems theory or ecological theory, 83.8% of the total group (n = 538) responded in the positive. Broken down into groups, 94.7% (n
78.4% (n = 192) of the school counselors received this type of theory training.

When asked if they had received training in family systems interventions, 76.1% (n = 483) of the total group reported they had. More school social workers (94.2%, n = 180) reported receiving this type of training than either the school counselor group (72.2%, n = 174) or the school psychologist group (63.5%, n = 129).

Approximately 65% of the total group (65.4 %, n = 409) reported taking a family counseling survey course at the university level. Approximately 84% of the school social workers (84.4%, n = 157), 59.1% (n = 139) of the school counselors, and 55.4% (n = 113) of the school psychologists reported taking a family therapy survey course.

When asked about having advanced family counseling coursework, only 35.4% of the total group (n = 202) received this type of training. The majority of school social workers (61.1%, n = 99) reported receiving this type of training while only 30.7% (n = 59) of school psychologists and 20.4% (n = 44) of school counselors reported having advanced family counseling coursework.

Supervised practica in family counseling was reported as a part of their university training by slightly more than one-quarter of the total group (27.6%, n = 155). Half of the school social workers who responded (50.3%, n = 78) reported having supervised practica while only 23.8% (n = 45) of the school psychologists and only 14.7% (n = 32) of the school counselors made this report. Table 7 contains the results of these analyses.
Table 7

Formal Training at University Level Related to Family Work and Family Counseling by Group and Subgroup

<table>
<thead>
<tr>
<th>Formal training at university level:</th>
<th>Entire Sch.</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems/ ecological theory</td>
<td>f 538</td>
<td>169</td>
<td>192</td>
<td>177</td>
</tr>
<tr>
<td></td>
<td>% 83.8</td>
<td>80.5</td>
<td>78.4</td>
<td>94.7</td>
</tr>
<tr>
<td>Family systems interventions</td>
<td>f 483</td>
<td>129</td>
<td>174</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>% 76.1</td>
<td>63.5</td>
<td>72.2</td>
<td>94.2</td>
</tr>
<tr>
<td>Family counseling survey course</td>
<td>f 409</td>
<td>113</td>
<td>139</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>% 65.4</td>
<td>55.4</td>
<td>59.1</td>
<td>84.4</td>
</tr>
<tr>
<td>Advanced coursework in family counseling</td>
<td>f 202</td>
<td>59</td>
<td>44</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>% 35.4</td>
<td>30.7</td>
<td>20.4</td>
<td>61.1</td>
</tr>
<tr>
<td>Supervised practica in family counseling</td>
<td>f 155</td>
<td>45</td>
<td>32</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>% 27.6</td>
<td>23.8</td>
<td>14.7</td>
<td>50.3</td>
</tr>
</tbody>
</table>
Q-7 HIGHEST LEVEL OF TRAINING HELD BY PRACTITIONERS PROVIDING SCHOOL-BASED FAMILY COUNSELING

When analyzing the results of those respondents who answered the second half of the questionnaire, which was strictly reserved for individuals practicing school-based family counseling, a total of 74 persons from the three school-based mental health professions completed this portion of the survey. Of this group, 27 reported holding a MSW (37.5%) as their highest level of training. The next highest frequency rate was at 27.8% (n = 20) for individuals holding a Master’s Degree plus 30. Approximately 11% (11.1%, n = 8) held a Master’s Degree, 9.7% (n = 7) held a doctorate, and 8.3% (n = 6) held an Educational Specialist Degree. Approximately 6% (5.6%, n = 4) held training other than listed degrees or certifications.

Q-39 SPECIFIC TYPE OR SOURCE OF FAMILY COUNSELING TRAINING OBTAINED BY PRACTITIONERS WHO ACTUALLY PROVIDED SCHOOL-BASED FAMILY COUNSELING

Respondents who reported practicing family counseling in the schools were asked what type of training they had received specifically in family counseling. The six answer choices were comprised of the following: (a) university degree program in preparation for job, (b) post-degree university coursework in family therapy, (c) free-standing institute in family therapy, (d) seminars or workshops in family therapy (apart from the school system), (e) seminars, workshops, or training sponsored or provided by the school system, and (f) training and supervision from a family therapist apart from the school system. Multiple answers were solicited (as applicable).
According to results of the total group, the highest percentage of respondents (76.7%, n = 56) received their family counseling training through seminars or workshops apart from the school system. The second highest percentage (60.4%, n = 44) resulted from respondents who reported obtaining training in family counseling from a university degree program in preparation for their job.

Approximately 40% (39.7%, n = 29) of the group also reported receiving training in family counseling through post-degree university coursework. As another source of training in family counseling, 31.5% (n = 23) of the total group of respondents cited seminars or workshops sponsored or provided by the school system.

One-quarter (24.7%, n = 18) of the respondents reported receiving training from a family therapist apart from the school system. Receiving training from a freestanding institute in family counseling showed as the least frequent source of family counseling training (17.8%, n = 13). Table 8 shows the frequencies and percentages of each training source by group and subgroups.
Table 8

Frequencies and Percentages of Family Counseling Training Sources of Professionals

Actually Practicing Family Counseling in the Schools, by Group and Subgroups

<table>
<thead>
<tr>
<th>Type of Training Source:</th>
<th>% Entire Sch.</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seminars/workshops apart</td>
<td>76.7</td>
<td>66.7</td>
<td>71.4</td>
<td>83.8</td>
</tr>
<tr>
<td>from school system</td>
<td>56</td>
<td>10</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>University degree program</td>
<td>60.3</td>
<td>53.3</td>
<td>52.4</td>
<td>67.6</td>
</tr>
<tr>
<td>Post-degree university coursework</td>
<td>39.7</td>
<td>40.0</td>
<td>38.1</td>
<td>40.5</td>
</tr>
<tr>
<td>Seminars/workshops sponsored by school system</td>
<td>31.5</td>
<td>20.0</td>
<td>28.6</td>
<td>37.8</td>
</tr>
<tr>
<td>Family therapist apart from school system</td>
<td>24.7</td>
<td>20.0</td>
<td>19.0</td>
<td>29.7</td>
</tr>
<tr>
<td>Free standing family therapy institute</td>
<td>17.8</td>
<td>13.3</td>
<td>9.5</td>
<td>24.3</td>
</tr>
</tbody>
</table>

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Q-40 LICENSURE TO PRACTICE THERAPY IN A COMMUNITY SETTING HELD BY SCHOOL PRACTITIONERS WHO PROVIDED SCHOOL-BASED FAMILY COUNSELING

When asked if respondents who practiced family counseling in the schools held a license to practice therapy in a community setting, the majority indicated that they did hold this licensure (68.5%, n = 50). An analysis of each subgroup showed an overwhelming number of school social workers (86.5%, n = 32) held this license. Approximately half of the school psychologists (53.3%, n = 8) and school counselors (47.6%, n = 10) held this type of licensure.

Q-41 LICENSURE SPECIFICALLY IN MARRIAGE AND FAMILY THERAPY OR FAMILY PSYCHOLOGY HELD BY SCHOOL PRACTITIONERS WHO PROVIDED SCHOOL-BASED FAMILY COUNSELING

Respondents who reported practicing family counseling in the schools were also queried about holding licensure specifically in marriage and family therapy or family psychology. Only 13.5% (n = 10) of the entire group responded in the affirmative. Broken down into separate mental health disciplines, 20.0% (n = 3) of the school psychologists, 15.8% (n = 6) of the school social workers, and 4.8% (n = 1) of the school counselors reported holding a license specific to marriage and family counseling or family psychology.
Research Question 3: How much school-based family counseling was provided by school counselors, school psychologists, and school social workers? Were the proportions of the provision of family counseling the same among or between these three groups?

Q-14 FREQUENCY OF FAMILY COUNSELING REPORTED AS A SCHOOL-BASED SERVICE IN PARTICIPANTS' SCHOOL DISTRICT

Participants were asked if family counseling was provided as a school-based service in their school district. The definition of school-based family counseling preceded the following answer choices: (a) yes, (b) no, and (c) not sure. Of the three groups of mental health professionals who were asked if family counseling was provided as a school-based service in their school district, a total of 18.0% (n = 119) indicated that family counseling was provided, 79.0% (n = 523) indicated that it was not provided, and 3.0% (n = 20) indicated that they were not sure. Twenty-three percent (n = 44) of the school social workers, 16.5% (n = 36) of the school psychologists, and 15.4% (n = 39) of the school counselors reported family counseling as a school-based service in their school district. Of those respondents who reported not being sure whether family counseling was provided in their school district, 5.0% (n = 11) were school psychologists, 3.1% (n = 6) were school social workers, and 1.2% (n = 3) were school counselors.

A two-way contingency table analysis examined whether school psychologists, school counselors, and school social workers reported—with equal proportions or levels—the provision of family counseling as a school-based service in their school districts. The two variables were the mental health professional groups hired by the school system and whether school-based family counseling was provided in their school districts. The first
variable—the mental health professional group—had three levels (school psychologists, school counselors, and school social workers). The second variable—the presence of school-based family counseling—contained three levels (yes, no, not sure). A significant difference was found among the three groups and the levels or amount of family counseling reported as a school-based service in respondents' school district, Pearson $\chi^2 (4, N = 662) = 10.97, p = .027$, Phi Coefficient = .129. The proportions of mental health professional groups that reported the presence of family counseling in their school districts were school psychologists at .165, school counselors at .154, and school social workers at .230. The proportions of school-based mental health groups that reported not being sure whether family counseling was provided in their school districts were school psychologists at .050, school counselors at .012, and school social workers at .031.

Follow-up comparisons examined the differences among obtained proportions. Refer to Table 9 for the results of these comparisons. The Least Squares Difference (LSD) method was used to control for Type I error. An alpha level of .05 was used across comparisons. Two follow-up comparisons proved significant: (a) school psychologists and school counselors in the response of not being sure and (b) school counselors and social workers in the response of not being sure.

The probability of family counseling being reported as a school-based service by school psychologists and school counselors showed little difference (psychologists were only 1.07 times (.165/.154) more likely than school counselors to make this report); however, of significance was the finding that school psychologists were 4.17 times (.050/.012) more likely than school counselors to select the response of "not sure" whether family counseling was provided in their school district.
The probability of family counseling being reported as a school-based service by school counselors and school social workers showed that school social workers were only 1.49 times (.230/.154) more likely than school counselors to select "yes", but 2.58 times (.031/.012) more likely to select "not sure."

The probability of family counseling being reported as a school-based service by school psychologists and school social workers showed that school social workers were only 1.39 times (.230/.165) more likely to respond "yes" than school psychologists, and school psychologists were only 1.61 times (.050/.031) more likely to select "not sure" than school social workers. These proportions were not statistically different.
### Table 9

**Frequency or Level of Family Counseling Provided in Participants’ School Districts:**

**Results of the Follow-up Comparisons Using the LSD Method**

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Pearson Chi-square</th>
<th>p-value</th>
<th>Required p-value</th>
<th>Significance</th>
<th>Phi for significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. Co.</td>
<td>6.31</td>
<td>.043</td>
<td>.05</td>
<td>*</td>
<td>.12</td>
</tr>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>3.39</td>
<td>.184</td>
<td>.05</td>
<td>NS</td>
<td>.09</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>6.70</td>
<td>.035</td>
<td>.05</td>
<td>*</td>
<td>.12</td>
</tr>
</tbody>
</table>

*Note.* *p*-value (required p-value for significance).


**Q-15 PERSONNEL PROVIDING FAMILY COUNSELING IN DISTRICTS THAT OFFERED THIS SERVICE**

In the school districts that were cited as providing family counseling, the three surveyed groups were probed about the personnel who provided these services. Answer choices included: (a) school counselors, (b) school psychologists, (c) school social workers/visiting teachers, (d) contracted mental health professionals working within the school system, (e) other personnel or arrangements not mentioned, and (f) not applicable due to not knowing whether family counseling was provided in respondents’ school district. Multiple answers were solicited (as applicable).
When respondents from all three groups were asked if school counselors provided family counseling in their school districts, a total of 34.9% (n = 44) of all three groups reported that school counselors provided this service. When broken down into the three groups surveyed, 47.6% (n = 20) of the school counselors reported that they (school counselors) provided this service while 32.4% (n = 12) of the school psychologists reported this finding along with 25.5% (n = 12) of the school social workers.

A two-way contingency analysis was done to determine whether school psychologists, school counselors, and school social workers reported equal proportions or levels of family counseling being done in the schools by school counselors. The two variables were first, the school-based mental health professionals with three levels (school psychologists, school counselors, and school social workers) and second, the mental health group providing school-based family counseling (school counselors). A significant difference was not found in the frequency at which school psychologists, school counselors, and school social workers reported that family counseling was being provided by the school counselors in their district, Pearson $\chi^2 (2, N = 126) = 4.90, p = .086, \text{Phi Coefficient} = .20$.

When respondents from all three groups were asked if school psychologists provided family counseling in their school district, a total of 28.6% (n = 36) responded in the affirmative. Broken into three separate groups, the analysis showed that 43.2% (n = 16) of the school psychologists reported that school psychologists provided this service. Approximately 30% (29.8%, n = 14) of the school social workers made this report and only 14.3% (n = 6) of the school counselors.
A two-way contingency analysis examined whether school psychologists, school counselors, and school social workers reported equal proportions or levels of family counseling being done in the schools by school psychologists. The two variables were first, the school-based mental health professionals with three levels (school psychologists, school counselors, and school social workers) and second, the mental health group providing school-based family counseling (school psychologists). A significant difference was found in the frequency at which school psychologists, school counselors, and school social workers reported that family counseling was being provided by the school psychologists in their district, Pearson $\chi^2 (2, N = 126) = 8.14, p = .017$, Phi Coefficient = .25. The proportions of school mental health professionals who reported that school psychologists conducted family counseling in their school district were as follows: school psychologists = .432, school social workers = .298, and school counselors = .143.

Follow-up pairwise comparisons appraised the differences among obtained proportions. Refer to Table 10 for the results of these comparative analyses. The Holm's Sequential Bonferroni method was used to control for Type I error. An alpha level of .05 was used across comparisons. One pairwise comparison produced a significant finding at the critical alpha level of .016. This comparison was between school psychologists and school counselors. School psychologists were 3.02 times ($\frac{.432}{.143}$) more likely than school counselors to report that school psychologists provided family counseling in their school district. (Approximately 43.2% of the school psychologists reported that they (school psychologists) provided family counseling while
only 14.3% of the school counselors reported that the school psychologists in their district provided in this service.)

Table 10

Frequency or Level of School Psychologists Providing Family Counseling in Respondents’ School Districts: Results of the Pairwise Comparisons Using the Holm’s Sequential Bonferroni Method

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Pearson Chi-square</th>
<th>p-value</th>
<th>Required p-value</th>
<th>Significance</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. Co.</td>
<td>8.21</td>
<td>.004</td>
<td>.016</td>
<td>*</td>
<td>.32</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>3.06</td>
<td>.080</td>
<td>.025</td>
<td>NS</td>
<td>-.19</td>
</tr>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>1.63</td>
<td>.201</td>
<td>.05</td>
<td>NS</td>
<td>.14</td>
</tr>
</tbody>
</table>

Note. *p-value (required p-value for significance).


When respondents from all three groups were asked if school social workers provided family counseling in their school districts, a total of 44.4% (n = 56) responded in the affirmative. Broken into three separate groups, the analysis showed that 72.3% (n = 34) of the school social workers reported that school social workers provided this
service. Approximately 30% (29.7%, n = 11) of the school psychologists made this report and 26.2% (n = 11) of the school counselors.

A two-way contingency analysis was performed to determine whether there was a significant difference in the proportions among the three mental health groups who reported that school social workers provided family counseling in their school districts. A significant difference was found between at least two groups who reported that school social workers provided school-based family counseling, Pearson χ² (2, N = 126) = 23.73, p = .000, Phi Coefficient = .43. The proportions of school mental health professionals reporting that school social workers provided school-based family counseling were: school social workers = .723, school psychologists = .297, and school counselors = .262.

Follow-up pairwise comparisons were used to determine the differences among obtained proportions. Table 11 displays the results of these comparative analyses. The Holm’s Sequential Bonferroni method was used to control for Type I error. An alpha level of .05 was used across comparisons. Two pairwise comparisons were significant. First, school social workers were 2.43 times (.723/.297) more likely than school psychologists to report that school social workers provided family counseling in their school districts. (The majority [72.3%] of school social workers reported that they provided this service compared to only 29.7% of the school psychologists who reported that school social workers provided this service.) Second, school social workers were 2.76 times (.723/.262) more likely than school counselors to report that they (school social workers) provided family counseling. (The majority [72.3%] of the school social
workers reported that they provided this service compared to only 26.2% of the school counselors.)

Table 11

Frequency or Level of School Social Workers Providing Family Counseling in Respondents' School Districts: Results of the Pairwise Comparisons Using the Holm's Sequential Bonferroni Method

<table>
<thead>
<tr>
<th>Comparisons</th>
<th>Pearson Chi-square</th>
<th>p-value</th>
<th>Required p-value</th>
<th>Significance</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>15.11</td>
<td>.000</td>
<td>.016</td>
<td>*</td>
<td>-.42</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>18.90</td>
<td>.000</td>
<td>.025</td>
<td>*</td>
<td>-.46</td>
</tr>
<tr>
<td>Sch. Psy. vs. Sch. Co.</td>
<td>.12</td>
<td>.726</td>
<td>.05</td>
<td>NS</td>
<td>.04</td>
</tr>
</tbody>
</table>

Note. *p-value (required p-value for significance).


When respondents from all three groups were asked if contracted mental health professionals provided family counseling in their school districts, a total of 45.2% (n = 57) responded in the affirmative. Broken into three separate groups, the analysis showed that 51.4% (n = 19) of the school psychologists reported that contracted mental health personnel provided this service. Approximately half (47.6%, n = 20) of the school counselors made this report along with 38.3% (n = 18) of the school social workers. Upon conducting a two-way contingency analysis, a significant difference was not found...
among the proportions of the three groups reporting that contracted mental health professionals provided family counseling.

When respondents from all three groups were asked if other arrangements (besides the personnel mentioned) were made for the provision of family counseling services in their school districts, a total of only 15.1% (n = 19) responded in the affirmative. Broken into three separate groups, the analysis showed that 16.2% (n = 6) of the school psychologists reported that "others" provided this service. Approximately 15% (14.9%, n = 7) of the school social workers made this report along with 14.3% (n = 6) of the school counselors. Upon conducting a two-way contingency analysis, a significant difference was not found among the proportions of the three groups reporting that arrangements other than the personnel listed provided family counseling.

A total of only 1.1% (n = 4) indicated that they were not sure whether family counseling was provided in their school district. Broken into three separate groups, the analysis showed that 1.6% (n = 2) of the school psychologists reported being unaware of this service along with 1.5% (n = 2) of the school counselors. None of the school social workers reported being unaware of whether family counseling was a service in their school districts. Upon conducting a two-way contingency analysis, a significant difference was not found among the proportions of the three groups that reported being unaware of whether family counseling was provided in their school districts.

**Q-18 FREQUENCY OF SCHOOL PSYCHOLOGISTS, SCHOOL COUNSELORS, AND SCHOOL SOCIAL WORKERS PRACTICING SCHOOL-BASED FAMILY COUNSELING**
Each participant was queried about whether he or she provided school-based family counseling. Only 12.7% (n = 84) of the total group of respondents reported practicing school-based family counseling. Approximately one-fifth of the school social workers (21.7%, n = 41), and only 9.9% (n = 25) of the school counselors and 8.3% (n = 18) of the school psychologists reported practicing school-based family counseling.

A two-way contingency analysis examined whether school psychologists, school counselors, and school social workers reported providing equal levels or proportions of family counseling in the schools. The two variables were the provision of family counseling and the professional group. The first variable—the provision of family counseling in the schools—contained two levels (“yes” they provided family counseling and “no” they did not provide family counseling). The second variable—the professional group—contained three levels (school psychologists, school counselors, and school social workers). A significant difference was found in the proportions of family counseling being reported by the three professional groups, Pearson χ² (2, N = 659) = 19.34, p = .000, Phi Coefficient = .17. The group proportions of school mental health professionals who reported that they provided family counseling services in the schools were as follows: school social workers = .217, school counselors = .099, and school psychologists = .083.

Differences among obtained proportions were determined by using follow-up pairwise comparisons. Refer to Table 12 for the results of these comparative analyses. The Holm’s Sequential Bonferroni method was used to control for Type I error. An alpha level of .05 was used across comparisons. Two pairwise comparisons were found significant.
The first significant comparison was found (at the critical alpha level of .016) between the school psychologists and the school social workers indicating a significant difference in the frequency that these two groups reported the practice of family counseling in the schools. The probability of school social workers reporting the practice of family counseling in the schools was 2.61 times (.217/.083) more likely than school psychologists. In other terms, school social workers were 2.61 times more likely to report providing school-based family counseling than school psychologists.

The second significant comparison was found (at the critical alpha level of .025) between the school social workers and the school counselors. School social workers were approximately 2.19 times (.217/.099) more likely than school counselors to report the practice of school-based family counseling. A significant difference was found between the frequency that school social workers reported practicing family counseling and the frequency that school counselors made this report.
Table 12

Frequency or Levels of School Psychologists, School Counselors, and School Social Workers Practicing School-Based Family Counseling: Results of the Pairwise Comparisons Using the Holm's Sequential Bonferroni Method

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Pearson Chi-square</th>
<th>p-value</th>
<th>Required p-value for significance</th>
<th>Significance</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>14.60</td>
<td>.000</td>
<td>.016</td>
<td>*</td>
<td>-.19</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>11.88</td>
<td>.001</td>
<td>.025</td>
<td>*</td>
<td>-.16</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. Psy.</td>
<td>.35</td>
<td>.552</td>
<td>.05</td>
<td>NS</td>
<td>-.03</td>
</tr>
</tbody>
</table>

Note. *p-value (required p-value for significance)


Q-21 INCLUSION OF FAMILY COUNSELING IN SCHOOL-BASED FAMILY COUNSELORS' JOB DESCRIPTIONS

For those three groups of mental health professionals who actually reported practicing school-based family counseling, approximately half (53.5%, n = 38) responded that family counseling was included in their job description. The greatest majority of school social workers (71.4%, n = 25) made this report followed by school counselors.
Only 13.3\% (n = 2) of the school psychologists reported having family counseling included in their job descriptions.

Research Question 4: What, if any, were the most frequent administrative barriers or factors to the practice of school-based family counseling? Were the proportions of the administrative barriers to the provision of school-based family counseling the same among the three groups?

Q-19 ADMINISTRATIVE BARRIERS THAT MOST RESTRICTED ABILITY TO PRACTICE SCHOOL-BASED FAMILY COUNSELING

Inquiry was made about possible administrative factors that respondents thought were barriers to their practice of family counseling in the schools. Seven answer choices were provided as follows: (a) administrative belief that family counseling was not compatible with job role, (b) lack of knowledge on the part of administrators about the benefits of school-based family counseling, (c) administrative belief that family issues were too sensitive to be dealt with in the schools, (d) administrative belief that family counseling was too time consuming, (e) lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms, (f) did not know what administrators in his or her own district thought about family counseling, and (g) none, the administrators supported family counseling.

Of the total group, the highest percentage (31.9\%, n = 204) reported not being sure what the administrators in their district thought about family counseling. The second highest percentage (23.2\%, n = 148) reported an administrative belief that family counseling was not compatible with their job role, and therefore, was restrictive in their
practice of family counseling. The third highest percentage of the total group (16.3%, \( n = 104 \)) reported that administrators supported family counseling. The fourth highest percentage of the total group (12.5%, \( n = 80 \)) reported lack of administrative support for family counseling in the form of money or accommodations for training, supervision, therapy rooms, etc. The remaining three administrative factors were selected by less than 6% of the entire group. These factors included administrative belief that family counseling was too time consuming (5.9% \( n = 38 \)), administrative belief that family issues were too sensitive to be dealt with in the schools (3.9% \( n = 25 \)), and lack of knowledge on the part of administrators about the benefits of family counseling (3.9%, \( n = 25 \)). Approximately 2% of the group (2.3%, \( n = 15 \)) gave multiple answers which indicated an inability to cite just one administrative factor that was most restrictive in the ability to practice family counseling. Table 13 shows the group and subgroup frequencies and percentages for each type of administrative barrier.
Table 13

Frequencies and Percentages of Administrative Barriers to Family Counseling per Group and Subgroup

<table>
<thead>
<tr>
<th>Administrative Barriers:</th>
<th>f</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
<td>Group</td>
</tr>
<tr>
<td>Not sure what administrators thought about family counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>family counseling</td>
<td>80</td>
<td>89</td>
<td>35</td>
<td>204</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>37.7</td>
<td>36.3</td>
<td>19.2</td>
<td>31.9</td>
<td></td>
</tr>
<tr>
<td>Administrative belief that family counseling was incompatible with job role</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>was incompatible with job role</td>
<td>44</td>
<td>62</td>
<td>42</td>
<td>148</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>20.8</td>
<td>25.3</td>
<td>23.1</td>
<td>23.2</td>
<td></td>
</tr>
<tr>
<td>None, administrators supported family counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>counseling</td>
<td>29</td>
<td>32</td>
<td>43</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>13.7</td>
<td>13.1</td>
<td>23.6</td>
<td>16.3</td>
<td></td>
</tr>
<tr>
<td>Lack of administrative support (money, accommodations for training, rooms)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>20</td>
<td>27</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>15.6</td>
<td>8.2</td>
<td>14.8</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>Administrative belief that family counseling was too time consuming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>was too time consuming</td>
<td>11</td>
<td>17</td>
<td>10</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>5.2</td>
<td>6.9</td>
<td>5.5</td>
<td>5.9</td>
<td></td>
</tr>
</tbody>
</table>
Table 13 con’t.

<table>
<thead>
<tr>
<th>Administrative Barriers:</th>
<th>f</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
<td>Group</td>
</tr>
<tr>
<td>Lack of administrative knowledge about the benefits of family counseling</td>
<td>3</td>
<td>9</td>
<td>13</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>3.7</td>
<td>7.1</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Administrative belief that family issues were too sensitive to be dealt with in the schools</td>
<td>7</td>
<td>10</td>
<td>8</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3</td>
<td>4.1</td>
<td>4.4</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Multiple responses</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>2.4</td>
<td>2.2</td>
<td>2.3</td>
<td></td>
</tr>
</tbody>
</table>


When analyzed separately by professional groups, the pattern of frequencies of school counselors generally mimicked the pattern of the total group’s responses. The highest percentage of school counselors (36.3%, n = 89) reported not being sure what their administrators thought about family counseling followed by 25.3% (n = 62) who reported an administrative belief that family counseling was not compatible with their job role. The third highest percentage of school counselors (13.1%, n = 32) reported that administrators in their school district supported family counseling while 8.2% (n = 20)
reported a lack of administrative support for family counseling in the form of money or other accommodations.

When responses from school social workers were analyzed, 23.6% (n = 43) of the school social workers maintained that administrators in their districts supported family counseling. However, 23.1% (n = 42) reported an administrative belief in their district that family counseling was not compatible with their (school social workers’) job description. Approximately 19% (19.2%, n = 35) were not sure what the administrators in their district thought about family counseling, followed by 14.8% (n = 27) who reported a lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms, etc. as a barrier to the practice of family counseling in their school district.

When school psychologists’ responses were analyzed, the highest percentage (37.7%, n = 80) were not sure what the administrators in their school district thought about family counseling while 20.8% (n = 44) reported an administrative belief that family counseling was incompatible with their job descriptions. The third highest percentage of school psychologists (15.6%, n = 33) reported lack of administrative support in the form of money and accommodations followed by 13.7% (n = 29) who reported that their administrators actually were supportive of family counseling.

A two-way contingency analysis was done to determine whether the three groups of school-based professionals reported equal proportions of administrative barriers. There were two variables. The first variable was school-based professionals with three levels (school psychologists, school counselors, and school social workers). The second variable was administrative restrictions or barriers to the practice of family counseling in
the schools that included six levels: (a) administrative belief that family counseling was not compatible with their job role, (b) administrative belief that family counseling was too time consuming, (c) administrative belief that family issues were too sensitive to be dealt with in the schools, (d) lack of knowledge on the part of administrators about the benefits of family counseling, (e) lack of administrative support in the form of money, accommodations for training, supervision, therapy rooms, etc., and (f) not being aware what administrators believed about family counseling. A seventh response was included to indicate no administrative barriers to the practice of family counseling in their school district; that administrators supported family counseling in their school district.

A significant difference was found among the three school-based professional groups and the type of administrative barriers to their practice of school-based family counseling, Pearson $\chi^2 (14, N = 639) = 37.77$, $p = .001$, Phi Coefficient = .24. Table 13 contains the frequency proportions of each type of administrative barrier reported by school psychologists, school counselors, and school social workers.

Follow-up comparisons were conducted to appraise the differences among the three groups and the proportions of the types of administrative barriers reported. Refer to Table 14, which cites the results of these comparative analyses. The Least Squares Difference (LSD) method was used as the post-hoc test of significance with a familywise alpha of .05. The follow-up comparisons that produced significance fell between both the school social workers and school psychologists and between the school social workers and school counselors. (A significant difference was not found between the school psychologists and the school counselors in their reports of the types of administrative barriers that restricted their practice of school-based family counseling.)
Table 14

Frequencies or Levels of Administrative Barriers: Results of the Follow-up Comparisons Using the LSD Method

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Pearson Chi-square</th>
<th>Pearson p-value</th>
<th>Required p-value</th>
<th>Significance</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. Co.</td>
<td>9.44</td>
<td>.222</td>
<td>.05</td>
<td>NS</td>
<td>.14</td>
</tr>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>25.32</td>
<td>.001</td>
<td>.05</td>
<td>*</td>
<td>.25</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>24.42</td>
<td>.001</td>
<td>.05</td>
<td>*</td>
<td>.24</td>
</tr>
</tbody>
</table>

Note. *p-value (required p-value for significance)


When comparing school social workers with school psychologists, school social workers were 5.07 times (.071/.014) more likely than school psychologists to select as a barrier administrative lack of knowledge about the benefits of family counseling. School psychologists were 1.96 times (.377/.192) more likely than school social workers to select the answer of not being sure what administrators in their school district thought about family counseling.
When comparing school social workers with school counselors, school social workers were 1.92 times (.071/.037) more likely than school counselors to select as a barrier administrative lack of knowledge about the benefits of family counseling. School social workers were 1.80 times (.148/.082) more likely than school counselors to select lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms, etc. School counselors were 1.89 times (.363/.192) more likely than school social workers to select the answer of not being sure what administrators in their school district thought about family counseling.

Research Question 5: What were the most frequent personal barriers or factors to the practice of school-based family counseling? Were the proportions of the personal barriers to the practice of school-based family counseling the same among the three groups?

Q-20 PERSONAL BARRIERS TO THE PRACTICE OF SCHOOL-BASED FAMILY COUNSELING

When asked what personal factor was most restrictive to the practice of family counseling in the schools, groups were given ten choices: (a) family counseling was incompatible with my job role or description, (b) others in the school system were assigned to do family counseling, (c) lack of time/too busy with other duties, (d) limited training in family counseling, (e) not sure this service should be provided by the schools, (f) encouraged by supervisors to refer out, (g) lack of flexible work hours to accommodate parents’ schedules, (h) lack of clinical supervision provided by the school system, and (i) other barriers not mentioned. One additional answer choice was provided
to indicate that none of the named factors were personal barriers in the ability to practice school-based family counseling.

When results from the total group were analyzed, the highest percentage of respondents (36.7%, \( n = 245 \)) chose lack of time/too busy with other duties. This finding was followed by 19.3% (\( n = 129 \)) of respondents who cited family counseling as incompatible with their job roles or descriptions. The third highest percentage (11.4%, \( n = 76 \)) cited the answer of not being sure family counseling should be provided by the schools. The fourth highest percentage (7.5%, \( n = 50 \)) reported that they were encouraged to “refer out” for family counseling services followed closely the fifth highest percentage (7.0%, \( n = 47 \)) of having limited training in family counseling. Table 15 reports the frequencies and percentages of personal barriers that most restricted the groups’ practice of school-based family counseling.
Table 15

*Frequencies and Percentages of Personal Barriers to Family Counseling by Group and Subgroup*

<table>
<thead>
<tr>
<th>Personal Barriers:</th>
<th>f</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time/too busy with other duties</td>
<td></td>
<td>84</td>
<td>87</td>
<td>74</td>
<td>245</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>38.9</td>
<td>34.1</td>
<td>37.8</td>
<td>36.7</td>
</tr>
<tr>
<td>Incompatible with job role or description</td>
<td></td>
<td>41</td>
<td>55</td>
<td>33</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>19.0</td>
<td>21.6</td>
<td>16.8</td>
<td>19.3</td>
</tr>
<tr>
<td>Not sure service should be provided by the schools</td>
<td>f</td>
<td>22</td>
<td>31</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>10.2</td>
<td>12.2</td>
<td>11.7</td>
<td>11.4</td>
</tr>
<tr>
<td>Encouraged by supervisors to “refer out”</td>
<td>f</td>
<td>7</td>
<td>28</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.2</td>
<td>11.0</td>
<td>7.7</td>
<td>7.5</td>
</tr>
<tr>
<td>Limited training in family counseling</td>
<td>f</td>
<td>25</td>
<td>19</td>
<td>3</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>11.6</td>
<td>7.5</td>
<td>1.5</td>
<td>7.0</td>
</tr>
</tbody>
</table>
Table 15 con’t.

<table>
<thead>
<tr>
<th>Personal Barriers:</th>
<th>f</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
<th>Total Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of named factors restricted ability</td>
<td>f</td>
<td>10</td>
<td>4</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>4.6</td>
<td>1.6</td>
<td>6.6</td>
<td>4.0</td>
</tr>
<tr>
<td>“Other” factors restricted ability to practice family counseling</td>
<td>f</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.7</td>
<td>2.7</td>
<td>4.1</td>
<td>3.4</td>
</tr>
<tr>
<td>Inflexible work hours to accommodate parents’ work schedules</td>
<td>f</td>
<td>3</td>
<td>6</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1.4</td>
<td>2.4</td>
<td>5.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Others in schools were assigned to provide this service</td>
<td>f</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2.3</td>
<td>2.7</td>
<td>1.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Lack of clinical supervision provided by the schools</td>
<td>f</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.5</td>
<td>0.8</td>
<td>1.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Multiple responses</td>
<td>f</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>4.6</td>
<td>3.5</td>
<td>5.1</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Compared to the results of the entire group, the school counselors also chose the same top five personal barriers to their practice of family counseling in the schools. The frequencies and percentages follow respectively: 34.1% (n = 87); 21.6% (n = 55); 12.2% (n = 31); 11.0% (n = 28), and 7.5% (n = 19).

The school social worker group nearly mimicked the top four percentage results of the entire group. These results were as follows: lack of time/too busy with other duties = 37.8% (n = 74), incompatible with job role = 16.8% (n = 33), not sure family counseling should be provided by the schools = 11.7% (n = 23), and encouraged by supervisors to “refer out” = 7.7%, (n = 15). However, the fifth highest frequency choice (6.6%, n = 13) was cited as having none of the personal barriers mentioned versus having limited training in family counseling. Limited training was cited by school social workers only 1.5% (n = 3) of the time.

The school psychologists most often chose lack of time as the biggest personal barrier (38.9%, n = 84), followed by viewing family counseling as incompatible with their job role (19.0%, n = 41). Different from the other two groups was having limited training in family counseling that showed as the third highest percentage cited by school psychologists (11.6%, n = 25) followed by not being sure this service should be provided by the schools (10.2%, n = 22). School psychologists chose the remaining barriers less than 5% of the time.

All remaining options were chosen by the entire group with 5% or less frequency. These barriers included having no personal barriers (4.0%, n = 27), other factors or barriers not mentioned (3.4%, n = 23), inflexible work hours (3.0%, n = 20), others in the school district assigned to do family counseling (2.2%, n = 15), and lack of clinical
supervision (0.9%, n = 6). Multiple responses were reported by 4.3% (n = 29) of the entire group indicating that they were unable to choose just one personal barrier as the most restrictive in their ability to practice family counseling in the schools.

A two-way contingency analysis assessed whether the three groups of school-based professionals reported equal proportions or levels of personal barriers to their practice of family counseling in the schools. Two variables were examined. The first variable was the school-based professional groups with three levels (school psychologists, school counselors, and school social workers). The second variable included the personal barriers with the ten levels named above. With an alpha level of .05, a Chi-square test yielded statistical significance, $\chi^2 (20, N = 667) = 44.09$, $p = .001$, Phi Coefficient = .26. Table 15 contains the proportions of each type of personal barrier reported by school psychologists, school counselors, and school social workers.

Follow-up comparisons were carried out to assess the differences among group proportions. Table 16 summarizes the findings of these comparative analyses. The Least Squares Difference (LSD) method was used as the post-hoc test of significance with a familywise alpha of .05. All three follow-up comparisons were significant.
Table 16

Frequencies or Levels of Personal Barriers: Results of the Follow-up Comparisons Using the LSD Method

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Pearson Chi-square</th>
<th>p-value</th>
<th>Required p-value for significance</th>
<th>Significance</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch. Psy. vs. Sch. Co.</td>
<td>18.29</td>
<td>.050</td>
<td>.05</td>
<td>*</td>
<td>.20</td>
</tr>
<tr>
<td>Sch. Psy. vs. Sch. S.W.</td>
<td>27.27</td>
<td>.002</td>
<td>.05</td>
<td>*</td>
<td>.26</td>
</tr>
<tr>
<td>Sch. Co. vs. Sch. S.W.</td>
<td>24.15</td>
<td>.007</td>
<td>.05</td>
<td>*</td>
<td>.23</td>
</tr>
</tbody>
</table>

Note. *p-value (required p-value for significance.)


When school psychologists and school counselors were compared, school counselors were 3.44 times (.110/.032) more likely than school psychologists to select the answer of being encouraged by supervisors to “refer out” for family counseling services. School psychologists were 2.88 times (.046/.016) more likely than school counselors to select the answer that none of the named personal factors was a barrier to their practice of family counseling in the schools. School counselors were 1.71 times (.024/.014) more likely than school psychologists to cite inflexible work hours as a personal barrier to providing family counseling. School psychologists were 1.55 times (.116/.075) more
likely than school counselors to report limited training in family counseling as a personal barrier.

When school psychologists and school social workers were compared, school psychologists were 7.73 times \((.116/.015)\) more likely than school social workers to select as a personal barrier having limited training in family counseling. School social workers were 4.00 times \((.056/.014)\) more likely than school psychologists to cite inflexible work hours as a personal barrier. School social workers were 2.41 times \((.077/.032)\) more likely than school psychologists to report that they were encouraged by supervisors to “refer out” for family counseling services. School social workers were 1.43 times \((.066/.046)\) more likely than school psychologists to report that none of the named factors was restrictive in their ability to practice family counseling in the schools.

When school counselors were compared to school social workers, this comparison showed that school counselors were 5.00 times \((.075/.015)\) more likely than school social workers to report as a personal barrier having limited training in family counseling. School social workers were 4.13 times \((.066/.016)\) more likely than school counselors to report that none of the named barriers was a personal factor in their ability to practice school-based family counseling. School social workers were 2.33 times \((.056/.024)\) more likely than school counselors to cite lack of flexible work hours to accommodate parents’ work schedules. School counselors were 1.80 times \((.027/.015)\) more likely than school social workers to report as a barrier that others in the schools were assigned to provide family counseling. School social workers selected “other” personal barriers (than the options cited in the questionnaire) 1.52 times \((.041/.027)\) more often than school counselors. School counselors were 1.43 times \((.110/.077)\) more likely than school social
workers to say that they were encouraged by supervisors to “refer out” for family counseling services. School social workers were 1.46 times (.051/.035) more likely than school counselors to cite multiple responses to this question indicating that they could not choose just one personal reason as the most restrictive barrier in their ability to practice family counseling in the schools.

Research Question 6: Among the school-based professionals who actually provided family counseling, what did school counselors, school psychologists, and school social workers perceive as the influences or factors that encouraged the practice of school-based family counseling?

Q-22 FACTORS THAT MOST INFLUENCED DECISION TO PRACTICE SCHOOL-BASED FAMILY COUNSELING

In the final portion of the questionnaire—reserved strictly for practitioners who actually provided school-based family counseling—participants were probed about the factors that most influenced their decision to provide school-based family counseling. Please refer to Table 17 for all answer choices. For these school-based family counseling professionals, the factor that most influenced the decision to practice family counseling in the schools was cited as a personal belief that family counseling should be provided at the school. Approximately half (50.7%, n = 36) of the total group responded with that answer. This statistic comprised 57.1% (n = 12) of the school counselors, 57.1% (n = 8) of the school psychologists, and 44.4% (n = 16) of the school social workers.

The next most frequent factor that influenced the decision to practice school-based family counseling was cited as having family counseling included in their job...
description; however, the entire group chose this selection only 14.1% of the time (n = 10). This data included 19.4% (n = 7) of the school social workers and 14.3% (n = 3) of the school counselors. None of the school psychologists made this selection. With equal frequency, 14.1% (n = 10) of the entire group also chose “other” factors not cited in the questionnaire as the most influential factor for making the decision to practice school-based family counseling.

The next most influential factor in practicing school-based family counseling was cited as support from school level personnel. Of the total group, 11.3% (n = 8) chose this reason, which broke down to 14.3% (n = 3) of the school counselors, 11.1% (n = 4) of the school social workers, and 7.1% (n = 1) of the school psychologists.

Of the total group, fewer than 6% chose the remaining factors as most influential in their reasons for practicing school-based family counseling. These factors included support from departmental supervisors (5.6%, n = 4), time allotted for family counseling (2.8%, n = 2), and received university training in family counseling (1.4%, n = 1). Table 17 contains the frequencies and percentages of the seven response choices by group and subgroup.
Table 17

Factors that Influenced Decision for School-Based Mental Health Professionals to Practice Family Counseling in their Schools

<table>
<thead>
<tr>
<th>Influences/Encouragers:</th>
<th>f</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
<td>Group</td>
</tr>
<tr>
<td>Personal belief that family counseling</td>
<td>f</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>should be provided in the schools</td>
<td>%</td>
<td>57.1</td>
<td>57.1</td>
<td>44.4</td>
<td>50.7</td>
</tr>
<tr>
<td>Family counseling in job description</td>
<td>f</td>
<td>3</td>
<td>7</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>14.3</td>
<td>19.4</td>
<td></td>
<td>14.1</td>
</tr>
<tr>
<td>“Other” factors besides those mentioned</td>
<td>f</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>28.6</td>
<td>9.5</td>
<td>11.1</td>
<td>14.1</td>
</tr>
<tr>
<td>Support from school-level personnel</td>
<td>f</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.1</td>
<td>14.3</td>
<td>11.1</td>
<td>11.3</td>
</tr>
<tr>
<td>Support from departmental supervisors</td>
<td>f</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.1</td>
<td>4.8</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Influences/Encouragers:</td>
<td>f</td>
<td>Sch. Psy. %</td>
<td>Sch. Co.</td>
<td>Sch. S.W.</td>
<td>Total Group</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---</td>
<td>-------------</td>
<td>---------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Time allotted for family counseling service</td>
<td>f</td>
<td>%</td>
<td>2</td>
<td>5.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Received university training in family counseling</td>
<td>f</td>
<td>%</td>
<td>1</td>
<td>2.8</td>
<td>1.4</td>
</tr>
</tbody>
</table>


**Q-21 INCLUSION OF FAMILY COUNSELING IN RESPONDENTS’ JOB DESCRIPTIONS**

For those school-based mental health professionals who actually reported practicing school-based family counseling, approximately half (53.5%, \( n = 38 \)) responded that family counseling was included in their job description. The greatest majority of school social workers (71.4%, \( n = 25 \)) made this report followed by school counselors (52.4%, \( n = 11 \)). Only 13.3% (\( n = 2 \)) of the school psychologists reported having family counseling included in their job description.

**Q-24 LEVEL OF SATISFACTION WITH THE TOTAL AMOUNT OF FAMILY COUNSELING DONE BY RESPONDENTS**
When asked about the level of satisfaction with the total amount of family counseling respondents provided in the schools, three answer choices were provided: (a) satisfied, (b) would like to do more, and (c) would like to do less. No one responded that he or she would like to do less. The majority of each group responded that they would like to do more family counseling than they were presently doing including 82.1% (n = 39) of the school social workers, 66.7% (n = 14) of the school counselors, and 64.3% (n = 9) of the school psychologists.

Approximately one-quarter of the entire group (25.7%, n = 19) was satisfied with the amount of family counseling they were providing in the schools. Included in this result were 35.7% (n = 5) of the school psychologists, 33.3% (n = 7) of the school counselors, and 17.9% (n = 7) of the school social workers.

Research Question 7: What were the typical practices of school counselors, school psychologists, and school social workers in their provision of school-based family counseling services?

Q-31 SCHOOL-BASED MENTAL HEALTH PROFESSIONALS' DEFINITION OF FAMILY COUNSELING

School-based mental health professionals were asked to identify their definition of family counseling by indicating persons who should most often attend family counseling sessions, average number of sessions per family, use of the systems perspective in their counseling approach, and whether or not written permission should be obtained. Five answer choices were available based on the individuals that school-based mental health professionals thought should attend the family counseling sessions. Table 18 shows the
five possible answer choices as well as the mean number of sessions, the frequency of using a systems perspective, and the frequency of obtaining written permission (based on respondents’ units of treatment). The subgroup’s as well as the entire group’s frequencies and percentages were included.

Data analyses of the entire group showed that a family counseling professional was one who met with the entire family and/or household (which was chosen most often [42.0%, n = 29]), followed closely by a professional who met with the parental figure(s) and one child (i.e., the referred student or identified patient). The latter option was chosen by 40.6% (n = 28) of the total group.

The third most frequently selected response of the entire group (23.2%, n = 16) was that a family counseling professional was someone who met with at least one parental figure, the referred child, plus several children or siblings. Only 15.0% (n = 11) of the total group selected a professional who met with parental figures only (no children) as part of the family counseling definition. Approximately 6% (5.8%, n = 4) of the school-based mental health professionals chose “other” participant configurations (not cited as options on the questionnaire).

When groups were analyzed separately, only results for the school social worker group followed the same pattern as the group in its entirety. A family counseling professional was someone who met with the entire household (45.7%, n = 16), followed by the second choice of meeting with parental figure(s) and one child (37.1%, n = 13), followed by the third choice of meeting with parental figure(s), the referred child, and several siblings (20.0%, n = 7), and finally the fourth choice of meeting with the parental figure(s) only.
School psychologists most often selected meeting with the entire family or household (53.3%, n = 8) followed by their second most selected option of meeting with the parental figure(s), the referred child, and several siblings (40.0%, n = 6). Their third selection emerged as meeting with the parental figure(s) only (26.7%, n = 4) followed by their fourth selection of meeting with the parental figure(s) and one child (20.0%, n = 3).

As part of their definition of family counseling, the majority of school counselors indicated that a family counseling professional was someone who met with the parental figure(s) and one child (63.2%, n = 12). This result was followed by their second choice of meeting with the entire family or household (26.3%, n = 5). This result was followed by two third place choices of meeting with the parental figure(s), the referred child, and several siblings (15.8%, n = 3) and meeting with the parental figure(s) only (15.8%, n = 3).

When asked about the average number of sessions these school-based professionals thought was appropriate with the family configuration chosen above, results of the entire group cited a mean of only 1.58 sessions (SD = 0.50) when meeting with the entire family of household. The highest mean of 5.93 (SD = 4.71) appeared when meeting with the parental figure(s), the referred child, and several siblings. Finally, the mean number of sessions was similar when meeting with the parental figure(s) and the referred child as well as when meeting with the parental figure(s) only (M = 2.82, SD = 1.19 and M = 2.55, SD = 1.51 respectively).

When the mean number of sessions was analyzed per group, both the school psychologists and the school social workers cited the highest mean sessions when they selected, as their preferred unit of treatment, meeting with the parental figure(s), the
referred child, and several siblings. Mean sessions for school psychologists were 7.20 (SD = 7.46) and 6.14 (SD = 3.13) for school social workers.

When asked whether or not a systems perspective was used in the practice of family counseling, the highest percentage of the entire group that selected meeting with the entire family or household responded in the affirmative (39.7%, n = 27): that a systems perspective should be used. The second highest percentage of the total group of respondents (32.8%, n = 22) reporting that they used a systems perspective was found within the group of respondents who selected meeting with the parental figure(s) and one child. This result was followed by the third highest percentage (17.9%, n = 12) of the total group who selected meeting with the parental figure(s), the referred child, and several siblings. Finally, the fourth place percentage of respondents (13.2%, n = 9) who reported using a systems perspective was found in the group that selected meeting with just the parental figure(s).

When asked if written permission should be obtained, 25.8% (n = 17) of the entire group who most frequently thought that a family counseling professional was one who met with the entire family or household also noted that written permission should be obtained. The second highest percentage of respondents (10.4%, n = 7) came from the group who thought a family counseling professional was one who met with the parental figure(s) and one child. This result was followed closely by the group who most often thought a family counseling professional should meet with parental figure(s), the referred child, and several siblings (9.0%, n = 6). Finally, the group that chose meeting only with parental figure(s) reported the lowest frequency of obtaining written permission (2.9%, n = 2).
Table 18

Frequencies, Percentages, and Means of School-Based Mental Health Professionals’

Definitional Components of Family Counseling

<table>
<thead>
<tr>
<th>Who Should Attend</th>
<th>Other Components of F.C.</th>
<th>%</th>
<th>Entire</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
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<tbody>
<tr>
<td>Sessions:</td>
<td></td>
<td>f</td>
<td>Group</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
</tr>
<tr>
<td>Definition</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entire family or</td>
<td></td>
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<td>5</td>
<td>16</td>
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<tr>
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<td>%</td>
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<td>53.3%</td>
<td>16.7%</td>
<td>45.7%</td>
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<td>f</td>
<td>27</td>
<td>8</td>
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<td>16</td>
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<td>42.9%</td>
<td>10.5%</td>
<td>27.3%</td>
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<td>1.47</td>
<td>1.74</td>
<td>1.54</td>
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<td>12</td>
<td>13</td>
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<td>37.1%</td>
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<tr>
<td>W.Perm.</td>
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<td>10.4%</td>
<td>6.7%</td>
<td>16.7%</td>
<td>8.8%</td>
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<td>f</td>
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<td>Sessions</td>
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Table 18 con’t.

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<th>Entire</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
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<tr>
<td>Sessions:</td>
<td></td>
<td></td>
<td>Group</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
</tr>
<tr>
<td>Definition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental figure(s), referred child, siblings</td>
<td></td>
<td></td>
<td>23.2%</td>
<td>40.0%</td>
<td>15.8%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Systems</td>
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<td></td>
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<td>6</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>W.Perm.</td>
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<td>17.9%</td>
<td>28.6%</td>
<td>10.5%</td>
<td>17.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>9.0%</td>
<td>21.4%</td>
<td>5.3%</td>
<td>5.9%</td>
<td></td>
</tr>
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<td>11.4%</td>
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<tr>
<td>Systems</td>
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<td>3</td>
<td>4</td>
<td></td>
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<td>%</td>
<td>13.2%</td>
<td>20.0%</td>
<td>11.1%</td>
<td>11.4%</td>
<td></td>
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<td>1</td>
<td>1</td>
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<tr>
<td>Sessions</td>
<td>M</td>
<td>2.55</td>
<td>3.25</td>
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<table>
<thead>
<tr>
<th>Who Should Attend</th>
<th>Other Components of F.C.</th>
<th>%</th>
<th>Entire</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
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<tbody>
<tr>
<td>Sessions:</td>
<td>f</td>
<td>M</td>
<td>Group</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
</tr>
<tr>
<td>Definition</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>“Other” participant configurations</th>
<th>%</th>
<th>5.8%</th>
<th>13.3%</th>
<th>10.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems</td>
<td>f</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>4.3%</td>
<td>6.7%</td>
<td>10.5%</td>
</tr>
<tr>
<td>W.Perm.</td>
<td>f</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>1.4%</td>
<td>5.3%</td>
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<tr>
<td>Sessions</td>
<td>M</td>
<td>5.67</td>
<td>3.50</td>
<td>10.00</td>
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</table>

Q – 32 UNIT OF TREATMENT MOST OFTEN INCLUDED IN ACTUAL FAMILY COUNSELING SESSIONS

To further determine actual practices, those family counseling practitioners surveyed were asked to indicate the unit of treatment most often included in their family counseling sessions. Five answer choices were listed including: (a) parental figure(s) only (no children), (b) parental figure(s) and one child (the referred child or identified patient), (c) parental figure(s), the referred child, plus several children or siblings, (d) the entire family or household that could include extended family members, and (e) “other” units of treatment.

The greatest majority of the entire group (67.1%, n = 47) as well as the majority of each subgroup—selected as the unit of treatment most often included in actual family counseling sessions—the parental figure(s) and one child. The remaining options were selected less than 15% of the time. (No one selected the “other” units of treatment option.) Table 19 below shows the results of the entire group plus the results of each professional group.
Table 19

Unit of Treatment Most Often Included in Actual Family Counseling Sessions
by Group and Subgroup

<table>
<thead>
<tr>
<th>Unit of Treatment:</th>
<th>%</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
<th>Entire Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental figure(s), one child</td>
<td>%</td>
<td>57.1</td>
<td>71.4</td>
<td>68.6</td>
<td>67.1</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>8</td>
<td>15</td>
<td>24</td>
<td>47</td>
</tr>
<tr>
<td>Parental figure(s) only</td>
<td>%</td>
<td>21.4</td>
<td>9.5</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Entire family or household</td>
<td>%</td>
<td>14.3</td>
<td>11.4</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Parental figure(s), child, and several siblings</td>
<td>%</td>
<td>21.4</td>
<td>4.8</td>
<td>5.7</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>


Q - 25 TERM OR LABEL MOST OFTEN USED IN THE PRACTICE OF SCHOOL-BASED FAMILY COUNSELING

Groups surveyed were probed about the term or label they most often used in their practice of family counseling. Answer choices included: (a) family counseling, (b) family therapy, (c) parent counseling, (d) parent conferencing, (e) parent consultation,
and (f) other terms or labels not included on the questionnaire. Approximately 26% 
(25.7%, n = 19) of the entire group of respondents indicated using the term “family 
counseling” most often. However, the term “parent consultation” was a close second 
(23.0%, n = 17) followed by 21.6% (n = 16) of the entire group using the term “parent 
conferencing.” Approximately 18% (17.6%, n = 13) said they used the term “parent 
counseling,” with only 8.1% (n = 6) who indicated that they used the term “family 
therapy.”

When broken down into separate school-based mental health groups, more school 
social workers (28.9%, n = 11) used the term “family counseling” than any other choice. 
More school psychologists (33.3%, n = 5) used the term “parent consultation” than any 
other choice. Both “family counseling” and “parent conferencing” were used equally 
often by the school counselors (33.3%, n = 7 for each term).

Q – 28 PROCEDURE MOST OFTEN USED TO INITIATE SCHOOL-BASED 
FAMILY COUNSELING

Inquiry was made into the procedure participants most often used with families 
when initiating school-based family counseling. Four choices were listed including: (a) 
the assumption that permission was granted by the family’s presence in the sessions 
(without obtaining written permission), (b) discussion of the procedures without actually 
obtaining written permission, (c) obtaining written permission before or during the first 
session without discussing informed consent, and (d) obtaining written permission before 
or during the first session, labeling this consent as “informed consent” and discussing 
rights, expectations, and procedures.
Results of the entire group showed that the largest percentage (39.7%, n = 29) assumed that permission was granted by the family’s presence in the session. This result was also found between the school counselors (52.4%, n = 11) and school social workers (40.5%, n = 15). The largest number of school psychologists (40.0%, n = 6), however, reported discussing procedures on an informal basis without obtaining written permission.

The second most frequent reported initiation procedure used by the total group was discussion of procedures on an informal basis without obtaining written permission (32.9%, n = 24). Obtaining written permission before or during the first session, labeling this consent as “informed consent” and discussing rights, expectations, and procedures was the third method used by the entire group (20.5%, n = 15). Obtaining written permission without labeling it “informed consent” was chosen as the least used initiation method (6.8%, n = 5).

Q–23 NUMBER OF SCHOOL-BASED FAMILY COUNSELING CASES TYPICALLY CARRIED AT ONE TIME

The number of family counseling cases the entire group of school-based mental professionals reported carrying at one time was cited as approximately 8 (M = 8.16, SD = 14.40) with a minimum and maximum range of 1 to 90. School social workers reported carrying the most cases at one time (M = 11.76, SD = 18.54) with a range from 1 to 90. School counselors reported a mean of 5.90 (SD = 9.53) with a range of 1 to 45. School psychologists reported carrying a mean caseload of 2.93 (SD = 2.09) with a range of 1 to 8.
Because carrying a family counseling caseload of 45 to 90 at one time seemed unfeasible, outlying ranges were eliminated and means were reanalyzed. (It is likely that this question was misunderstood, more in the realm of how many families— in general— these professionals were in contact with during a given period of time.) Only one out of 20 counselors (n = 20) and 6 out of 36 (n = 36) school social workers reported carrying more than 15 cases at one time. As a result, caseloads of 15 or less were reanalyzed, with school social workers continuing to have the highest mean number of cases (M = 5.53, SD = 4.23). The school counselors’ readjusted mean number of cases was 3.84 (SD = 2.52).

Q-29 NUMBER OF SESSIONS PER FAMILY TYPICALLY PROVIDED DURING SCHOOL-BASED FAMILY COUNSELING

The average number of sessions typically provided by the entire group was reported as approximately five (M = 4.78, SD = 4.73). School psychologists reported providing a mean of 6.53 sessions (SD = 6.95), school social workers reported a mean of 4.81 sessions (SD = 4.63), and school counselors reported a mean of 3.32 sessions (SD = 1.29).

Q-27 THEORETICAL APPROACHES MOST OFTEN USED IN SCHOOL-BASED FAMILY COUNSELING

School-based mental health professionals were asked to indicate the theoretical approach they most often used in family counseling. Major approaches were listed and included structural, brief solution-focused, cognitive/behavioral, eclectic/integrative, communication/strategic, and experiential/humanistic. “Other approaches” was included as an additional option. The majority of the total group (50.7%, n = 35) reported most
often using the brief, solution-focused approach. The cognitive/behavioral approach and an eclectic/integrative approach were cited as the second and third most often used family counseling theoretical orientations (20.3%, \( n = 14 \) and 18.8% \( n = 13 \) respectively). School social workers (57.6%, \( n = 19 \)) and school counselors (52.4%, \( n = 11 \)) most often chose the solution-focused approach while school psychologists (40.0%, \( n = 6 \)) most often chose the cognitive/behavioral approach. Table 20 shows the frequencies and percentages of the theoretical approaches most often used by the entire group including the approaches used by each of the three groups comprising the entire group.

Table 20

Theoretical Approach Most Often Used in the Schools, by Group and Subgroups

<table>
<thead>
<tr>
<th>Theoretical Approach:</th>
<th>Sch. Psy. Co. S.W. Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Solution-Focused</td>
<td>5 11 19 35</td>
</tr>
<tr>
<td>%</td>
<td>33.3 52.4 57.6 50.7</td>
</tr>
<tr>
<td>Cognitive/Behavioral</td>
<td>6 5 3 14</td>
</tr>
<tr>
<td>%</td>
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<tr>
<td>Eclectic/Integrative</td>
<td>2 3 8 13</td>
</tr>
<tr>
<td>%</td>
<td>13.3 14.3 24.2 18.8</td>
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<tr>
<td>Other approaches</td>
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<td>%</td>
<td>13.3 3.0 4.3</td>
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Table 20 con’t.

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<td>Structural</td>
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</tr>
<tr>
<td></td>
<td>%</td>
<td>4.8</td>
<td>3.0</td>
<td>2.9</td>
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</tr>
<tr>
<td>Communication/Strategic</td>
<td>f</td>
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<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.0</td>
<td>1.4</td>
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<td></td>
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<tr>
<td>Experiential/Humanistic</td>
<td>f</td>
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</tr>
<tr>
<td></td>
<td>%</td>
<td>4.8</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Sch. Psy. (school psychologists), Sch. Co. (school counselors), Sch. S.W. (school social workers).

Q-26 MOST FREQUENT REFERRAL SOURCES FOR SCHOOL-BASED FAMILY COUNSELING

When probed about the most frequent sources of referrals for school-based family counseling services, the following answer choices were provided: (a) departmental supervisors/directors, (b) teachers, (c) direct requests from parents, (d), recommendations from student/instructional support team members, and (e) principals. Approximately half of the entire group of respondents (50.7%, n = 34) indicated that the most frequent referral source for family counseling services came directly from parents. The highest percentage of each group of school-based mental health professionals also
reported this result. Table 21 shows response choices and the frequencies and percentages of each professional group as well as the group in its entirety. (No one selected principals as the most frequent referral source.) Both school social workers (33.3%, n = 11) and school psychologists (28.6%, n = 4) chose secondly, recommendations from student/instructional support team members. One-quarter of the school counselors (25.0%, n = 5) chose teachers as their second most often referral source.

Table 21

Most Frequent Referral Source by Group and Subgroups

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>f</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Sch.</th>
<th>Entire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Psy.</td>
<td>Co.</td>
<td>S.W.</td>
<td>Group</td>
</tr>
<tr>
<td>Direct parent requests</td>
<td></td>
<td>7</td>
<td>13</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>50.0</td>
<td>65.0</td>
<td>42.4</td>
<td>50.7</td>
</tr>
<tr>
<td>Student support teams</td>
<td></td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>28.6</td>
<td>10.0</td>
<td>33.3</td>
<td>25.4</td>
</tr>
<tr>
<td>Teachers</td>
<td></td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>14.3</td>
<td>25.0</td>
<td>21.2</td>
<td>20.9</td>
</tr>
<tr>
<td>Departmental supervisors</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.1</td>
<td>3.0</td>
<td>3.0</td>
<td></td>
</tr>
</tbody>
</table>

Q-38 TYPES OF SERVICE DELIVERY FORMATS USED FOR SCHOOL-BASED

FAMILY COUNSELING

The service delivery format investigated the arrangements or conditions within which school-based mental health professionals (school counselors, school psychologists, and school social workers) practiced family counseling. Five answer choices were included: (a) family counseling was a departmental program (single profession or discipline only), (b) family counseling was part of a combined effort of departments such as school counseling, school psychology, or school social work, (c) family counseling was part of a comprehensive mental health program that included resources for families provided by on-staff personnel and/or contractual personnel in full service schools, clinics, etc., (d) “other” arrangements not mentioned on the questionnaire, and (e) not applicable: respondents practiced school-based family counseling singly on his or her own, not part of a larger program or group.

A total of 71 persons responded to the service delivery format question. Results of the entire group showed that the highest percentage of respondents (36.6%, n = 26) practiced family counseling within a combined effort of departments such as school counseling, school psychology, and school social work. The second highest percentage of respondents (32.4%, n = 23) indicated that they did not practice family counseling as a part of a program or larger group; that they practiced singly on their own.

Approximately 16% (15.5%, n = 11) of those people who responded reported that they practiced school-based family counseling as part of a single departmental program. This result was followed by 12.7% (n = 9) who reported that they practiced school-based family counseling as part of a comprehensive mental health program. Approximately 3%
(2.8%, n = 2) reported practicing family counseling in the schools under some other arrangement. Table 22 shows the entire group's results and each professional group's results of the service delivery format most often used in the provision of school-based family counseling.

Table 22

Service Delivery Format for the Practice of School-Based Family Counseling by Group and Subgroup

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined school departments</td>
<td>36.6</td>
<td>46.7</td>
<td>25.0</td>
<td>38.9</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>7</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Practice on own; not part of program</td>
<td>32.4</td>
<td>40.0</td>
<td>25.0</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>6</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Single departmental program</td>
<td>15.5</td>
<td>30.0</td>
<td>13.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>6</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Comprehensive mental health program</td>
<td>12.7</td>
<td>6.7</td>
<td>15.0</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>&quot;Other&quot; service delivery format</td>
<td>2.8</td>
<td>6.7</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Q-30 TYPE OF STUDENT PROBLEM MOST OFTEN REFERRED FOR SCHOOL-BASED FAMILY COUNSELING

When the groups were asked what problems were most often referred for family counseling in the schools, the following seven answer choices were provided: (a) externalizing type behaviors, (b) internalizing type behaviors, (c) drugs/alcohol of student, (d) student/parent conflict, (e) academic with low motivation, (f) academic with high motivation, and (g) other. The largest percentage of the total group of respondents (50.7%, n = 35) picked externalizing type behaviors (such as conduct problems) as the most frequently referred type of student problem. This result held true for school psychologists (64.3%, n = 9), school social workers (48.6%, n = 17), and school counselors (45.0%, n = 9). (The total number of respondents was 69.)

Internalizing type behavior (such as depression or anxiety) was chosen by the entire group (n = 10) 14.5% of the time, while types of student problems other than those listed were chosen by the entire group (n = 9) 13.0% of the time. Student/parent conflict was chosen by the entire group (n = 8) 11.6% of the time. These problems were followed by academic problems with low motivation, chosen at a frequency rate of 7.2% (n = 5), and drugs or alcohol usage of student chosen at a frequency rate of 2.9% (n = 2). No one chose academic problems with high motivation.

Research Question 8: How much ongoing clinical supervision in family counseling did the school counselors, school psychologists, and school social workers receive surrounding their practice of school-based family counseling?
Q-33 FREQUENCY OF SCHOOL-BASED PROFESSIONALS RECEIVING ONGOING CLINICAL SUPERVISION

Of the school-based mental health professionals who reported providing school-based family counseling, inquiry was made into how many received ongoing clinical supervision surrounding this practice. A total of 72 persons responded. Results of the entire group showed that 22.2% (n = 16) reported receiving clinical supervision in their work of school-based family counseling. This statistic broke down to 25.0% (n = 5) of the school counselors, 21.6% (n = 8) of the school social workers, and 20.0% (n = 3) of the school psychologists.

In summary, only about one-fifth to one-quarter of those persons who provided school-based family counseling reported receiving ongoing clinical supervision. Similar percentages were reported in each group.

Q-35 FREQUENCY OF RECEIVING INDIVIDUAL CLINICAL SUPERVISION

When asked about the frequency of receiving individual clinical supervision, results of the entire group showed that 37.5% (n = 6) of the entire group received individual supervision weekly. Sixteen people responded to this question. The remaining three response categories—bimonthly, monthly, as needed—were reported with the same frequencies at 18.8% (n = 3) each. In addition, one person reported not receiving individual supervision (which was feasible given the question about the possibility of receiving group versus individual supervision). Table 23 shows the answer choices with accompanying frequencies of receiving individual supervision per group and subgroup.
Table 23

Frequency of Receiving Individual Clinical Supervision, by Group and Subgroup

<table>
<thead>
<tr>
<th>Group:</th>
<th>%</th>
<th>Weekly</th>
<th>Bimonthly</th>
<th>Monthly</th>
<th>As Needed</th>
<th>Not Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Group</td>
<td>%</td>
<td>37.5</td>
<td>18.8</td>
<td>18.3</td>
<td>18.8</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>School Psychologists</td>
<td>%</td>
<td>66.7</td>
<td></td>
<td></td>
<td></td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>School Counselors</td>
<td>%</td>
<td>40.0</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>School Social Workers</td>
<td>%</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Q-36 FREQUENCY OF RECEIVING GROUP CLINICAL SUPERVISION

Those respondents who reported receiving clinical supervision in their practice of school-based family counseling were probed about the amount of group supervision they received. A total of 16 people responded to this question. The highest percentage of the total group (31.3%, n = 5) reported receiving group supervision bimonthly, followed by 25.0% (n = 4) who reported receiving group supervision on a weekly basis and the same
percentage who reported receiving group supervision on a monthly basis. Only 6.3% (n = 1) reported receiving group supervision as needed while 12.5% (n = 2) reported not receiving group supervision. Included in Table 24 are the answer choices with accompanying frequency results of respondents who reported receiving group supervision.

Table 24

Frequency of Receiving Group Supervision by Group and Subgroup

<table>
<thead>
<tr>
<th>Group:</th>
<th>%</th>
<th>Bimonthly</th>
<th>Weekly</th>
<th>Monthly</th>
<th>As Needed</th>
<th>Not Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Group</td>
<td>31.3</td>
<td>25.0</td>
<td>25.0</td>
<td>6.3</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>School Psychologists</td>
<td>66.7</td>
<td></td>
<td></td>
<td></td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>School Counselors</td>
<td>20.0</td>
<td>40.0</td>
<td>40.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Social Workers</td>
<td>50.0</td>
<td></td>
<td></td>
<td>25.0</td>
<td>25.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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Q-34 SOURCE OR PERSONNEL PROVIDING CLINICAL SUPERVISION

School-based mental health professionals who reported receiving clinical supervision were surveyed about the source of their clinical supervision surrounding their practice of school-based family counseling. Five response choices were given: (a) school system provided on-staff supervisory personnel trained in family counseling, (b) school system contracted with a community therapist trained in family counseling, (c) school system provided opportunity for peer supervision, (d) respondents obtained supervision apart from the school system, and (e) "other" sources of supervision not mentioned on the questionnaire.

A total of 15 individuals responded to this question. The highest percentage of this group (40.0%, n = 6) reported receiving their clinical supervision apart from the school system. The second highest percentage reported receiving peer supervision (33.3%, n = 5). The three remaining responses were reported with equal frequencies at 13.3% (n = 2): on-staff supervision, community therapist contracted by the school system, and "other" sources of supervision not mentioned on the questionnaire. Table 25 includes the frequencies and percentages per professional group and total group.
Table 25

**Frequencies and Percentages of Who Provides Clinical Supervision for School-Based Personnel Actually Engaging in School-Based Family Counseling**

<table>
<thead>
<tr>
<th>Sources of Clinical Supervision:</th>
<th>f</th>
<th>Entire</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision apart from school</td>
<td>f</td>
<td>40.0</td>
<td>33.3</td>
<td>60.0</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Peer supervision</td>
<td>f</td>
<td>33.3</td>
<td></td>
<td>20.0</td>
<td>57.1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5</td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>On-staff supervision</td>
<td>f</td>
<td>13.3</td>
<td></td>
<td></td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Contracted community therapist</td>
<td>f</td>
<td>13.3</td>
<td></td>
<td>20.0</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>“Other” sources of supervision</td>
<td>f</td>
<td>13.3</td>
<td></td>
<td>66.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>


Q-37 TYPE OF SUPERVISION ACTIVITY THAT WAS MOST TYPICAL

When probed about the types of clinical supervision activities that typically took place, respondents were given six answer choices: (a) case presentations (review of
family cases with a written report using theoretical hypotheses and analyses), (b) review of counseling notes or logs (self-report of family’s issues with discussion of appropriate interventions), (c) review of videotapes, (d) review of audiotapes or transcripts, (e) live supervision, and (f) use of didactic information to increase knowledge about family therapy. (Respondents were asked to check all answer choices that applied.)

Results of the entire group showed that the greatest majority (68.8%, n = 11) reported that case presentation was the most typical activity during their family counseling supervision sessions. Sixteen people responded to this question. Approximately 56% (56.3%, n = 9) of the entire group reported that review of counseling notes or logs was the most typical supervision activity. The third most typical clinical supervision activity (31.3%, n = 5) was use of didactic information to increase knowledge about family therapy. Live supervision was chosen by only 6.3% (n = 1) of the entire group. No one selected review of videotapes or review of audiotapes or transcripts as typical clinical supervision activities. Table 26 shows the frequencies and percentages of supervision activities by group and subgroups.
Table 26

Typical Types of Clinical Supervision Activities by Group and Subgroup

<table>
<thead>
<tr>
<th>Type of Supervision Activity:</th>
<th>%</th>
<th>Entire</th>
<th>Sch. Psy.</th>
<th>Sch. Co.</th>
<th>Sch. S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case presentations</td>
<td>68.8</td>
<td>100.0</td>
<td>80.0</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Review of counseling notes or logs</td>
<td>56.3</td>
<td>80.0</td>
<td>62.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Didactic information</td>
<td>31.3</td>
<td>60.0</td>
<td>25.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live supervision</td>
<td>6.3</td>
<td>20.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of videotapes</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of audiotapes or transcripts</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Green, Salkind, and Akey (2000) was used as a reference for statistical analyses information related to two-way contingency table analysis (chi-square), follow-up tests, and APA formatting in writing the results. The Statistical Package for the Social Sciences (SPSS), Version 10.0 was used to analyze all data.

Summary Demographics of the Sample

From a randomized sample of 1,079 school counselors, school psychologists, and school social workers, an overall response rate of 73.2% was achieved with a useable response rate of 62.9%. The highest useable response rate came from the school counselor group (71.5%). The remaining two groups, school psychologists and school social workers, had nearly equal useable response rates of 58.9% and 58.3%, respectively.

In order to better understand the sample of respondents, summary demographics will be presented. Where appropriate, total group results as well as comparisons between and among the three disciplines will be included.

Most school counselors, school psychologists, and school social workers worked in public schools in a suburban setting. Almost all the school counselors had an office that was housed in the school in which they worked. The majority of school social workers also had offices housed in the schools in which they worked. However, though still in the majority, fewer school psychologists than school counselors or school social workers reported this office arrangement.
When asked about the number of schools assigned and the total number of students for which the three groups of school practitioners were responsible, comparisons were made among the three groups surveyed. School psychologists were assigned to the highest number of schools and the highest number of students. School counselors were assigned to the fewest number of schools and to the fewest number of students.

Based on the number of grade level assignments and number of school building assignments, school psychologists and school social workers were generally assigned to multi-grade levels while school counselors were generally assigned to one grade level. As a group, school counselors were fairly evenly distributed across the major grade levels (i.e., elementary, middle, and high school).

School psychologists had the highest level of training with 25.2% reporting doctoral status. However, the highest percentage (35.3%) of school psychologists reported earning a Master’s Degree plus 30. The great majority of school social workers held a Master of Social Work (MSW). The highest percentage of school counselors (nearly half) held a Master’s Degree plus 30. Less than 2% of the school social workers and school counselors held doctorates.

School counselors received their highest level of training most recently with the highest percentage falling in the range from 1997 to 2002. School psychologists received their highest level of training between the years of 1981 to 1989. School social workers received their highest level of training between the years of 1962 to 1980. (The range of years in which school practitioners received their highest level of training was found more meaningful for interpretation than the mean year.)
Based on years employed, school counselors worked the fewest number of years (0 to 7 at 44.6%). (As this survey was conducted in the fall near the beginning of the school year, some practitioners likely had just started their careers and not yet worked a full year.) Most school social workers worked between 13 and 19 years followed closely by many working more than 19 years. The highest percentage of school psychologists (34.4%) worked more than 19 years. Based on the mean hours worked and the typical weekly hours required by many school systems, the great majority of practitioners reported full-time work status.

According to ages, approximately half of the school social workers fell into the 51- to 60-year-old range. In addition, the highest percentage of school counselors also fell into this age range (51 to 60). The highest percentage of school psychologists fell into a slightly younger age range from 41- to 50-years-old.

In summary, though the highest percentage of school counselors fell into the oldest age range, they were the newest to their profession. School social workers fell into the oldest age range also, but were the least current in training. School psychologists, by comparison, were the youngest, but had worked more years in their profession than either the school social workers or the school counselors.

The highest percentage of females was found in the school social worker group (82.7%) followed by 81.3% of the school counselor group. The highest percentage of males (31.2%) was found in the school psychologist group.

According to race and ethnicity, respondents were predominantly white/Caucasian. More than 85% of all three groups were white/Caucasian. Approximately 5% of the total group was black/African American, with the highest
frequency rate (8.5%) representing the school social worker group and the lowest frequency rate representing the school psychologist group.

Groups surveyed represented a total of 53 states, territories or commonwealths. The Northeast was the most heavily represented by all three groups except for the Southeast. The Southeast and Northeast were nearly equally represented by school counselors. When examining results from the entire group, the Southeast and Midwest were nearly equally represented. Close to 60% of the entire group represented the Eastern half of the United States (which excludes the Midwest). Based on results of the disciplines as a whole, the West and the Southwest were the least represented regions (14.3% and 3.8% respectively).

**Summary of Research Results Based on Research Questions**

**Research Question 1: What type of family-oriented work was most frequently being done by school counselors, school psychologists, and school social workers?**

**Q-16 TYPE OF FAMILY WORK MOST OFTEN PROVIDED BY SCHOOL COUNSELORS, SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS**

As an entire group of respondents, parent conferencing or consultation apart from support team meetings or special education evaluations was the type of family work most often provided (42.1%). This statistic included the largest percentage of school counselors and school social workers. School psychologists reported—with highest frequency—parent conferencing or consultation during special education evaluations as the most often engaged in type of family work. Also, the entire group chose this latter
of the entire group reported doing none of the family work listed, with the highest percentage of this group (6.0%, n = 12) being school psychologists.

Both school social workers and school counselors most frequently engaged in parent conferencing or consultation apart from support team meetings or special education evaluations spending, on average, nine hours per week and six hours per week respectively. School psychologists spent an average of five hours per week in their most frequent family work (i.e., parent conferencing or consultation during special education evaluations).

Research Question 2: What type of training in family systems work and family counseling did school counselors, school psychologists, and school social workers typically have?

Q-17 FORMAL TRAINING AT THE UNIVERSITY LEVEL RELATED TO FAMILY SYSTEMS THEORY AND FAMILY COUNSELING OBTAINED BY THE THREE GROUPS OF MENTAL HEALTH PROFESSIONALS WHO DID AND DID NOT PROVIDE SCHOOL-BASED FAMILY COUNSELING

The great majority of all three groups (83.8%) received training in family systems or ecological theory. Also, the majority of all three groups received training in family systems interventions and reported taking a family counseling survey course. Between one-third to one quarter of the entire group reported taking advanced coursework in family counseling including supervised practica. As a subgroup, school social workers reported the highest frequency rate of training in university level coursework related to
family work and family counseling. The majority of school social workers (50.3% and above) cited having taken coursework in all five topics or areas. These areas or topics included general systems or ecological theory, family systems interventions, a family counseling survey course, advanced coursework in family counseling, and supervised practica in family counseling.

Q-7 HIGHEST DEGREE OR LEVEL OF TRAINING OBTAINED BY PRACTITIONERS WHO ACTUALLY PROVIDED SCHOOL-BASED FAMILY COUNSELING

When analyzing the highest degree or level of training obtained by practitioners who reported actually providing school-based family counseling, 27 out of 74 reported holding a MSW (37.5%) as their highest level of training. The next highest frequency rate was at 27.8% for individuals holding a Master’s Degree plus 30. Approximately 11% held a Master’s Degree, 9.7% held a doctorate, and 8.3% earned an Educational Specialist Degree. Approximately 6% held training other than listed degrees or certifications.

Q-39 SPECIFIC TYPE OR SOURCE OF FAMILY COUNSELING TRAINING OBTAINED BY PRACTITIONERS WHO ACTUALLY PROVIDED SCHOOL-BASED FAMILY COUNSELING

When the practitioners who actually provided family counseling were probed, the most frequent source (76.7%) for obtaining family counseling training by all three groups registered as seminars or workshops apart from the school system. Obtaining family counseling training from a university degree program in preparation for the job was cited with the second greatest frequency by the majority of the entire group (60.3%). In fact,
over half of each group reported receiving training in family counseling from a university degree program in preparation for their job. The remaining sources were cited in descending order by the entire group: post-degree university coursework (39.7%), seminars or workshops sponsored or provided by the school system (31.5%), family therapist apart from the school system (24.7%), and free-standing family therapy institute (17.8%).

Q-40 LICENSURE TO PRACTICE THERAPY IN A COMMUNITY SETTING HELD BY SCHOOL PRACTITIONERS WHO PROVIDED SCHOOL-BASED FAMILY COUNSELING

The majority of the entire group (68.5%) who provided family counseling in the schools reported holding a license to practice therapy in a community setting. Nearly 87% (86.5%) of the school social workers were licensed to practice in the community along with approximately half of the school psychologists (53.3%) and half of the school counselors (47.6%).

Q-41 LICENSURE SPECIFICALLY IN MARRIAGE AND FAMILY THERAPY OR FAMILY PSYCHOLOGY HELD BY SCHOOL PRACTITIONERS WHO PROVIDED SCHOOL-BASED FAMILY COUNSELING

Of the entire group who reported providing family counseling in the schools, only 13.5% held licensure in marriage and family therapy or family psychology. Twenty percent (20.0%) were school psychologists, 15.8% were school social workers, and 4.8% were school counselors.
Research Question 3: How much family counseling was provided by school counselors, school psychologists, and school social workers? Were the proportions of the provision of family counseling the same among these three groups?

Q-13 TYPE OF COUNSELING MOST OFTEN PROVIDED BY SCHOOL COUNSELORS, SCHOOL PSYCHOLOGISTS, AND SCHOOL SOCIAL WORKERS

All three groups reported providing individual counseling (50.2%) most often. Group counseling followed with the next highest frequency rate as reported by school counselors and school social workers, but not school psychologists. School psychologists provided crisis counseling at a slightly higher frequency rate than group counseling, and more crisis counseling than either the school counselors or school social workers. As a total group, family counseling was seldom provided more often than individual, group or crisis counseling. The few who reported most often providing school-based family counseling were school social workers.

Q-14 FREQUENCY OF FAMILY COUNSELING REPORTED AS A SCHOOL-BASED SERVICE IN PARTICIPANTS’ SCHOOL DISTRICT

Of the total group, 18% (18.0%) indicated that family counseling was being offered in the respondents’ schools. Few differences were found in the levels or proportions reported by the three groups except in the area of not being sure whether family counseling was a service in their school districts when school psychologists and school counselors were compared and when school counselors and school social workers were compared. Within these comparisons, school psychologists were about four times more likely than school counselors of not being sure whether family counseling was
provided in their school districts. In addition, school social workers were about two and one-half times more likely than school counselors in not being sure whether family counseling was provided in their school districts. When compared to school psychologists and school social workers, results suggested that school counselors were more certain about the status of family counseling being offered in their school districts.

Q-15 PERSONNEL PROVIDING FAMILY COUNSELING IN DISTRICTS THAT OFFERED THIS SERVICE

The three groups of school practitioners were asked who provided family counseling in their school districts. When comparing the frequency rates of the three groups of school-based mental health professionals, school social workers were reported as providing family counseling with the highest frequency (44.4%) with significantly more school social workers making this report than either school psychologists or school counselors. School counselors were cited as providing family counseling with the second highest frequency at 34.9%. No significant differences were found in the frequencies of this report by school counselors, school psychologists, and school social workers. School psychologists were cited as providing family counseling with the third highest frequency at 28.6% with significantly more (three times more) school psychologists than school counselors making this report.

In addition to the three school-owned mental health groups, contracted mental health professionals also provided family counseling at a frequency rate of 45.2%, a rate slightly higher than any one of the three school-based mental health groups. Personnel or arrangements other than those listed on the survey provided family counseling at a reported frequency rate of 15.1%. Approximately 1% of the respondents was not sure
whether family counseling was provided in their school districts. There were no statistical differences among the levels or proportions of the three groups reporting that contracted mental health professionals and other professionals provided family counseling in their schools. In addition, there were no significant differences among the reported levels or proportions of the three groups being aware of the provision of family counseling services in their school system.

Q-18 FREQUENCY OF SCHOOL PSYCHOLOGISTS, SCHOOL COUNSELORS, AND SCHOOL SOCIAL WORKERS WHO PRACTICED SCHOOL-BASED FAMILY COUNSELING

Practitioners were asked directly if they provided family counseling. Approximately 13% (12.7%) of the entire group of mental health professionals surveyed reported providing family counseling in the schools. By subgroups, approximately 22% (21.7%) of the school social workers, 10% (9.9%) of the school counselors, and 8% (8.3%) of the school psychologists claimed they provided school-based family counseling. As just noted, the percentages of individual professionals who reported actually providing family counseling dropped considerably when compared to being asked what professional groups in their school districts provided this service.

A higher percentage of school social workers reported the practice of school-based family counseling than either the school psychologists or school counselors. School social workers were 2.61 times more likely than school psychologists to report the practice of family counseling, and 2.19 times more likely than school counselors to report the practice of family counseling. The differences in both comparisons were found to be statistically significant.
When asked to complete the last portion of the questionnaire reserved solely for school-based family practitioners, the percentages of professionals who provided family counseling dropped even further. (The last half of the questionnaire was reserved for participants who actually reported practicing family counseling in the schools.) In the first half of the questionnaire, 84 respondents from the total group (12.7%) reported practicing family counseling in the schools; however, only 74 total (10.9%; 74/679) actually completed the last portion of the questionnaire. Of this number, 15 (N = 221, 6.8%) were school psychologists, 21 (N = 258, 8.1%) were school counselors, and 38 (N = 200, 19.0%) were school social workers. Based on the participants who actually completed the last half of the questionnaire, 10.9% of the total group versus the initial 12.7% actually practiced family counseling in the schools. By subgroup, this left 15 versus 18 school psychologists who actually provided school-based family counseling, along with 21 versus 25 school counselors and 38 versus 41 school social workers who actually provided school-based family counseling. It is noted that as the questions about the provision of school-based family counseling became more direct, detailed, and/or personal, the percentages of school counselors, school psychologists, and school social workers who reported providing school-based family counseling decreased.

Research Question 4: What, if any, were the most frequent administrative barriers to the practice of school-based family counseling? Were the proportions of the administrative barriers to the provision of school-based family counseling the same among the three groups?
Q-19 ADMINISTRATIVE BARRIERS THAT MOST RESTRICTED ABILITY TO
PRACTICE SCHOOL-BASED FAMILY COUNSELING

Total group results showed that with greatest frequency (31.9%), school-based mental health professionals were not sure what administrators thought about family counseling. This result was followed by an administrative belief that family counseling was incompatible with their job role (23.2%). The third most frequent choice emerged as no administrative barriers; that administrators supported family counseling, followed by lack of administrative support in the form of money, accommodations for training, supervision, rooms, etc. (Approximately 16% (16.3%) of the total group cited no administrative barriers; that school administrators supported family counseling in the schools.)

As a subgroup, the school counselors selected the same top four choices as the entire group. School psychologists most frequently selected the same top two barriers as the entire group. The school social workers’ patterns of responses were most divergent. School social workers chose, as their first and most frequent selection, administrative support of family counseling followed closely by an administrative belief that family counseling was incompatible with their job role.

A statistically significant difference was found between the levels or proportions that school social workers and school psychologists reported not being sure what administrators in their district thought about family counseling and the lack of administrative knowledge about the benefits of family counseling. School psychologists were approximately twice as likely when compared to school social workers to report not being sure what administrators in their school district thought about family counseling

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while school social workers were approximately five times more likely than school psychologists to select, as a barrier, an administrative lack of knowledge about the benefits of family counseling.

A significant difference was also found between the levels or proportions that school social workers and school counselors reported not being sure what administrators thought about family counseling and also the lack of administrative knowledge about the benefits of family counseling. In addition, reported levels of the lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms, etc., was found to be significantly different between the school social workers and school counselors. School social workers were about twice as likely as school counselors to select as barriers a lack of administrative support in the form of money or accommodations as well as a lack of administrative knowledge about the benefits of family counseling. School counselors were about twice as likely when compared to school social workers to report not being sure what administrators thought about family counseling.

Research Question 5: What were the most frequent personal barriers or factors to the practice of school-based family counseling? Were the proportions of the personal barriers to the practice of school-based family counseling the same among the three groups?

Q-20 PERSONAL BARRIERS TO THE PRACTICE OF SCHOOL-BASED FAMILY COUNSELING
As the greatest personal barrier to the practice of family counseling in the schools, lack of time/too busy with other duties was selected by the highest percentage (and nearly equal percentage) of respondents in all three groups (34.1% to 38.9%). Incompatibility with job role was chosen with the second greatest frequency by the entire group (19.3%), followed by not being sure this service should be provided in the schools, chosen third by the entire group (11.4%). However, this barrier (i.e., not being sure this service should be provided in the schools) was chosen as the third option by school social workers (11.7%) and school counselors (12.2%), but not by school psychologists. School psychologists' third barrier registered as having limited training in family counseling (11.6%) followed by not being sure the schools should provide family counseling (10.2%). Encouraged by supervisors to “refer out” was the fourth most frequently cited barrier by the entire group (7.5%) with school social workers and school counselors both making this report, but as just noted, not school psychologists. Limited training in family counseling was reported with the fifth greatest frequency by school counselors (7.5%). Limited training was rarely cited as a barrier by school social workers (1.5%).

A significant difference was found in the levels or proportions that school counselors versus school psychologists reported that they were encouraged by their supervisors to refer out for family counseling services. School counselors were about three and one-half times more likely than school psychologists to select this barrier. In addition, school psychologists were approximately three times more likely than school counselors to report that none of the named personal factors was a barrier to their practice of school-based family counseling. When compared to school counselors, school social
workers were about four times more likely to report that none of the named barriers was a personal factor in their ability to practice school-based family counseling.

Another significant difference surfaced when comparing the training in family counseling between school counselors and school social workers. School counselors were five times more likely than school social workers to report as a personal barrier having limited training in family counseling. A significant difference in family counseling training also surfaced between school psychologists and school social workers. School psychologists were 7.73 times more likely than school social workers to report having limited training in family counseling.

Research Question 6: Among the school-based professionals who actually provided family counseling, what did school counselors, school psychologists, and school social workers perceive as the influences or factors that encouraged the practice of school-based family counseling?

Q-22 FACTORS THAT MOST INFLUENCED DECISION TO PRACTICE SCHOOL-BASED FAMILY COUNSELING

At least half of the entire group of professionals (50.7%) that reported practicing family counseling cited having a personal belief that family counseling should be provided in the schools. All three groups chose—with a frequency (44.4% to 57.1%) considerably higher than other choices—a personal belief that family counseling should be provided in the schools. The remaining factors that influenced the decision to practice family counseling in the schools were chosen by less than 15% of the group as a whole. Of those subgroups who provided school-based family counseling, it was noted that
approximately 19.4% of the school social workers and 14.3% of the school counselors cited having family counseling in their job descriptions as the second most frequent reason for practicing family counseling in the schools (though many more as noted below had family counseling in their job descriptions).

Q-21 INCLUSION OF FAMILY COUNSELING IN RESPONDENTS' JOB DESCRIPTIONS

The group of practitioners that reported providing school-based family counseling was queried about whether family counseling was included in job descriptions. Approximately three-quarter (71.4%) of the school social workers who reported providing school-based family counseling indicated that family counseling was included in their job descriptions. Approximately half (52.4%) of the school counselors who practiced school-based family counseling reported having family counseling in their job descriptions while only 13.3% of the school psychologists gave this report.

Q-24 LEVEL OF SATISFACTION WITH THE TOTAL AMOUNT OF SCHOOL-BASED FAMILY COUNSELING PROVIDED BY RESPONDENTS

Of the group who provided school-based family counseling, the greatest majority of all three groups reported that they would like to do more family counseling than they were presently doing. No one reported that they would like to do less.

Research Question 7: What were the typical practices of school counselors, school psychologists, and school social workers in their provision of school-based family counseling services?
Q-31 SCHOOL-BASED MENTAL HEALTH PROFESSIONALS’ DEFINITION OF FAMILY COUNSELING

As part of the definition of family counseling given by professionals actually providing school-based family counseling, the appropriate unit of treatment for family counseling was most often reported (by the entire group) as the entire family or household (42.0%) followed closely by the parental figure(s) and only one child (40.6%). Inconsistent use of the systems perspective was reported. Written permission was reported as infrequently obtained regardless of the unit of treatment chosen. The mean number of sessions was least for the entire group’s first choice of including the entire family or household in family counseling sessions (M = 1.58), and the highest when including the parental figure(s), referred child, and several siblings (M = 5.93).

Q-32 UNIT OF TREATMENT MOST OFTEN INCLUDED IN ACTUAL FAMILY COUNSELING SESSIONS

In actual family counseling sessions, the actual unit of treatment most often selected by the majority of each group surveyed was parental figure(s) and one child only, chosen by the entire group 67.1% of the time. This finding compared to the ideal or most appropriate unit of treatment—the entire family or household—chosen 42.0% of the time by the entire group. (During actual family counseling sessions, the entire family or household was chosen for treatment only 10.0% of the time though this configuration was identified in the definition of family counseling as the school practitioners’ most ideal unit of treatment.)

Q-25 TERM OR LABEL MOST OFTEN USED IN THE PRACTICE OF SCHOOL-BASED FAMILY COUNSELING
As an entire group, more school practitioners (25.7%) used the term "family counseling" than any other choice. However, the terms "parent consultation," "parent conferencing," and "parent counseling" were also used with similar frequencies at 23.0%, 21.6%, and 17.6% respectively. Few school practitioners used the term "family therapy." When compared to other terms or labels, more school social workers (28.9%) used the term "family counseling," more school psychologists (33.3%) used the term "parent consultation," and an equal number of school counselors (33.3% each) used either "parent conferencing" or "family counseling."

Q-28 PROCEDURE MOST OFTEN USED TO INITIATE SCHOOL-BASED FAMILY COUNSELING

Written permission was most often assumed by the presence of the family, chosen at an overall frequency rate of 39.7% by the entire group. Over half of the school counselors (52.4%) and 40.5% of the school social workers used this initiation method. This finding was followed by discussing procedures on an informal basis without actually obtaining written permission, chosen at an overall frequency rate of 32.9%, which included 40.0% of the school psychologists (their most often selected option). When written permission was obtained, it was usually labeled "informed consent," chosen by 20.5% of the entire group.

Q-23 NUMBER OF SCHOOL-BASED FAMILY COUNSELING CASES TYPICALLY CARRIED AT ONE TIME

Analyzing the data as given, the mean number of family counseling cases typically carried at one time was cited as close to eight (M = 8.16). School social workers reported having the highest number of cases (M = 11.76) and school
psychologists reported having the least ($M = 2.93$). School counselors reported a mean caseload of 5.90. However, due to the ranges in caseloads from 45 to 90 reported by both school social workers and school counselors (which seemed unfeasible), the data was reanalyzed to include a maximum caseload of 15. (It is likely that this question was misunderstood more in the realm of how many families—in general—these school social workers and school counselors were in contact with during a given period of time.) Upon reanalyzing the data, school social workers continued to have the highest caseloads ($M = 5.53$) while school counselors had a mean caseload of 3.84.

**Q-29 NUMBER OF SESSIONS PER FAMILY TYPICALLY PROVIDED IN SCHOOL-BASED FAMILY COUNSELING**

The mean number of sessions per family typically provided in school-based family counseling was reported by the entire group as approximately five ($M = 4.78$). School psychologists reported having the most sessions ($M = 6.53$). School social workers reported having approximately five ($M = 4.81$), followed by school counselors who reported about three ($M = 3.32$).

**Q-27 THEORECTICAL APPROACHES MOST OFTEN USED IN SCHOOL-BASED FAMILY COUNSELING**

Half of the entire group (50.7%) used the brief, solution-focused approach as its most frequent theoretical approach for family counseling followed by one-fifth of the group (20.3%) using the cognitive/behavioral approach. School social workers and school counselors most often reported using the brief, solution-focused approach while school psychologists most often reported using the cognitive/behavioral approach.
Q-26 MOST FREQUENT REFERRAL SOURCE FOR SCHOOL-BASED FAMILY COUNSELING

Half of the entire group (50.7%) maintained that its most frequent referral source for family counseling came as direct requests from parents. This finding was consistent with the highest rate obtained within each practitioner group. School psychologists and school social workers noted recommendations from student support teams as their second highest referral source, while school counselors noted requests from teachers.

Q-30 TYPE OF STUDENT PROBLEM MOST OFTEN REFERRED FOR SCHOOL-BASED FAMILY COUNSELING

The largest percentage of the entire group (50.7%) picked externalizing behaviors as the most frequently referred student problem for family counseling. This result held true for 64.3% of the school psychologists, 48.6% of the school social workers, and 45.0% of the school counselors. This referral problem was followed by internalizing type behaviors chosen by 14.5% of the group, “other” types of problems not listed chosen by 13.0% of the group, student-parent conflicts chosen by 11.6% of the group, academic problems with low motivation chosen by 7.2% of the group, and finally, student drugs or alcohol usage chosen by 2.9% of the group.

Q-38 TYPES OF SERVICE DELIVERY FORMATS USED FOR SCHOOL-BASED FAMILY COUNSELING

The highest percentage of each group reported that they practiced family counseling within combined school departments such as school psychology, schools counseling, and/or school social work. This finding equaled to 36.6% of the entire group. Practicing school-based family counseling on respondents’ own, not part of a larger
program or group was reported with the second highest frequency. Approximately 32% (32.4%) of the respondents indicated that their practice of school-based family counseling was not done as part of a more formalized program or group. Only 12.7% reported practicing school-based family counseling as part of a comprehensive mental health program.

**Research Question 8: How much ongoing clinical supervision in family counseling did the school counselors, school psychologists, and school social workers receive surrounding their practice of school-based family counseling?**

Q-33, 34, 35, 36, 37 FREQUENCY OF SCHOOL-BASED PROFESSIONALS RECEIVING CLINICAL SUPERVISION (INCLUDING INDIVIDUAL AND GROUP SUPERVISION) AS WELL AS SOURCES OR PERSONNEL PROVIDING CLINICAL SUPERVISION AND THE TYPES OF SUPERVISION ACTIVITIES THAT WERE MOST TYPICAL

A summary of the responses to the inquiry about clinical supervision showed that less than one-quarter (22.2%) of those persons who actually provided school-based family counseling reported receiving ongoing clinical supervision. This percentage included 25.0% of the school counselors, 21.6% of the school social workers, and 20.0% of the school psychologists. Of the entire group, 37.5% (the highest percentage of the total group) received weekly individual supervision and 31.3% received bimonthly group supervision. The highest frequency of respondents (40.0%) obtained their clinical supervision apart from the school system. Case presentation was the most typical supervision activity reported by the entire group (68.8%) followed by review of
counseling notes or logs depicted by 56.3% of the respondents. No one selected review of videotapes or review of audiotapes or transcripts. Only 6.3% (n = 1) reported receiving live supervision. Case presentation was described on the questionnaire as a more formal and theoretical process than reviewing counseling notes or logs. Case presentations involved reviewing family counseling cases via written reports that used theoretical hypotheses and analyses while the review of counseling notes or logs involved self-reports of the families' issues along with discussions of appropriate interventions.
Chapter Five

Interpretation of Research Results and Conclusions

The two primary research questions were: (a) the extent to which the systemic mental health intervention--family counseling--was currently being conducted in the schools by school counselors, school psychologists, and school social workers, and (b) the differences, if any, in the school-based family counseling practices and attitudes that existed among these three groups. In order to examine and answer these questions, three national surveys were undertaken. All group members were affiliated with their professional organizations at the national level.

This chapter is divided into four sections. The first section presents a discussion of the current research compared to past research along with implications. The second section contains the research limitations. The third section consists of the highlights of the research followed by the final section of recommendations.

Discussion of Research Results and Comparison to Past Research

Current prevalence of the practice of school-based family counseling among school counselors, school psychologists, and school social workers, noting significant differences in the proportions of the provision of family counseling among these three groups.

At total of 18.0% of all respondents reported that family counseling was offered as a school-based service in their school districts. Three percent (3.0%) reported not being
sure whether this service was provided, leaving 79.0% who reported that family
counseling was not provided as a school-based service in their school districts.

Groups surveyed were then asked who provided family counseling services. In
school districts that offered this service, school social workers were more frequently cited
as providing family counseling than either school counselors or school psychologists.
Reported frequency rates were 44.4% for school social workers, 34.9% for school
counselors, and 28.6% for school psychologists. When compared to the school
 counselors’ and school psychologists’ reports about whether school social workers
provided family counseling in their school districts, a significantly higher proportion of
school social workers reported that their group provided family counseling. In addition, a
significantly higher proportion of school psychologists than school counselors reported
that family counseling was provided by their own group of school psychologists. When
compared to the three school-based mental health disciplines, contracted mental health
professionals were more often cited as providing family counseling than any single
school-based group, including school social workers. A frequency rate of 45.2% was
reported, which compares to the 44.4% frequency rate for school social workers. There
were no statistical differences among the proportions of the three groups reporting that
contracted mental health professionals provided family counseling in the schools.

When asked directly if respondents practiced family counseling, only 12.7% (n =
84) replied “yes.” This finding included 21.7% (n = 41) of the school social workers,
9.9% (n = 25) of the school counselors, and 8.3% (n = 18) of the school psychologists.
School social workers were at least twice as likely to report the practice of family
counseling than either school counselors or school psychologists. Compared to the initial
percentages obtained when asked to identify what groups or personnel provided family counseling in respondents' school districts, percentages of practitioners who reported their own practice of family counseling decreased dramatically.

In addition, when asked to complete the last portion of the questionnaire reserved strictly for family counseling practitioners, another discrepancy emerged. Of the 84 respondents who originally claimed that they practiced family counseling in the schools, only 74 actually completed the last portion of the questionnaire. Based on this sample (n = 74), the percentage of respondents who actually provided family counseling dropped from 12.7% to 10.9%. Broken into groups, 19.0% (n = 38) were school social workers, 8.1% (n = 21) were school counselors, and 6.8% (n = 15) were school psychologists.

Regarding these discrepancies, as the questions became more specific to the practices of a particular respondent, the percentages of family counseling practitioners decreased. Several assumptions were possible: (a) that each profession over-stated the provision of family counseling when initially referring to its own professional group, (b) that members of one profession held a perception that other school-owned professionals should have provided family counseling when in actuality they did not, and (c) that individual professionals possessed limited knowledge about the provision of this service in his or her school district when offered by groups or individuals other than just him or herself. These answers remain unknown given the inability to probe further, which was one limitation of this survey. Sometimes a lack of knowledge about the services provided within a school system indicates fragmented services, which was cited in the literature as common among these three school-based mental health disciplines (Center for Mental Health in Schools, 2001).
When comparing the current extent with the past extent of family counseling being provided by school counselors, school psychologists, and school social workers, no survey research at the national level was ever conducted collectively. However, two surveys were done specifically with school psychologists in the late 1980s. In the Carlson and Sincavage study published in 1987, nearly a quarter (22%) of the NASP school psychologists reported conducting parent and family therapy, with 15% spending one to five hours per week doing brief family therapy and 7% spending one to five hours per week doing long-term family therapy. In Spencer’s study (1989), fewer (16%) of the NASP school psychologists surveyed reported engaging in parent and family counseling. Compared to the current study, Carlson and Sincavage’s (1987) survey produced a higher percentage of school psychologists doing parent and family counseling while Spencer’s (1989) survey produced a percentage closer to the current findings. It is likely that the definitions used for family counseling were discrepant enough to create these differences. Parent counseling is sometimes construed as synonymous with family counseling, and family counseling is sometimes construed as synonymous with parent counseling. It is speculated that, in the schools, these terms (i.e., family counseling and parent counseling) are often interpreted broadly, and more from a consultative model than from a counseling model.

In Beck’s survey of school counselors in a regional Midwest area (1984), 49.5% claimed they provided family counseling “sometimes” with 57.4% desiring more. Only 0.9% reported that they provided family counseling “often.” Again, respondents’ interpretation of the term “family counseling” is called into question. School counselors
in Beck’s survey (1984) indicated that family counseling was provided in their schools, with 49.0% reporting that this service was provided by the school social workers.

The current research suggested that, across the nation, school social workers provided more family counseling than either school counselors or school psychologists, though to a limited degree. Few studies of school social workers’ practice of family counseling were found in the professional literature though social workers were cited as providing school-based family counseling in several studies that involved other pupil services personnel including school psychologists and school counselors (Beck, 1984; Fausold-Mowers, 1998; Merrill et al. 1992). In the single survey study found of school social workers’ practice of family counseling, Staudt’s (1991) survey of school social workers as well as teachers and principals cited limited frequency of the provision of parent/family counseling by school social workers. In this school district in the Midwest, teachers and principals desired more of these services than were being provided.

Currently, findings suggest that contracted mental health professionals are providing slightly more school-based family counseling than school social workers, and relatively more school-based family counseling than school counselors or school psychologists. These results support the practice trends described in the ASCA survey results published by O’Rourke in 1991. In this study, many school systems were cited as developing partnerships with community mental health agencies in order to obtain the needed counseling services.

Types of family work in which school-based practitioners were most frequently engaged.
With a total of only 11% to 13% of the school-owned mental health practitioners providing family counseling services, inquiry was made about other types of family work they provided. Parent conferencing or consultation apart from student support team meetings or special education evaluations was reported with the highest frequency by both school social workers (39.0%) and school counselors (63.6%). School counselors averaged six hours per week while school social workers averaged nine hours per week in this type of family work. For school psychologists, they were most frequently engaged in parent conferencing or consultation during special education evaluations (45.2%), averaging approximately five hours weekly. Of interest was that approximately 3% (2.9%, n = 18) of the total group of practitioners did none of the family work listed. Most of these individuals were school psychologists.

In Telfer's (1987) study, parent conferencing was the most frequent type of parent intervention provided by school psychologists working in Ohio. This type of family work was reported at a significantly higher frequency than other types of family work including parent consultation and family systems interventions, which were in the top three interventions yielded in Telfer's (1987) survey. For school psychologists, current survey results remain consistent with Telfer's findings, and tend to confirm a more consultative approach to parent interventions than counseling approach.

When comparing the types of counseling provided by the three groups of school-owned professionals, the type of counseling all three groups reported doing most often was individual student counseling. This was reported with 50.2% frequency. Of note was that 11.4% (n = 75) indicated that they did not provide counseling, the highest
percentage of whom were school psychologists. As a whole, family counseling was rarely provided more often than other types of counseling.

The survey done by Roberts and Borders (1994) showed that individual and group counseling were the most common types of job role activities among school counselors. With this regional group of school counselors, the person centered approach was used most often while the family systems approach was used least often. The Prout et al. (1993) survey of school psychologists showed that individual counseling was done more than other types of counseling though family problems ranked first in the types of problems referred for counseling. Results of the Carlson and Sincavage (1987) survey suggested a continued focus on individual versus family systems interventions among school psychologists, with suggestions that this focus continues to hold true into the present, based on the current research findings.

Requisite training as well as ongoing training or clinical supervision in family systems interventions and family counseling.

BACKGROUND TRAINING

The majority of all three pupil services personnel groups (63% and above) reported receiving training in both family systems or ecological theories and family systems interventions. The majority of these three groups also indicated taking a family counseling survey course (55% and above). At least half of the school social workers reported receiving advanced family counseling coursework and supervised practica. Far fewer school counselors and school psychologists reported having advanced family counseling coursework or supervised practica. When compared to school social workers,
significantly more school counselors and school psychologists cited limited training as a barrier to the practice of family counseling in the schools.

For those persons who actually practiced family counseling in the schools, a Master’s Degree plus 30 or MSW were the most common levels of training. Only about 10% of the total group that actually provided school-based family counseling held a doctorate. The majority of the family counseling practitioners (68.5%), however, held a license to practice therapy in a community setting while only 13.5% held a license in marriage and family therapy or family psychology.

For practitioners who reported providing school-based family counseling, training in family counseling was most often obtained by all three groups from seminars or workshops apart from the school systems. However, over half of each group received family counseling training from a university degree program in preparation for their job.

In general, training in family systems and ecological approaches is expected to become more commonplace (Gurman & Kniskern, 1992). Because much of the work done in schools still appears to be intrapsychic and individually centered, it would be easy to think that school practitioners have received little training in family systems theory or ecological theory. Given the current finding that most school practitioners (over three-quarters of each group) have received specific training in family systems theory and ecological theory, results suggest, that at the very least, they have been exposed to these theories, but might not be applying this knowledge to the fullest extent.

In addition, well over three-quarters of the school social workers and school psychologists and nearly half of the school counselors held at least a Master’s Degree plus 30. Therefore, these three groups of professionals have the requisite foundational
skills to expand their mental health roles. Reported background training would lend itself to conceptualizing counseling cases in a systemic manner in order to work with families versus just individual students as shown in the study by Sawatzky, Eckert and Ryan (1993). School counselors in that qualitative study were easily trained in systems thinking with little reported dissonance between this new paradigm and their predominantly held individual, child-centered paradigm.

Studies by both Carlson and Sincavage (1987) and Spencer (1989) found more doctoral than master's level school psychologists providing family counseling. As an aggregate group, the majority of school practitioners actually providing family counseling in the current study held either a Master's Degree plus 30 or a MSW. In a recent survey of school psychologists' involvement with consultative family-school partnership activities (Pelco et al. 2000), no differences in these practices or outlooks were found between doctoral and master's level practitioners.

Tally and Short (1994) recommended that school psychologists obtain licensure to provide a broad array of mental health services to students and their families while Crepsi (1997) called for school psychologists to obtain licensure specifically in marriage and family therapy (MFT). Though the majority of school practitioners who provided school-based family counseling in the current survey did not hold MFT or family psychology licensure, the majority held licensure to practice counseling in a community setting.

CLINICAL SUPERVISION/ONGOING TRAINING

Less than one-quarter (22.2%, n = 16) of the current school practitioners surveyed who provided family counseling in their schools reported receiving ongoing clinical supervision. Of the small group who received clinical supervision (16 out of 72

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respondents), approximately one-third obtained individual supervision on a weekly basis (37.5%) and/or group supervision on a bimonthly basis (31.3%). Clinical supervision was obtained (with the highest frequency) apart from the school system (40.0%) with approximately one-third (33.3%) also citing the receipt of peer supervision.

Case presentation was the most typical supervision activity reported by the group of school practitioners providing family counseling. This activity was followed by review of counseling notes or logs. Approximately 6% of the total group received live supervision and no one indicated the review of videotapes, audiotapes, or transcripts.

Regardless of what type of counseling school practitioners were providing, only 37% of school counselors in the North Carolina survey conducted by Roberts and Borders (1994) reported receiving clinical supervision, with 79% desiring more of this type of supervision. In two nationwide surveys of school psychologists having NASP membership, Ross and Goh (1993) found 31.1% being clinically supervised while Zins, Murphy and Wess (1989) found only 22.9% of the school psychologists being clinically supervised.

In the Robert’s and Border’s (1994) survey of school counselors, self-report emerged as the most common clinical supervisory activity while live supervision was found to be the least common. In the Zins, Murphy and Wess (1989) survey of school psychologists, of the 22.9% who reported receiving clinical supervision, 45.1% received direct supervision while only 5.5% received clinical supervision through review of audio or videotapes.

McComb (1981), editor of a special issue of a journal in school counseling, recommended both training and supervision in family counseling if school counselors
were going to engage in family counseling. According to McIntosh and Phelps (2000), supervision for school psychologists was essential practice in meeting the APA and NASP guidelines. These recommendations were supported in Merrill’s et al. (1992) descriptive study where clinical supervision was cited as crucial to the success of this program and highly recommended. Merrill et al. (1992) described a family counseling program that could be used as a model for school-based family counseling. In this program, school counselors, school psychologists, and school social workers were trained and supervised by an experienced professional in family counseling provided by the school system. Videotapes, seminars, and readings were used as typical supervision activities. When the family counseling supervisory professional was replaced by peer supervision, the group of practitioners reportedly became less cohesive.

According to current and past research, receipt of clinical supervision in school settings was found to be minimal. However, results show in the current study that introductory exposure to family systems/ecological theory as well as exposure to family systems interventions was reported by well over half of the three groups surveyed. This amount of exposure to systems theory and interventions was surprising based on their limited number of hours engaged in more traditionally oriented family interventions (as identified in the current study).

**Typical styles of school-based family counseling practices among school counselors, school psychologists, and school social workers who provided this service.**

Family counseling practitioners in the schools were asked about their definition of family counseling including the unit of treatment thought to be most appropriate, whether or not a systems theoretical approach was used, and whether or not they obtained written
permission. (Written permission was addressed because of families' rights to "informed consent" and to distinguish family counseling from other types of family work in the schools that do not require formalized written permission.) As part of the definition of family counseling, the unit of treatment cited as most appropriate by the entire group of family counseling school practitioners was the treatment of the entire family or household (42.0%), though inclusion of the parent figure(s) and one child configuration was a close second (40.6%). Use of the systems perspective was cited inconsistently bringing into question the knowledge of family systems counseling held by these pupil services personnel. The average number of sessions varied from 3.3 to 6.5 based upon the family configuration or unit of treatment involved. Formalizing the process by obtaining written permission was done infrequently. This latter practice also brings into question whether the term "family counseling" was construed in a broader sense to include parent consultation or parent conferencing.

During actual practice, however, the unit of treatment most often included in family counseling sessions led by the school practitioners was reported as parental figures(s) and one child (67.1%). This compared to 42.0% of the practitioners who, in their definition of family counseling, cited the entire family or household as the "ideal" unit of treatment. This "ideal" unit of treatment was most often seen in actual family counseling sessions only 10.0% of the time.

Of special interest in the current findings was the inconsistent use of the systems approach. In the professional literature, using a systems perspective was acclaimed as essential in the definition of family counseling (Goldenberg & Goldenberg, 1988, 1996; Nichols & Schwartz, 1998). In fact, using a systems perspective was what sets family
counseling apart from other types of therapies regardless of the unit of treatment, whether it was the entire family, dyads, triads, or just one person.

The theoretical approaches used in the schools with family counseling were most often behaviorally oriented with half (50.7%) of the entire group citing the use of the brief, solution-focused approach and one-fifth (20.3%) citing the use of the cognitive/behavioral approach. The third most cited family counseling approach was eclectic or integrative. As subgroups, school social workers and school counselors most often cited the use of the brief solution-focused approach while school psychologists most often cited the use of the cognitive/behavioral approach. Given the inconsistent use of the family systems approach as reported in these school practitioners’ definition of family counseling, it is unclear whether these theoretical approaches were, in fact, family counseling approaches or individual models applied to counseling with the family unit.

The term most frequently used by family counseling school practitioners was “family counseling.” The term “family therapy” was used least often. As separate groups, school social workers most often used “family counseling,” school psychologists most often used “parent consultation,” and school counselors most often used “parent conferencing” or “family counseling.” Except for the use of “family counseling” by school counselors, the terms used most often by separate groups are traditionally associated with each particular discipline.

Based on the results of all three groups surveyed (50.7%), the most frequent source of referrals for family counseling came directly from parents. According to school counselors, the second highest frequency rate of referrals came from teachers. According to school social workers and school psychologists, the second highest
frequency rate came from student support teams. These findings are consistent, in
general, with school psychologists' and school social workers' practice of being assigned
to more than one school but working on student support teams. Additionally, school
counselors are typically assigned to one school and therefore have more contact with
teachers.

The type of student problem most often referred for family counseling was
externalizing behaviors such as conduct problems, noted by approximately half of the
entire group (50.7%). (Other referral type problems were chosen with less than 15%
frequency.)

During actual practice, written permission was most often assumed by the
presence of the family without obtaining informed consent. Compared to the
practitioners' views about the definition of family counseling, results suggest that both
ideally and in actuality, formalizing the process of family counseling by obtaining written
permission and informed consent was not considered important. Because permission is
not usually obtained in the school setting for parent consultation and parent conferencing,
the practice of not obtaining written permission for family counseling calls into question
how broadly this term was interpreted and applied by these pupil services personnel.

The average number of sessions per family was reported as approximately three
for school counselors to approximately seven for school psychologists with a mean of
4.78 for the entire group. The average number of family counseling cases carried at any
one time ranged from approximately three for school psychologists to approximately six
using the readjusted means (due to outliers) for school social workers and approximately
four for school counselors.
In regards to the type of service delivery format used for school-based family counseling, approximately 37% (36.6%)—the highest frequency rate of the entire group—reported practicing family counseling within combined departments (e.g., school psychology, school social worker, or school counseling). Of special note was that 32% (32.4%) of the entire group indicated that their practice was not done as part of a formalized program or group. In other words, these professionals practiced school-based family counseling on an independent basis. An equal number of school counselors (25.0%) practiced under one or the other of these two service delivery types (either combined departments or singly on their own). The implications of the practice of providing school-based family counseling apart from a school sponsored program suggest that there is little formalized support from supervisors for school-based family counseling. In addition, most of the family counseling done by these three groups of school-based professionals was not part of a comprehensive mental health program such a full service school, community school, etc. In fact, only 13% (12.7%) practiced within comprehensive mental health programs. Implications of this finding suggest that little inroads have been made in pupil services personnel’s involvement with comprehensive mental health programs though the current findings are limited to information about school-based family counseling.

How did the typical practices of family counseling practitioners compare to the recommended practices in the professional literature? Pinsof and Wynne (1995, 2000) summarized the empirical research on marriage and family therapy based on research articles included in a 1995 special issue of the Journal of Marital and Family Therapy (see chapter two). In general, family therapy produced effective outcomes and was found
to be clinically more effective than standard or individual treatments for a number of childhood problems including conduct disorders. One theoretical orientation was not found to be significantly superior to another though behavioral and systemic therapies tended to produce stronger effects than non-behavioral therapies according to the meta-analytic study done by Shadish and associates in 1993.

In the professional literature pertaining to family practices in the schools, brief forms of family counseling were generally recommended (Franklin, 2000; Greene, Jones, Frappier, Klein, & Culton, 1996; Millard, 1990/1997; Ziesemer, Marcoux & Davis, 1991). The most frequently recommended theoretical approaches were: (a) solution-focused (Franklin, 2000; Kral, 1992; Kraus, 1998), (b) structural (Hinkle & Wells, 1995; Kraus, 1998; Millard, 1990/1997), and (c) strategic (Conoley, 1987b, Hinkle & Wells, 1995, Kraus, 1998; Millard, 1990/1997). In addition, behavioral and cognitive/behavioral approaches were deemed appropriate by Goldenberg and Goldenberg (1981/1988), Millard (1990/1997), and Franklin (2000).

Comparing current survey results to past survey results, though not specific to family counseling, school psychologists in the Prout's et al. (1993) study favored brief, behaviorally-oriented counseling interventions. Compared to the current research, not only did school psychologists who practiced school-based family counseling favor brief forms of therapy, but also school social workers and school counselors.

Of interest was Fausold-Mower's (1998) study of a school-based family counseling program showing that approximately 30% of the families who used this program had more than 21 sessions. At least 85% of the families who responded in the Fausold-Mower's (1998) survey were satisfied with most aspects of the program. This
program used structural and strategic theoretical approaches. In the program described by Merrill et al. (1992), the structural approach and Haley’s life sequences were used. School practitioners carried two to three cases per year and met with families on an average of 11 times (Merrill et al. 1992). These two descriptive program studies used traditional family systems approaches over time versus the briefer, behaviorally oriented approaches favored in the current survey research. Here again, in the current study, the issue of whether a family systems counseling approach was used or an individual counseling approach applied to family units remains unresolved. This is of special concern in light of the inconsistent use of the family systems approach as part of these practitioners’ definition of family counseling.

Though counseling practitioners generally identify with a primary theoretical approach (Aradi & Kaslow, 1987; Rait, 1988), many are more eclectic or integrative than purists (Rait, 1988). In the current study, applying the definition of family counseling in its ideal or purist form was found discrepant from applying it in actuality. This finding was consistent with the study by Rait (1988) that cited similar findings among family therapists who practiced in community or private settings. Despite all theoretical approaches in Rait’s (1988) survey being clearly identified with family systems counseling, the majority of family counseling practitioners responding to that study used an eclectic approach, followed by the most popular well-known family systems approach, Structural Family Therapy.

**Barriers to the practice of family counseling in the schools and differences in proportions among the three groups of school practitioners.**

**ADMINISTRATIVE BARRIERS**
When the entire group was probed about perceived administrative barriers to the practice of family counseling in the schools, the highest percentage of school-based professionals (31.9%) cited that they were not sure what administrators in their district thought about family counseling. This finding was followed secondly (23.2%) by a perception that administrators held a belief that family counseling was incompatible with their job roles. However, the third most frequent response emerged as a view that no administrative barriers existed; that administrators in their school district supported family counseling. This view was held mainly by school social workers, which was their highest response (23.6%). Lack of administrative support in the form of money, accommodations for training, supervision, therapy rooms, etc. emerged as the fourth most frequent barrier.

School social workers and school psychologists were divided about the issues of not being sure what administrators thought about family counseling, with school psychologists being twice as likely to be unsure when compared to school social workers. School counselors were also about twice as likely to be unsure when compared to school social workers.

Additionally, school social workers and school psychologists were divided about the issue of administrators’ lack of knowledge regarding the benefits of family counseling, with school social workers being about five times more likely than school psychologists to report this as a barrier. In addition, when compared to school counselors, school social workers were about twice as likely to make this report.

School social workers and school counselors were divided about still another issue involving administrative support in the form of money and accommodations.
School social workers were about twice as likely to report the lack of administrative support in the form of money and accommodations.

Approximately 16% (16.3%) of the total group cited no administrative barriers; that school administrators supported family counseling in the schools. This finding was consistent with 18% of the total group that reported the provision of family counseling in their school districts.

In reviewing the past research, a survey of school psychologists conducted by Carlson and Sincavage (1987) suggested lack of administrative support as a barrier to providing parent or family counseling. In Spencer's (1989) survey, findings suggested that school psychologists were more likely to engage in parent and family counseling with perceived administrative support. Of interest was Beck's (1984) survey of school counselors noting that administrative attitude toward family counseling was perceived as far less of a barrier by school counselors than the counselor educators thought it would be. (Administrative attitude was perceived as a barrier by only 20.2% of the school counselors while the majority [65.4%] of counselor educators perceived it as a barrier.) Other authors in the professional literature such as Hinkle (1993/1997) and Kraus (1998) cited lack of administrative support as problematic and an issue with which to deal in the schools.

Of interest in the current study is that, most often, school practitioners did not know what administrators thought about family counseling. This finding brings into question whether the subject of family counseling ever emerged as a viable or compatible job role for these practitioners. In addition, the second most frequent barrier held by pupil services personnel was the perception that administrators viewed family counseling
as incompatible with the job roles of these school practitioners. This latter finding implies that there was little voiced support for the practice of school-based family counseling as a method of removing the external and internal barriers to students’ learning.

PERSONAL BARRIERS

When the entire group was asked about the personal barriers to the practice of family counseling in the schools, lack of time (being too busy with other duties) was cited most frequently (36.7%) and almost equally by all three groups. Second to the lack of time, incompatibility with job role was viewed as the top personal barrier by 19.3% of the group, followed by not being sure family counseling should be provided by the schools (11.4%).

Approximately 8% (7.5%) viewed the encouragement by supervisors to refer out for this service as a personal barrier to providing family counseling. School counselors were about three and one-half times more likely than school psychologists to present this view.

Though limited training in family counseling was cited as a primary personal barrier by only 7.0% of the total group, school counselors were five times more likely and school psychologists were almost eight times more likely than school social workers to cite this as a barrier. As only 1.5% of the school social workers reported limited training as the most restrictive personal barrier to the practice of family counseling, this finding was consistent with the amount of advanced coursework and training in family systems theory and interventions reported in this survey by school social workers. When compared to school counselors, school social workers were about four times more likely
to report none of the named barriers as a personal factor to the practice of family counseling. In general, the social worker's role has always been oriented to working with families (Bardill & Saunders, 1988). In the schools, a school social worker's job role predominantly connects with parents and focuses on being a parent/school liaison.

In the research literature, insufficient or limited training was also cited as a barrier to the practice of school-based family counseling. Lack of training was cited as a barrier by 71.1% of the school counselors in the survey conducted by Beck (1984), with the majority of these school counselors (84%) indicating an interest in obtaining additional family counseling training. School psychologists in the Carlson and Sincavage (1987) survey indicated only moderate satisfaction with their training in family systems interventions. Spencer's (1989) survey of school psychologists suggested similar findings. Different from the latter two studies where doctoral status was associated with a more family-oriented practice, is the current study where degrees such as a master's plus 30 or a MSW were the most frequent levels of training reported by the practitioners who actually provided family counseling.

As a barrier to working with families in the schools, insufficient time was also cited in past survey research. In the study by Carlson and Sincavage (1987), the majority of school psychologists were found to be dissatisfied with the limited amount of time they had to work with parents and/or families. The time allotted to working with parents and families was also found to be a factor in Spencer's survey (1989). Workload and lack of meeting time with families were barriers to the practice of family counseling with the school counselors who were surveyed in Beck's study (1984).

Factors or influences in the decision to practice family counseling in the schools.
Of those practitioners who actually provided family counseling in the schools, approximately one-half (50.7%) seemed guided by a personal belief that family counseling should be provided in the schools. All other factors were chosen with less than 15% frequency. Only 14.1% of the entire group practiced family counseling because it was in their job description. Included in the remaining list were having time allotted for family counseling (2.8%), having support from school level personnel (11.3%) and departmental supervisors (5.6%) as well as having received university training in family counseling in preparation for the job (1.4%). (Having training opportunities or clinical supervision provided by the school system were not chosen by any respondent as factors that most influenced their decision to practice family counseling in the schools.)

A total of 87.3% to 89.1% of all respondents did not practice family counseling. In addition, approximately 11% (11.4%) thought that family counseling should not be provided by the schools, and cited this as the biggest personal barrier to the practice of family counseling. Moreover, approximately one-fifth (19.3%) of the total group of respondents viewed family counseling as incompatible with their job role, and approximately one-quarter (23.2%) viewed administrators as having this same belief (that family counseling was incompatible with practitioners' job roles.)

Approximately three-quarters of the school social workers (71.4%) who actually practiced family counseling in the schools reported the inclusion of family counseling in their job descriptions, though this was not chosen as the primary reason for providing family counseling except by 19.4% of the school social workers. In addition, approximately one-half (52.4%) of the school counselors reported having family
counseling in their job descriptions though only 14.3% cited this as the main reason for providing family counseling. By comparison to the school social workers and school counselors, far fewer school psychologists (13.3%) reported having family counseling in their job descriptions, with none of them reporting this as the primary reason for doing family counseling. No one in the group of school practitioners who provided school-based family counseling wanted to do less family counseling, and the great majority of all three groups desired more family counseling than they were presently providing.

Factors that appeared to influence school psychologists’ decisions to practice parent or family counseling in Spencer’s study in 1989 were identified as support from parents, teachers, and administrators, time allotted to practice this type of counseling, citation of this duty in their job descriptions, and perceptions of having personal control of job role functions. The school psychologist/student ratio was not a significant factor. Holding a view that family systems approaches were useful was found related to the school psychologists who actually conducted parent and family therapy. While 58.6% strongly agreed that direct counseling or therapy with parent or families was needed in the schools, 14% disagreed that school psychologists should provide this service. Spencer’s (1989) statistics compare to the 10.2% of the school psychologists in the current study who were not sure that family counseling should be provided by the schools and another 19.0% who thought that family counseling was not compatible with their job roles.

In Beck’s (1984) survey of school counselors and counselor educators in the Midwest, 81.5% of the school counselors and 78.3% of the counselor educators thought that family counseling was needed in the schools. Approximately 90% (90.4%) of the
school counselors and 92.3% of the counselor educators thought that the role of family counseling was appropriate for school counselors. Compared to the current results of the nationwide sample of school counselors, 12.2% were not sure that family counseling should be provided by the schools and another 21.6% thought that family counseling was incompatible with their job roles as school counselors.

Suggestions from the current research are that approximately one-third of school counselors and school psychologists perceive family counseling as incompatible with their job roles and a barrier to their own practice of school-based family counseling. This percentage includes the belief that the schools should not be providing this service. These findings have grave implications about family counseling being a readily endorsed intervention for helping families and children in the school setting.

Limitations

In general, limitations of survey research often include issues surrounding reliability and validity. To address these issues, the self-designed questionnaire was piloted to ensure face validity and clarity of questions. However, the psychometric properties of the questionnaire were not specifically established; therefore, the results of this study should not be over-interpreted.

When evaluating the previous research, there was lack of uniform modes in comparing the data. This created difficulty in making direct comparisons because studies often examined slightly different aspects of the practice of family systems interventions or family counseling in the schools, used terms that were dissimilar or not clearly defined, or used divergent statistical analyses. For example, the definition of family
counseling in the current research was more clearly defined and restrictive than on previous surveys, likely causing the decline in numbers of professionals who reported the provision of this service. (When studies with uniform definitions can be assessed and weighed relative to each other, a clearer picture of the systems perspective practices among school-based mental health professionals can emerge.)

The sample surveyed was both randomized and nationwide. In this study, the sample of respondents as a whole represented suburban school districts. Therefore, current results might not reflect the actual family counseling practices in either urban or rural school districts. It is unknown if additional family counseling is being conducted in urban school districts where the No Child Left Behind legislation (H. R. Rep. No. 63, 2001) suggests that, due to the effects of poverty, there is need for more school reform and mental health services.

The sample in greater proportions represented the eastern half of the U. S. The West and especially the Southwest were under-represented. Current survey results might not present a clear picture of the family counseling practices in under-represented portions of the nation.

The ideal response rate of 80%, which is considered most representative of the population (Gall, Borg, & Gall, 1996), was not achieved. The school counselor group came closest at 71.47%. This creates a need for caution when interpreting these results. In addition, the sample size of those mental health practitioners who actually provided school-based family counseling was small, and small enough to possibly effect the precision of the prevalence and practices of school-based family counseling.
Results of survey research can be skewed toward respondents who have an interest in the subject matter. Though this study collected a random sample, which helped ensure representation of the population, it is possible that results of the current research were skewed toward school practitioners who possessed a stronger interest in or opinion about family work and family counseling than those who did not. In order to limit this problem, survey questions were used that reached more than just those school professionals who practiced family counseling. In addition, respondents could have given biased answers to produce a more desired response than actually existed. Attempts were made to avoid leading questions and to word questions that encouraged an honest response regardless of a perceived bias on the questionnaire. Another skew could have possibly resulted from respondents belonging solely to professional organizations. As the sample came from members of professional organizations at the national level, it is unknown if results would have been different if compared to professionals who were not members of national organizations.

Inherent in survey research is limited probing. Because questionnaires are often structured to include specified choices, answers regarding beliefs and feelings are not examined in-depth (Gall, Borg, & Gall, 1996). Descriptors can be found, but often without identification of the underlying reasons. This could serve as a limitation. To their merit, descriptive data can provide enticing information and leads for follow-up research, both quantitative and qualitative.
Summary Highlights of the Research

Family counseling was purported as a viable role for school practitioners as early as 1976 (Friesen, 1976). Numerous leaders and researchers have since called for role expansion in this area for the three groups of school-based mental health practitioners under investigation (Beck, 1984; Carlson & Sincavage, 1987; Crepsi, 1997; Fausold-Mowers, 1998; Johnston & Zemitzsch, 1997; Millard, 1990/1997; Spencer, 1989).

However, only 10.9% to 12.7% of the three groups of school practitioners in this nationwide survey actually provided school-based family counseling. When comparing the three school-based groups of mental health professionals, significantly more school social workers (19.0% to 21.7%) reported providing family counseling than school counselors or school psychologists. From 8.1% to 9.9% of the school counselors reported doing family counseling while 6.8% to 8.3% of the school psychologists cited this practice. This leaves the vast majority of school-based mental health practitioners who were not engaged in this practice.

Only 18% of the school districts represented in this survey provided school-based family counseling. Slightly more family counseling was being done by contracted mental health professionals than by school social workers who were doing more than either school counselors or school psychologists.

Several barriers to the practice of school-based family counseling in the schools by school counselors, school psychologists, and school social workers were identified. First, the greatest personal barrier reported by all three groups was lack of time or being
too busy with other duties. More than one-third of the school practitioners (36.7%) cited insufficient time as a personal barrier to providing family counseling.

Second, nearly one-third of all school practitioners surveyed perceived personal barriers related to role appropriateness including the role of the schools in providing family counseling or to the role of their own discipline in the provision of family counseling. More specifically, a total of 30.7% presented perceptions that family counseling was either incompatible with their job roles (19.3%) or should not be provided by the schools (11.4%). In addition, the second largest administrative barrier (23.2%) also involved the perception that administrators viewed family counseling as incompatible with practitioners’ job roles.

The largest administrative barrier to school-based family counseling was identified as not being sure what administrators thought about family counseling. In other words, school-owned professionals cited unknown administrative support as the most frequent administrative barrier to family counseling. Of interest was that school social workers were doing the most family counseling and reported the fewest administrative barriers. Their highest response rate of 23.6% indicated no administrative barriers; that administrators in their school districts supported family counseling. Approximately three quarters of the social workers who actually practiced school-based family counseling had family counseling in their job descriptions though this was generally not the primary reason for engaging in family counseling.

Third, for school counselors and school psychologists, specific training in family counseling was also viewed as a personal barrier. School social workers reported more advanced training in family counseling than did school counselors or school
psychologists, and hence did more family counseling than either the counselor or psychologist group. Noteworthy was the frequency at which training in systems theory and ecological theory as well as training in family systems interventions was reported by all three groups. However, except for school social workers, more advanced training specifically in family counseling coursework and practica was limited.

One of the differences between the groups of school practitioners who did and did not practice family counseling suggested that those individuals who did provide family counseling were driven by a personal belief that the schools should provide family counseling. Only 14.1% indicated that they provided family counseling because it was in their job descriptions. In addition, most (36.6%) practiced as part of a combined departmental effort; however, nearly one-third (32.4%) of these school-based family counseling practitioners practiced singly on their own, not part of an organized program or group. Additionally, most of the family counseling practitioners were not practicing within comprehensive mental health programs.

The majority of the school practitioners who did practice family counseling were not doctoral level, but held a license to practice therapy in a community setting. Most wanted to do more family counseling than they were presently providing.

Current results unveiled several descriptors to help characterize the practice of school-based family counseling. The practice of family counseling by school-owned practitioners favored brief, behaviorally oriented forms of family counseling including the brief, solution-focused approach and the cognitive/behavioral approach. The unit of treatment most often served in actual school-based family counseling sessions was cited as parental figure(s) and one child. Three to approximately six family cases (adjusted
means) were typically carried at one time with an average of three to seven sessions per family.

When referring to family counseling, the term most often used in the schools was “family counseling.” The least often used term was “family therapy.” Interestingly, each professional discipline tended to use—with the highest frequency—the term most closely associated with its own profession (e.g., school psychologists used “parent consultation,” school social workers used “family counseling”, and school counselors used “parent conferencing” or “family counseling”).

The most frequent referral source for family counseling reported by all groups came directly from parents. As a second source of referrals, school counselors most often received referrals from teachers while school social workers and school psychologists most often received referrals from student support services teams.

The type of student problem most often referred for school-based family counseling was externalizing behaviors that included conduct problems. All other types of student problems were reported with less than 15% frequency.

When initiating family counseling services, permission was most often assumed by the family’s presence in the session. In other words, written permission was not generally obtained and informed consent was not generally addressed. It must be remembered that the term “informed consent” is not often used in the schools and therefore, may not be a familiar term. In the family counseling field, informed consent is considered an ethical right that should be afforded all families.

In the definition of family counseling, the ideal unit of treatment was identified as the entire family or household, though the actual unit of treatment was generally the
parental figure(s) and one child. Disturbing was the inconsistent use of the systems perspective within the family counseling practitioners’ definition of family counseling.

Among the group of practitioners providing family counseling, ongoing clinical supervision was nearly non-existent. (Only 22.2% \([n = 16]\) of family counseling practitioners received ongoing clinical supervision.) Most of the clinical supervision received in family counseling was obtained from sources outside the school systems. As a part of supervision, live supervision and review of audio or videotapes were rarely, if ever, reported. Additionally, most of the training received in family counseling was obtained through seminars and workshops apart from the school systems.

Have school mental health practitioners made a paradigm switch from the intrapsychic-child centered approach to a more ecological or family systems approach? The current results suggest that little has changed (at least for school psychologists) since the studies by Carlson and Sincavage in 1987 and Spencer in 1989. (These studies were restricted to school psychologists.) Additionally, in Beck’s study (1984) of school counselors, there was strong rhetoric and support given to the appropriateness of the role of school counselors being family counselors. Current research results suggest little change in actual family-oriented practice for school counselors, also.

When asked what type of family work in which school practitioners were most frequently engaged, current responses were related to traditional job roles. School counselors as well as school social workers reported—with the highest frequency—doing parent conferencing or consultation apart from student support team meetings or special education evaluations. School psychologists reported doing parent conferencing or consultation during special education evaluations. Approximately five to nine hours
weekly were spent engaged in their most frequent types of family work, with school social workers reporting the most hours and school psychologists reporting the least hours. In addition, individual student counseling was the most frequent type of school-based counseling. Of note was that approximately 3% of the entire group did no family work and 11.4% provided no type of counseling, the majority in both areas being school psychologists.

Results suggest that these three professional groups as a whole are engaged in their most frequent type of family work—which relates more to consultation and conferencing than to counseling—approximately one-half to one day per week. These results further suggest that school practitioners are not often engaged in family work from a family systems counseling model. In addition, even the use of the systems perspective by the family counseling practitioners appears limited, evidenced by the inconsistent use of this perspective in their definitions of family counseling.

One of the rationales for school-based family counseling was stated by Conti already in 1971. Few families actually followed through with referrals for counseling when provided in a community setting. Studies regarding school-based mental health services continue to bear out this finding today for both families (Atkins et al. 2003) and students (Adelman, Barker, & Nelson, 1993; Kaplan et al. 1998). In addition, several studies (Fausold-Mowers, 1998; Goodman & Kjonaas, 1984/1988) found minimal parental concern about using mental health services with school sponsorship. In fact, Fausold-Mower's (1998) study of a school-based family counseling program showed that families appreciated the knowledge that the practitioners possessed about the school and their ability to join together in helping with school-related concerns. Moreover, the
general research in parent and family counseling was found effective with many child and adolescent conduct problems (Estrada & Pinsof, 1995), the very problems that were most often referred for family counseling in the current study.

Calls for role expansion and the need to provide mental health counseling with students and their families have been made for the three groups of pupil services personnel (Center for Mental Health in Schools, 2001; H. R. Rep. No. 63, 2001; Johnston & Zemitzsch, 1997). In addition, calls for a paradigm shift to accommodate these changes have also been made (Crespi, 1997; Fine & Gardner, 1991/1997). However, the current survey research suggests minimal family-systems practice by the three groups of mental health professionals. Available to pupil services personnel with the appropriate training, clinical supervision, and administrative support is family counseling, which provides an innovative change in the provision of school-based mental health services. In review of the professional literature, family counseling also can provide a link between families and school personnel and can help remove the barriers to student learning by addressing the needs of the whole child. Though school social workers reported doing more family counseling than school counselors or school psychologists and spent more hours weekly engaged in family work, it is curious that more family counseling is not being done by this group since they traditionally are the most family oriented. Given the current results of school counselors, school psychologists, and school social workers, it appears that a lag continues between actual family systems practice and the previously stated desire or need for this type of service. When these three groups are actually engaged in parent interventions, current research results tend to confirm a more consultative approach to parent interventions than a counseling approach. (In general, a
consultative approach is considered a more traditional type of school-family intervention.)

Recommendations

Based on the above highlights of the current research, higher education trainers in conjunction with school-based departmental mental health supervisors should reassess the status of today’s students in order to better meet their mental health needs and remove their barriers to learning. The primary mission of the schools has traditionally been education (Policy Leadership Cadre for Mental Health in Schools, 2001). With a traditionally slow evolution of restructuring within the schools, the speed at which the students’ needs have changed appears to have outpaced the changes necessary to meet these needs.

Schools can no longer just address the students’ academic needs; they are called upon to address the whole child by linking contextual influences on that child (H. R. Rep. No. 63, 2001; Policy Leadership Cadre for Mental Health in Schools, 2001). The literature abounds with calls for school counselors, school psychologists, and school social workers to better meet the needs of today’s students by removing the barriers to teaching and learning. This calls for reassessing or reprioritizing the roles of the three school-owned mental health disciplines, tasks that should be done jointly or collaboratively by public school officials, professional organization leaders, and university trainers.

The current research suggests that one of the barriers to a more family-oriented practice is a role perception or prevailing attitude among school-based mental health
professionals that is tied into the traditional mission of the schools (i.e., academic achievement and a linear approach to problem solving) versus the contemporary mission (education of the whole child and a systems approach to problem solving). When family counseling is taught at the university level and included as a part of the job role for which one is trained, it can become a regular part of a professional's work routine. Time can be made in practitioners' weekly schedules for this service. The current research shows an example of a personal belief among school-based family counseling practitioners that appeared strong enough to transcend the noted barriers of insufficient time as well as limited administrative support.

Do school-based mental health practitioners view family systems interventions as vital to the removal of the barriers to learning? In order for family counseling to become more commonplace in the schools, it must be viewed as one intervention among other family systems interventions that is vital to the removal of students' barriers to learning. During job preparation, it would be helpful to place an emphasis on systems/ecological theory and how this paradigm could be applied in the schools using a counseling model. This pertains to all three school-based mental health disciplines.

In addition, encouragement for all school mental health practitioners to obtain licensure to practice therapy in a community setting, along with ongoing clinical supervision that is specifically structured into school level programs for school counselors, school psychologists, and school social workers should be considered. Licensure would then encourage greater latitude and liberties in providing a broad array of services to students and their families.
A trend in using contracted mental health personnel to provide counseling can be expected if the current school-owned practitioners are unable or unwilling to expand their repertoire of counseling skills as recommended by recent leaders in the field. The practice of outsourcing family counseling services tends to by-pass the link between school personnel and families, one of the top three goals of education. Johnston and Zemitzsch (1997) proclaimed that when all three groups of school-owned mental health professionals--school counselors, school psychologists, and school social workers--are trained in family counseling, schools will benefit.

The current survey research calls for: (a) more research into the role perceptions regarding the expansion of the mental health duties among the three school-based mental health groups, (b) further study into the family-oriented training of the three groups, (c) and how effective school-based family counseling is in ameliorating the needs of today's students by removing the barriers to learning and better meeting the needs of the whole child.
References


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competence (pp. 19-51). Silver Spring, MD: National Association of School Psychologists.


(Eds.), *Family counseling in school settings* (pp. 39-47). Springfield, IL: Charles C. Thomas Publisher, LTD.


Counseling and Therapy – these terms are used interchangeably; distinctions between these terms are considered superficial with no critical differences between them (Patterson, 1986).

Family Systems Interventions – an approach that addresses the individual within his or her interactive system or systems, and treats dysfunctions from an interpersonal versus intrapsychic perspective.

Family Therapy/Counseling – a formalized counseling process that uses a family systems approach with one or more of the sessions conducted jointly with at least one parent figure and one child. Other household members or extended family are often included. Family counseling is formalized by addressing parental rights and responsibilities and obtaining informed consent for these services. This intervention process is not parent conferencing or consultation. In the schools, brief counseling often has a duration of 3 to 6 sessions while long-term counseling has a duration of 6 to 12 sessions. Twelve sessions for family counseling is considered average by the AAMFT (2001d).
Parent Consultation or Conferencing - traditional methods of parent-school interventions engaged in by a variety of school personnel often with the purpose of improving home-school collaboration and children's school performance. Parent consultation and/or conferencing activities generally do not require written permission and can include general guidance and problem solving, but do not include family counseling, which must be provided by qualified mental health professionals.

Pupil Services Personnel – "The term 'pupil services personnel' means school counselors, school social workers, school psychologists, and other qualified professional personnel involved in providing assessment, diagnoses, counseling, education, therapeutic and other necessary services...as part of a comprehensive program to meet students' needs" (H. R. Rep. No. 63, 2001, p. 225).

School-Based Services – services that are provided within a school owned facility by professionals hired and paid for by the school system (McKinney & Peak, 1994).

School Counselor – a professional generally hired by the school system as a member of a school's interdisciplinary team or pupil services personnel; holds state certification or its equivalent in the area of school counseling with a minimum of a Master's Degree in school counseling from an approved or accredited program such as the Council for Accreditation of Counseling Related Education Program (CACREP) (H. R. Rep. No. 63, 2001).
School Psychologist – a professional generally hired by a school system as part of a school’s interdisciplinary team or pupil services personnel team; holds a state licensure or certification upon completing a minimum of 60 credit hours in school psychology at the graduate level with 1200 clock hours of internship (H. R. Rep. No. 63, 2001).

School Social Worker - a professional generally hired by a school system as a member of a school’s interdisciplinary team or pupil services personnel team; holds a minimum of a Master’s Degree in school social work or its equivalent. In several states, a visiting teacher works in an equivalent position to a school social worker (H. R. Rep. No. 63, 2001).

Supervision – an evaluative relationship provided by an experienced senior member of a profession (often referred to as “supervisor”) to a less experienced member (often referred to as “supervisee”) or members of that same profession. This process helps monitor the competence and quality of services being provided by the supervisee (Bernard & Goodyear, 1998).
APPENDIX B

School Counselors

Initial Letter
Follow-up Letter
Questionnaire
November 4, 2002

Dear

As a school counselor, you have been chosen to participate in a nationwide survey regarding your views and practices related to family interventions, including family counseling. This information is vital in keeping your profession strong and effective in providing cutting-edge services.

As you well know, our nation's schools are in the midst of restructuring to better meet the academic and behavioral needs of America's students. As a doctoral candidate in Counseling Education at The College of William and Mary, I am gathering data on the current family intervention practices of school counselors, school psychologists, and school social workers/visiting teachers, with an emphasis on family counseling.

Your input is greatly desired and will reflect the family services that are currently being rendered in our nation's schools. Additional comments throughout the questionnaire are welcomed. Once completed, please use the return envelope that has been stamped and addressed for your convenience. Please return this survey form by November 18. This will help me complete other portions of this study in a timely manner.

Be assured that your responses will be held in the strictest confidence. Only group results will be reported. If you would like a copy of the final results, please print your name and address on the small yellow sheet that is enclosed. You may return it with your questionnaire. Your participation in this survey is voluntary. You may withdraw from this study at any time without penalty by using the addresses provided below.

Thank you for your cooperation and assistance. Completing the enclosed questionnaire takes approximately 10 to 20 minutes. As a token of my appreciation for your time and input, please accept the small gift that is enclosed.

Sincerely,

Karen Whitmore, Ed.S.
William & Mary Doctoral Candidate
1208 Manchester Ave.
Norfolk, VA 23508
E-mail Address: kwhitm@infi.net

Enclosures: Questionnaire, stamped return envelope, yellow address sheet, twist cap pen

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December 2, 2002

Dear

As a doctoral student at The College of William & Mary, I recently sent you a questionnaire regarding your views and practices in the area of family interventions, with special emphasis given to family counseling. If you have already sent back the questionnaire, thank you! If you have not, I would like to encourage you to take 10 to 20 minutes to share your views and practices. For your convenience, I have enclosed another questionnaire, along with a stamped, addressed return envelope. If possible, please return the questionnaire by December 16.

I am writing to you again due to the importance of your responses as a school counselor in our nation’s schools. Results of this survey will reflect the family services being provided in schools nationwide, and will also provide—from a practitioner’s vantage point— invaluable information about these services.

As a reminder, your responses will be held in strict confidence with only group results reported. If you would like a copy of the final results, please print your name and address on the small yellow slip that is enclosed and return it with your survey form. (If you prefer, you may e-mail this request.) Your participation is voluntary, and you may withdraw at any time without penalty by using the addresses below.

Thank you for your assistance and cooperation. As a token of my appreciation for your time and input, please accept the enclosed bookmark.

Sincerely,

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The College of William and Mary: School of Education

FAMILY COUNSELING QUESTIONNAIRE: Survey for ASCA School Counselors

Below are questions related to your practice of family interventions, including family counseling. Though it is your right not to answer all questions, please answer as many questions as you are willing. Additional comments are welcomed. When completed, please return this survey in the stamped, addressed envelope enclosed. If you are not employed as a practitioner in a school setting serving school-aged students, please answer #1 and return. Thank you.

1. As a school counselor, in which setting do you work? (check one in each category that applies)
   - Public School (Setting: check one: __urban, __suburban, __rural)
   - Private School (Setting: check one: __urban, __suburban, __rural)
   - Residential School (Setting: check one: __urban, __suburban, __rural)
   - School Administration: Departmental Supervisor of School Counselors
   - University Setting: Counselor Education/School Counselor Trainer
   - State Department of Education
   - Mental Health Agency or Private Practice

2. To what grade levels are you assigned? (check all that apply)
   - preschool, __elementary, __middle school, __high school, __post-secondary

3. Number of schools to which you are assigned: ______ number of schools

4. Is your office housed within a school or centrally located in a building other than the school(s) in which you work? (Check one): school, located in building other than school(s) in which I work

5. Approximate number of students for which you are totally responsible (counselor/student ratio): ______ # of students

6. What is the highest level of training that you have obtained? (check one)
   - master’s, master’s, plus 30, MSW, educational specialist, doctorate, other: __________ (specify)

7. What year did you obtain your highest level of training? __________ year obtained

8. a) Please indicate your age: _______ years; b) _____ Male, _____ Female

9. How many years have you been employed as a school counselor? __________ year(s)

10. How many hours per week do you work as a school counselor? __________ hours

11. In what state do you live? _______ state

12. What is your ethnicity? (check all that apply)
   - American Indian or Alaska Native
   - Black/African American
   - Puerto Rican
   - White/Caucasian
   - Asian-American or Pacific Islander
   - Chicano/Mexican-American
   - Other Hispanic/Latino
   - Other: (please specify) _______________________

13. If you provide counseling services in your school(s), what type of counseling do you most often provide? (check 1)
   - ______ individual (student), ______ group (students), ______ crisis, ______ family, ______ I do not provide counseling

14. Is family counseling provided as a school-based service in your school system? (check one)
   (School-based family counseling is defined as a service that is delivered directly on site at the schools or school-owned facilities by either internal (on staff) mental health professionals or external mental health professionals contracted by the school system. Family counseling is defined as counseling with at least one parental figure and one child [together for at least one session] with a duration goal of 3 sessions or more. It is not parent conferencing or consultation.)
   - _____ Yes, _____ No, _____ Not Sure

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15. If family counseling is provided as a school-based service within your school system, who provides this service? (check all that apply)
- school counselor,
- school psychologist,
- school social worker/visiting teacher,
- contracted mental health professionals working within the school system,
- other: (please specify)
- Not Applicable (I am not aware of family counseling being provided in my school district)

16. What type of family work do you most often provide in your school(s)? Choose from the following list: a) referral services for parents/families, b) parent conferencing and/or consultation during student support team meetings, c) parent conferencing and/or consultation during special education evaluations, d) parent conferencing and/or consultation apart from student support team meetings or special education evaluations (e.g., providing academic or career counseling with parents/students; working with parents on discipline problems, etc), e) parent education, training, or support groups, f) crisis counseling with students that require parent involvement, g) family counseling, or h) I do not provide any of the above family interventions. Please write in the letter that best describes your family work; estimate the amount of time per week doing this family work or intervention.

The letter a through h that best describes your family work: ___________, # of hours per week: ________

17. Have you had formal training at the university level on the following topics? (check yes or no for each item)

Yes No
- general systems theory and/or ecological theory
- family systems interventions
- family counseling/family therapy survey course
- advanced coursework in family counseling
- supervised practica in family counseling

18. In your current position, do you practice family counseling in your schools? _____ Yes, _____ No

19. What administrative factor, if any, most restricts your ability to practice family counseling in the schools? (check the most restrictive; check 1 only)
- administrative belief that family counseling is not compatible with my job role;
- lack of knowledge on the part of administrators about the benefits of school-based family counseling;
- administrative belief that family issues are too sensitive to be dealt with in the schools;
- administrative belief that family counseling is too time consuming;
- lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms;
- don’t know: I’m not sure what administrators in my district think about family counseling;
- None, the administrators in my school district support family counseling

20. What personal factor, if any, most restricts your ability to practice family counseling in the schools? (Check the most restrictive; check 1 only)
- incompatible with my job role or description; not sure this service should be provided by the schools
- others in the schools are assigned to do this; encouraged by supervisors to “refer out”
- lack of time/too busy with other duties; lack of flexible work hours to accommodate parents’ schedules
- limited training in family counseling; lack of clinical supervision provided by the school system
- other: (please specify)
- None of these factors restricts my ability to practice family counseling

NOTE: If you do NOT practice family counseling in the schools, you are finished! Thank you for your participation!
Please send this questionnaire to Karen Whitmore, 1208 Manchester Ave.; Norfolk, VA 23508. A stamped, addressed envelope is provided for your convenience: Please let me know if you would like a copy of the final results of this survey.

If you DO practice family counseling in the schools, please continue with the next question. (see next page)
21. If you do practice family counseling in your school(s), is family counseling in your job description?  
   Yes,  No

22. If you do practice family counseling in your school(s), what factor most influences this decision? (check one only)
   ___ support from school level personnel;  ___ support from departmental supervisors;
   ___ training opportunities provided by the school system;  ___ time allotted for family counseling service;
   ___ clinical supervision provided by the school system;  ___ family counseling is in my job description;
   ___ personal belief that family counseling should be provided at the school;
   ___ received university training in family counseling in preparation for my job;
   __ other: ________________________________________________________________

23. In your practice of family counseling in the schools, how many cases do you typically carry at one time?  
   number of cases __________

24. What is your level of satisfaction with the total amount of family counseling that you provide in the schools?  
   (check one):  ___ satisfied,  ___ would like to do more,  ___ would like to do less

25. In your school-based counseling with families, what term or label is most often used? (check one only)
   ___ family counseling,  ___ family therapy,  ___ parent counseling,
   ___ parent conferencing,  ___ parent consultation,  ___ other: ________________________

26. Who are the most frequent referral sources for school-based family counseling? (check one only)
   ___ departmental supervisors/directors,  ___ teachers,  ___ direct requests from parents,
   ___ recommendations from student/instructional support team members,  ___ principals

27. When practicing family therapy, what theoretical approach do you most often use? (check one only)
   ___ structural,  ___ communication/strategic,
   ___ brief, solution-focused,  ___ experiential/humanistic,
   ___ cognitive/behavioral,  ___ Bowenian,
   ___ eclectic/integrative,  ___ other: (please specify) ________________________________

28. When initiating family counseling services, what procedure do you most often use? (check the one that most applies):
   ___ assume that permission is granted by the family’s presence in the session (written permission NOT obtained);
   ___ discuss procedures on an informal basis without obtaining written permission;
   ___ obtain written permission before or during the first session (without actually discussing informed consent);
   ___ obtain written permission before or during the first session, labeling this consent as “informed consent” and discussing rights, expectations, and procedures

29. How many counseling sessions per family do you typically provide?  ______ average number of sessions

30. What type of student problem is most often referred for family counseling? (check one only)
   ___ behavioral: externalizing (e.g., conduct problems);  ___ academic with low motivation;
   ___ behavioral: internalizing (e.g., depression, anxiety);  ___ academic with high motivation;
   ___ drugs/alcohol of student;  ___ student/parent conflict;
   ___ other: (please specify) ________________________________________________________________

31. In your mind, what is the definition of “family counseling?”

<table>
<thead>
<tr>
<th>A professional who meets with:</th>
<th>Average # of Sessions</th>
<th>Uses Systems Perspective? Yes or No</th>
<th>Gets Written Permission? Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental figure(s) only, no children</td>
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<tr>
<td>Parental figure(s) and one child (i.e., the referred student/identified patient)</td>
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<tr>
<td>Parental figure(s), the referred child, plus several children/siblings</td>
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<tr>
<td>Entire family and/or household (can include extended family members)</td>
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<tr>
<td>Other: (please specify)</td>
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</tbody>
</table>

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32. What “unit” of treatment do you most often include in your family counseling sessions? (check one only)
   ___ parental figure(s) only, no children;
   ___ parental figure(s) and one child (i.e., the referred student/identified patient);
   ___ parental figure(s), the referred child, plus several children/siblings;
   ___ entire family and/or household (can include extended family members)
   ___ Other (please specify): ____________________________________________________

33. In your practice of family counseling, do you receive ongoing, clinical supervision? (This does not include administrative supervision):
   ___ Yes,    ___ No (If “NO”, proceed to question #38)

34. If you do receive clinical supervision for family counseling, who provides this clinical supervision? (check all that apply)
   ___ school system provides on-staff supervisory personnel who are trained in family counseling;
   ___ school system contracts with a community therapist trained in family counseling;
   ___ school system provides opportunity for peer supervision;
   ___ I obtain my supervision apart from the school system;
   ___ other: __________________________________________

35. How often do you receive individual clinical supervision for your family counseling work? (check one only)
   ___ weekly,    ___ every 2 weeks/bimonthly,   ___ once a month,   ___ as needed only,   ___ do not receive

36. How often do you receive group clinical supervision for your family counseling work? (check one only)
   ___ weekly,    ___ every 2 weeks/bimonthly,   ___ once a month,   ___ as needed only,   ___ do not receive

37. If you do receive clinical supervision for family counseling, what supervision activities typically take place? (check all that apply)
   ___ case presentations (review of family cases with written report using theoretical hypotheses and analyses);
   ___ review of counseling notes/logs (self-report of family’s issues with discussion of appropriate interventions);
   ___ review of videotapes;
   ___ review of audiotapes or transcripts;
   ___ live supervision;
   ___ use of didactic information to increase knowledge about family therapy

38. If you practice school-based family counseling, what service delivery format is used? (check one only)
   ___ family counseling is a departmental program (my profession or discipline only);
   ___ family counseling is part of a combined effort of departments such as school counseling, school psychology, and/or school social work;
   ___ family counseling is part of a comprehensive mental health program that includes resources for families provided by on-staff personnel and/or contractual personnel (e.g., in full service schools, clinics);
   ___ other: (please specify) __________________________________________
   ___ Not applicable: I practice school-based family counseling singly on my own, not part of a larger program or group

39. What type of training have you received specifically in family counseling? (check all that apply)
   ___ university degree program in preparation for my job;
   ___ post-degree university coursework in family therapy;
   ___ free-standing institute in family therapy;
   ___ seminars or workshops in family therapy (apart from the school system);
   ___ seminars, workshops, or training sponsored and/or provided by the school system;
   ___ training and supervision from a family therapist apart from the school system;

40. Are you licensed to practice therapy in a community setting?    ___ Yes,    ___ No

41. Do you hold credentials specifically in marriage and family therapy or family psychology?    ___ Yes,    ___ No
APPENDIX C

School Psychologists

Initial Letter
Follow-up Letter
Questionnaire
November 4, 2002

Dear

As a school psychologist, you have been chosen to participate in a nationwide survey regarding your views and practices related to family interventions, including family counseling. This information is vital in keeping your profession strong and effective in providing cutting-edge services.

As you well know, our nation’s schools are in the midst of restructuring to better meet the academic and behavioral needs of America’s students. As a practicing school psychologist and doctoral candidate in Counseling Education at The College of William and Mary, I am gathering data on the current family intervention practices of school psychologists, school social workers/visiting teachers, and school counselors, with an emphasis on family counseling.

Your input is greatly desired and will reflect the family services that are currently being rendered in our nation’s schools. Additional comments throughout the questionnaire are welcomed. Once completed, please use the return envelope that has been stamped and addressed for your convenience. Please return this survey form by November 18. This will help me complete other portions of this study in a timely manner.

Be assured that your responses will be held in the strictest confidence. Only group results will be reported. If you would like a copy of the final results, please print your name and address on the small yellow sheet that is enclosed. You may return it with your questionnaire. Your participation in this survey is voluntary. You may withdraw from this study at any time without penalty by using the addresses provided below.

Thank you for your assistance and cooperation. Completing the enclosed questionnaire takes approximately 10 to 20 minutes. As a token of my appreciation for your time and input, please accept the small gift that is enclosed.

Sincerely,

Karen Whitmore, Ed.S.
William & Mary Doctoral Candidate
1208 Manchester Ave.
Norfolk, VA 23508
E-mail Address: kwhitm@infi.net

Research Supervisor:

Victoria Foster, Ed.D
William & Mary Associate Professor
Dissertation Committee Chairperson
E-mail Address: vafost@wm.edu
Phone: (757)221-2321

Enclosures: Questionnaire, stamped return envelope, yellow address sheet, twist cap pen

Chartered 1693
December 2, 2002

Dear

As a doctoral student at The College of William & Mary, I recently sent you a questionnaire regarding your views and practices in the area of family interventions, with special emphasis given to family counseling. If you have already sent back the questionnaire, thank you! If you have not, I would like to encourage you to take 10 to 20 minutes to share your views and practices. For your convenience, I have enclosed another questionnaire, along with a stamped, addressed return envelope. If possible, please return the questionnaire by December 16.

I am writing to you again due to the importance of your responses as a school psychologist in our nation’s schools. Results of this survey will reflect the family services being provided in schools nationwide, and will also provide—from a practitioner’s vantage point—valuable information about these services.

As a reminder, your responses will be held in strict confidence with only group results reported. If you would like a copy of the final results, please print your name and address on the small yellow slip that is enclosed and return it with your survey form. (If you prefer, you may e-mail this request.) Your participation is voluntary, and you may withdraw at any time without penalty by using the addresses below.

Thank you for your assistance and cooperation. As a token of my appreciation for your time and input, please accept the enclosed bookmark.

Sincerely,

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William & Mary Doctoral Candidate
1208 Manchester Ave.
Norfolk, VA 23508
E-mail Address: kwhitm@infi.net

Victoria Foster, Ed.D.
William & Mary Associate Professor
Dissertation Committee Chairperson
E-mail Address: vafost@wm.edu
Phone: 757-221-2321

Enclosures: Questionnaire, stamped return envelope, yellow address slip, bookmark
Below are questions related to your practice of family interventions, including family counseling. Though it is your right not to answer all questions, please answer as many questions as you are willing. Additional comments are welcomed. When completed, please return this survey in the stamped, addressed envelope enclosed. If you are not employed as a practitioner in a school setting serving school-aged students, please answer #1 and return. Thank you.

1. As a school psychologist, in which setting do you work? (check one in each category that applies)
   - Public School
     - Setting: check one: __ urban, __ suburban, __ rural
   - Private School
     - Setting: check one: __ urban, __ suburban, __ rural
   - Residential School
     - Setting: check one: __ urban, __ suburban, __ rural
   - School Administration: Departmental Supervisor of School Psychologists
   - University Setting: School Psychology Trainer
   - State Department of Education
   - Mental Health Agency or Private Practice

2. To what grade levels are you assigned? (check all that apply)
   - preschool, elementary, middle school, high school, post-secondary

3. Number of schools to which you are assigned: __ number of schools

4. Is your office housed within a school or centrally located in a building other than the school(s) in which you work? (Check one): __ school, __ located in building other than school(s) in which I work

5. Approximate number of students for which you are totally responsible (psychologist/student ratio): __ # of students

6. What is the highest level of training that you have obtained? (check one)
   - master’s, master’s, plus 30, MSW, educational specialist, doctorate, other: ___

7. What year did you obtain your highest level of training? __________ year obtained

8. a) Please indicate your age: ________ years; b) ____________ Male, ____________ Female

9. How many years have you been employed as a school psychologist? ________ year(s)

10. How many hours per week do you work as a school psychologist? ________ hours

11. In what state do you live? _____________________________________ state

12. What is your ethnicity? (check all that apply)
   - American Indian or Alaska Native
   - Black/African American
   - Puerto Rican
   - White/Caucasian

13. If you provide counseling services in your school(s), what type of counseling do you most often provide? (check 1)
   - individual (student), group (students), crisis, family, I do not provide counseling

14. Is family counseling provided as a school-based service in your school system? (check one)

(School-based family counseling is defined as a service that is delivered directly on site at the schools or school-owned facilities by either internal (on staff) mental health professionals or external mental health professionals contracted by the school system. Family counseling is defined as counseling with at least one parental figure and one child [together for at least one session] with a duration goal of 3 sessions or more. It is not parent conferencing or consultation.)

   - Yes, No, Not Sure
15. If family counseling is provided as a school-based service within your school system, who provides this service? (check all that apply)

- school counselor, __________
- contracted mental health professionals working within the school system, __________
- school psychologist, __________
- school social worker/visiting teacher, __________
- other: (please specify) ______________________________
- Not Applicable (I am not aware of family counseling being provided in my school district)

16. What type of family work do you most often provide in your school(s)? Choose from the following list: a) referral services for parents/families, b) parent conferencing and/or consultation during student support team meetings, c) parent conferencing and/or consultation during special education evaluations, d) parent conferencing and/or consultation apart from student support team meetings or special education evaluations (e.g., providing academic or career counseling with parents/students; working with parents on discipline problems, etc), e) parent education, training, or support groups, f) crisis counseling with students that require parent involvement, g) family counseling, or h) I do not provide any of the above family interventions. Please write in the letter that best describes your family work; estimate the amount of time per week doing this family work or intervention.

The letter a through h that best describes your family work: __________, # of hours per week: __________

17. Have you had formal training at the university level on the following topics? (check yes or no for each item)

- __________ general systems theory and/or ecological theory
- __________ family systems interventions
- __________ family counseling/family therapy survey course
- __________ advanced coursework in family counseling
- __________ supervised practica in family counseling

18. In your current position, do you practice family counseling in your schools? _____ Yes, ____ No

19. What administrative factor, if any, most restricts your ability to practice family counseling in the schools? (check the most restrictive; check 1 only)

- __________ administrative belief that family counseling is not compatible with my job role;
- __________ lack of knowledge on the part of administrators about the benefits of school-based family counseling;
- __________ administrative belief that family issues are too sensitive to be dealt with in the schools;
- __________ administrative belief that family counseling is too time consuming;
- __________ lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms;
- __________ don’t know: I’m not sure what administrators in my district think about family counseling;
- __________ None, the administrators in my school district support family counseling

20. What personal factor, if any, most restricts your ability to practice family counseling in the schools? (Check the most restrictive; check 1 only)

- __________ incompatible with my job role or description;
- __________ others in the schools are assigned to do this;
- __________ lack of time/too busy with other duties;
- __________ limited training in family counseling;
- __________ not sure this service should be provided by the schools;
- __________ encouraged by supervisors to “refer out”;
- __________ lack of flexible work hours to accommodate parents’ schedules;
- __________ lack of clinical supervision provided by the school system;
- __________ other: (please specify) ______________________________
- __________ None of these factors restricts my ability to practice family counseling

NOTE: If you do NOT practice family counseling in the schools, you are finished! Thank you for your participation! Please send this questionnaire to Karen Whitmore, 1208 Manchester Ave., Norfolk, VA 23508. A stamped, addressed envelope is provided for your convenience. Please let me know if you would like a copy of the final results of this survey.

If you DO practice family counseling in the schools, please continue with the next question. (see next page)
21. If you do practice **family counseling** in your school(s), is family counseling in your job description?  
   _Yes, ___ No

22. If you do practice family counseling in your school(s), what factor most influences this decision? (check one only)
   ___ support from school level personnel; ___ support from departmental supervisors;
   ___ training opportunities provided by the school system; ___ time allotted for family counseling service;
   ___ clinical supervision provided by the school system; ___ family counseling is in my job description;
   ___ personal belief that family counseling should be provided at the school;
   ___ received university training in family counseling in preparation for my job;
   ___ other: ___________________________________________________________

23. In your practice of family counseling in the schools, how many cases do you typically carry at one time?
   ____ number of cases

24. What is your level of satisfaction with the total amount of family counseling that you provide in the schools? 
   (check one):   ____ satisfied, ____ would like to do more, ____ would like to do less

25. In your school-based counseling with families, what term or label is most often used? (check one only)
   ____ family counseling, ____ family therapy, ____ parent counseling, 
   ____ parent conferencing, ____ parent consultation, ____ other: _________________________

26. Who are the most frequent referral sources for school-based family counseling? (check one only)
   ___ departmental supervisors/directors, ___ teachers, ___ direct requests from parents, 
   ___ recommendations from student/instructional support team members, ___ principals

27. When practicing family therapy, what theoretical approach do you most often use? (check one only)
   ____ structural, ____ communication/strategic, 
   ____ brief, solution-focused, ____ experiential/humanistic, 
   ____ cognitive/behavioral, ___ Bowenian, ___ eclectic/integrative, ___ other: (please specify)

28. When initiating family counseling services, what procedure do you most often use? (check the one that most applies):
   ___ assume that permission is granted by the family’s presence in the session (written permission not obtained); 
   ___ discuss procedures on an informal basis without obtaining written permission; 
   ___ obtain written permission before or during the first session (without actually discussing informed consent); 
   ___ obtain written permission before or during the first session, labeling this consent as “informed consent” and 
   discussing rights, expectations, and procedures

29. How many counseling sessions per family do you typically provide?  ____ average number of sessions

30. What type of student problem is most often referred for family counseling? (check one only)
   ___ behavioral: externalizing (e.g., conduct problems); ____ academic with low motivation;
   ___ behavioral: internalizing (e.g., depression, anxiety); ____ academic with high motivation;
   ___ drugs/alcohol of student; ____ student/parent conflict; 
   ___ other: (please specify)

31. In your mind, what is the definition of “family counseling?”

<table>
<thead>
<tr>
<th>A professional who meets with:</th>
<th>Average # of Sessions</th>
<th>Uses Systems Perspective?</th>
<th>Gets Written Permission?</th>
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<tbody>
<tr>
<td>Check 1 and complete grid for your selection</td>
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<td>Parental figure(s) only, no children</td>
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<td>Parental figure(s) and one child (i.e., the referred student/identified patient)</td>
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<td>Parental figure(s), the referred child, plus several children/siblings</td>
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<td>Entire family and/or household (can include extended family members)</td>
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<tr>
<td>Other: (please specify)</td>
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</tbody>
</table>

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32. What “unit” of treatment do you most often include in your family counseling sessions? (check one only)
   - parental figure(s) only, no children;
   - parental figure(s) and one child (i.e., the referred student/identified patient);
   - parental figure(s), the referred child, plus several children/siblings;
   - entire family and/or household (can include extended family members)
   - Other (please specify):

33. In your practice of family counseling, do you receive ongoing, clinical supervision? (This does not include administrative supervision):
   - Yes,   --- No   (If “NO”, proceed to question # 38)

34. If you do receive clinical supervision for family counseling, who provides this clinical supervision? (check all that apply)
   - school system provides on-staff supervisory personnel who are trained in family counseling;
   - school system contracts with a community therapist trained in family counseling;
   - school system provides opportunity for peer supervision;
   - I obtain my supervision apart from the school system;
   - other: ___________________________________

35. How often do you receive individual clinical supervision for your family counseling work? (check 1 only)
   - weekly,   --- every 2 weeks/bimonthly,   --- once a month,   --- as needed only,   --- do not receive

36. How often do you receive group clinical supervision for your family counseling work? (check 1 only)
   - weekly,   --- every 2 weeks/bimonthly,   --- once a month,   --- as needed only,   --- do not receive

37. If you do receive clinical supervision for family counseling, what supervision activities typically take place? (check all that apply)
   - case presentations (review of family cases with written report using theoretical hypotheses and analyses);
   - review of counseling notes/logs (self-report of family’s issues with discussion of appropriate interventions);
   - review of videotapes;
   - review of audiotapes or transcripts;
   - live supervision;
   - use of didactic information to increase knowledge about family therapy

38. If you practice school-based family counseling, what service delivery format is used? (check one only)
   - family counseling is a departmental program (my profession or discipline only);
   - family counseling is part of a combined effort of departments such as school counseling, school psychology, and/or school social work;
   - family counseling is part of a comprehensive mental health program that includes resources for families provided by on-staff personnel and/or contractual personnel (e.g., in full service schools, clinics);
   - other: (please specify) __________
   - Not applicable: I practice school-based family counseling singly on my own, not part of a larger program or group

39. What type of training have you received specifically in family counseling? (check all that apply)
   - university degree program in preparation for my job;
   - post-degree university coursework in family therapy;
   - free-standing institute in family therapy;
   - seminars or workshops in family therapy (apart from the school system);
   - seminars, workshops, or training sponsored and/or provided by the school system;
   - training and supervision from a family therapist apart from the school system;

40. Are you licensed to practice therapy in a community setting?   --- Yes,   --- No

41. Do you hold credentials specifically in marriage and family therapy or family psychology?   --- Yes,   --- No

Thank you for your participation! Please send this questionnaire to Karen Whitmore, 1208 Manchester Ave, Norfolk, VA 23508. A stamped, addressed envelope is provided for your convenience. If you should have any questions, my e-mail address is: kwhitm@infi.net. Please let know if you would like to receive a copy of the final results of this survey.
APPENDIX D

School Social Workers

Initial Letter
Follow-up Letter
Questionnaire
Dear

As a school social worker/visiting teacher, you have been chosen to participate in a nationwide survey regarding your views and practices related to family interventions, including family counseling. This information is vital in keeping your profession strong and effective in providing cutting-edge services.

As you well know, our nation's schools are in the midst of restructuring to better meet the academic and behavioral needs of America's students. As a doctoral candidate in Counseling Education at The College of William and Mary, I am gathering data on the current family intervention practices of school social workers/visiting teachers, school psychologists, and school counselors, with an emphasis on family counseling.

Your input is greatly desired and will reflect the family services that are currently being rendered in our nation's schools. Additional comments throughout the questionnaire are welcomed. Once completed, please use the return envelope that has been stamped and addressed for your convenience. Please return this survey form by November 18. This will help me complete other portions of this study in a timely manner.

Be assured that your responses will be held in the strictest confidence. Only group results will be reported. If you would like a copy of the final results, please print your name and address on the small yellow sheet that is enclosed. You may return it with your questionnaire. Your participation in this survey is voluntary. You may withdraw from this study at any time without penalty by using the addresses provided below.

Thank you for your assistance and cooperation. Completing the enclosed questionnaire takes approximately 10 to 20 minutes. As a token of my appreciation for your time and input, please accept the small gift that is enclosed.

Sincerely,

Karen Whitmore,
William & Mary Doctoral Candidate
1208 Manchester Ave.
Norfolk, VA 23508
E-mail Address: kwhitm@infi.net

Sincerely,

Research Supervisor:

Karen Whitmore,
William & Mary Doctoral Candidate
1208 Manchester Ave.
Norfolk, VA 23508
E-mail Address: kwhitm@infi.net

Victoria Foster, Ed.D.
William & Mary Associate Professor
Dissertation Committee Chairperson
E-mail Address: vafost@wm.edu
Phone: (757)221-2321

Enclosures: Questionnaire, stamped return envelope, yellow address sheet, twist cap pen

Chartered 1693
December 2, 2002

Dear

As a doctoral student at The College of William & Mary, I recently sent you a questionnaire regarding your views and practices in the area of family interventions, with special emphasis given to family counseling. If you have already sent back the questionnaire, thank you! If you have not, I would like to encourage you to take 10 to 20 minutes to share your views and practices. For your convenience, I have enclosed another questionnaire, along with a stamped, addressed return envelope. If possible, please return the questionnaire by December 16.

I am writing to you again due to the importance of your responses as a school social worker/visiting teacher in our nation’s schools. Results of this survey will reflect the family services being provided in schools nationwide, and will also provide--from a practitioner’s vantage point--invaluable information about these services.

As a reminder, your responses will be held in strict confidence with only group results reported. If you would like a copy of the final results, please print your name and address on the small yellow slip that is enclosed and return it with your survey form. (If you prefer, you may e-mail this request.) Your participation is voluntary, and you may withdraw at any time without penalty by using the addresses below.

Thank you for your assistance and cooperation. As a token of my appreciation for your time and input, please accept the enclosed bookmark.

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Victoria Foster, Ed.D.
William & Mary Associate Professor
Dissertation Committee Chairperson
E-mail Address: vafost@wm.edu
Phone: 757-221-2321

Enclosures: Questionnaire, stamped return envelope, yellow address slip, bookmark
Below are questions related to your practice of family interventions, including family counseling. Though it is your right not to answer all questions, please answer as many questions as you are willing. Additional comments are welcomed. When completed, please return this survey in the stamped, addressed envelope enclosed. If you are not employed as a practitioner in a school setting serving school-aged students, please answer # 1 and return. Thank you.

1. As a school social worker/visiting teacher, in which setting do you work? (check one in each category that applies)
   - Public School (Setting: check one: _____ urban, _____ suburban, _____ rural)
   - Private School (Setting: check one: _____ urban, _____ suburban, _____ rural)
   - Residential School (Setting: check one: _____ urban, _____ suburban, _____ rural)
   - School Administration: Departmental Supervisor of School Social Workers/Visiting Teachers
   - University Setting: School Social Worker Trainer
   - State Department of Education
   - Mental Health Agency or Private Practice

2. To what grade levels are you assigned? (check all that apply)
   - preschool, elementary, middle school, high school, post-secondary

3. Number of schools to which you are assigned: ______ number of schools

4. Is your office housed within a school or centrally located in a building other than the school(s) in which you work? (Check one): ______ school, ______ located in building other than school(s) in which I work

5. Approximate number of students for which you are totally responsible (social worker/student ratio): ______ # of students

6. What is the highest level of training that you have obtained? (check one)
   - master’s, master’s, plus 30, MSW, educational specialist, doctorate, other: ______

7. What year did you obtain your highest level of training? ________ year obtained

8. a) Please indicate your age: ________ years; b) ______ Male, ______ Female

9. How many years have you been employed as a school social worker/visiting teacher? ________ year(s)

10. How many hours per week do you work as a school social worker/visiting teacher? ________ hours

11. In what state do you live? __________________________ state

12. What is your ethnicity? (check all that apply)
   - American Indian or Alaska Native, Asian-American or Pacific Islander
   - Black/African American, Chicano/Mexican-American
   - Puerto Rican, Other Hispanic/Latino
   - White/Caucasian, Other: (please specify)

13. If you provide counseling services in your school(s), what type of counseling do you most often provide? (check 1)
   - individual (student), group (students), crisis, family, I do not provide counseling

14. Is family counseling provided as a school-based service in your school system? (check one)
   - Yes, No, Not Sure

(School-based family counseling is defined as a service that is delivered directly on site at the schools or school-owned facilities by either internal (on staff) mental health professionals or external mental health professionals contracted by the school system. Family counseling is defined as counseling with at least one parental figure and one child [together for at least one session] with a duration goal of 3 sessions or more. It is not parent conferencing or consultation.)
15. If family counseling is provided as a school-based service within your school system, who provides this service? (check all that apply)

- school counselor,
- school psychologist,
- school social worker/visiting teacher,
- contracted mental health professionals working within the school system,
- other: (please specify) ______________________________________________________________________
- Not Applicable (I am not aware of family counseling being provided in my school district)

16. What type of family work do you most often provide in your school(s)? Choose from the following list:

- a) referral services for parents/families,
- b) parent conferencing and/or consultation during student support team meetings,
- c) parent conferencing and/or consultation during special education evaluations (e.g., providing academic or career counseling with parents/students; working with parents on discipline problems, etc.),
- d) parent education, training, or support groups, or e) crisis counseling with students that require parent involvement,
- g) family counseling, or h) I do not provide any of the above family interventions. Please write in the letter that best describes your family work; estimate the amount of time per week doing this family work or intervention.

   The letter a through h that best describes your family work: ______________, # of hours per week: __________
   (one letter only)

17. Have you had formal training at the university level on the following topics? (check yes or no for each item)

- __________ general systems theory and/or ecological theory
- __________ family systems interventions
- __________ family counseling/family therapy survey course
- __________ advanced coursework in family counseling
- __________ supervised practica in family counseling

18. In your current position, do you practice family counseling in your schools? _____ Yes, _____ No

19. What administrative factor, if any, most restricts your ability to practice family counseling in the schools? (check the most restrictive; check 1 only)

   - administrative belief that family counseling is not compatible with my job role;
   - lack of knowledge on the part of administrators about the benefits of school-based family counseling;
   - administrative belief that family issues are too sensitive to be dealt with in the schools;
   - administrative belief that family counseling is too time consuming;
   - lack of administrative support in the form of money or accommodations for training, supervision, therapy rooms;
   - I don’t know: I’m not sure what administrators in my district think about family counseling;
   - None, the administrators in my school district support family counseling

20. What personal factor, if any, most restricts your ability to practice family counseling in the schools? (Check the most restrictive; check 1 only)

   - incompatible with my job role or description;
   - others in the schools are assigned to do this;
   - encouraged by supervisors to “refer out”;
   - lack of time/ too busy with other duties;
   - limited training in family counseling;
   - lack of clinical supervision provided by the school system
   - other: (please specify) ______________________________________________________________________

   None of these factors restricts my ability to practice family counseling

NOTE: If you do NOT practice family counseling in the schools, you are finished! Thank you for your participation!
Please send this questionnaire to Karen Whitmore, 1208 Manchester Ave., Norfolk, VA 23508. A stamped, addressed envelope is provided for your convenience. Please let me know if you would like a copy of the final results of this survey.

If you DO practice family counseling in the schools, please continue with the next question. (see next page)
21. If you do practice family counseling in your school(s), is family counseling in your job description?  
   Yes,  No

22. If you do practice family counseling in your school(s), what factor most influences this decision? (check one only)
   - support from school level personnel;
   - support from departmental supervisors;
   - training opportunities provided by the school system;
   - time allotted for family counseling service;
   - clinical supervision provided by the school system;
   - family counseling is in my job description;
   - personal belief that family counseling should be provided at the school;
   - received university training in family counseling in preparation for my job;
   - other: __________________________________________________________________________

23. In your practice of family counseling in the schools, how many cases do you typically carry at one time?
   ________________________

24. What is your level of satisfaction with the total amount of family counseling that you provide in the schools? 
   (check one):  satisfied,  would like to do more,  would like to do less

25. In your school-based counseling with families, what term or label is most often used? (check one only)
   - family counseling,  - family therapy,  - parent counseling,
   - parent conferencing,  - parent consultation,  - other: ________________________

26. Who are the most frequent referral sources for school-based family counseling? (check one only)
   - departmental supervisors/directors,  - teachers,  - direct requests from parents,
   - recommendations from student/instructional support team members,  - principals

27. When practicing family therapy, what theoretical approach do you most often use? (check one only)
   - structural,  - communication/strategic,
   - brief, solution-focused,  - experiential/humanistic,
   - cognitive/behavioral,  - Bowenian,
   - eclectic/integrative,  - other: (please specify)

28. When initiating family counseling services, what procedure do you most often use? (check the one that most applies):
   - assume that permission is granted by the family’s presence in the session (written permission not obtained);
   - discuss procedures on an informal basis without obtaining written permission;
   - obtain written permission before or during the first session (without actually discussing informed consent);
   - obtain written permission before or during the first session, labeling this consent as “informed consent” and discussing rights, expectations, and procedures

29. How many counseling sessions per family do you typically provide?  _______ average number of sessions

30. What type of student problem is most often referred for family counseling? (check one only)
   - behavioral: externalizing (e.g., conduct problems);  - academic with low motivation;
   - behavioral: internalizing (e.g., depression, anxiety);  - academic with high motivation;
   - drugs/alcohol of student;  - student/parent conflict;
   - other: (please specify)

31. In your mind, what is the definition of “family counseling?”

| A professional who meets with: | Average # of Sessions | Uses Systems Perspective? Yes or No | Gets Written Permission? Yes or No |
| Check 1 and complete grid for your selection | | | |
| Parental figure(s) only, no children | | | |
| Parental figure(s) and one child (i.e., the referred student/identified patient) | | | |
| Parental figure(s), the referred child, plus several children/siblings | | | |
| Entire family and/or household (can include extended family members) | | | |
| Other: (please specify) | | | |

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32. What “unit” of treatment do you most often include in your family counseling sessions? (check one only)
   ___ parental figure(s) only, no children;
   ___ parental figure(s) and one child (i.e., the referred student/identified patient);
   ___ parental figure(s), the referred child, plus several children/siblings;
   ___ entire family and/or household (can include extended family members)
   ___ Other (please specify): ______________________________________________________

33. In your practice of family counseling, do you receive ongoing, clinical supervision? (This does not include administrative supervision): ___ Yes, ___ No (If “NO”, proceed to question # 38)

34. If you do receive clinical supervision for family counseling, who provides this clinical supervision? (check all that apply)
   ___ school system provides on-staff supervisory personnel who are trained in family counseling;
   ___ school system contracts with a community therapist trained in family counseling;
   ___ school system provides opportunity for peer supervision;
   ___ I obtain my supervision apart from the school system;
   ___ other: ___________________________________

35. How often do you receive individual clinical supervision for your family counseling work? (check 1 only)
   ___ weekly, ___ every 2 weeks/bimonthly, ___ once a month, ___ as needed only, ___ do not receive

36. How often do you receive group clinical supervision for your family counseling work? (check 1 only)
   ___ weekly, ___ every 2 weeks/bimonthly, ___ once a month, ___ as needed only, ___ do not receive

37. If you do receive clinical supervision for family counseling, what supervision activities typically take place? (check all that apply)
   ___ case presentations (review of family cases with written report using theoretical hypotheses and analyses);
   ___ review of counseling notes/logs (self-report of family’s issues with discussion of appropriate interventions);
   ___ review of videotapes;
   ___ review of audiotapes or transcripts;
   ___ live supervision;
   ___ use of didactic information to increase knowledge about family therapy

38. If you practice school-based family counseling, what service delivery format is used? (check one only)
   ___ family counseling is a departmental program (my profession or discipline only);
   ___ family counseling is part of a combined effort of departments such as school counseling, school psychology, and/or school social work;
   ___ family counseling is part of a comprehensive mental health program that includes resources for families provided by on-staff personnel and/or contractual personnel (e.g., in full service schools, clinics);
   ___ other: (please specify) __________________________________________
   ___ Not applicable: I practice school-based family counseling singly on my own, not part of a larger program or group

39. What type of training have you received specifically in family counseling? (check all that apply)
   ___ university degree program in preparation for my job;
   ___ post-degree university coursework in family therapy;
   ___ free-standing institute in family therapy;
   ___ seminars or workshops in family therapy (apart from the school system);
   ___ seminars, workshops, or training sponsored and/or provided by the school system;
   ___ training and supervision from a family therapist apart from the school system;

40. Are you licensed to practice therapy in a community setting? ___ Yes, ___ No

41. Do you hold credentials specifically in marriage and family therapy or family psychology? ___ Yes, ___ No

Thank you for your participation! Please send this questionnaire to Karen Whitmore, 1208 Manchester Ave, Norfolk, VA 23508. A stamped, addressed envelope is provided for your convenience. If you should have any questions, my e-mail address is: kwhitm@infi.net. Please let know if you would like to receive a copy of the final results of this survey.
October 28, 2002

Dear

I am a doctoral student at The College of William & Mary, and am conducting a nationwide survey to obtain current information about your field as it relates to family interventions, including family counseling. As a mental health practitioner in our nation's schools, your views and practices regarding this important work are greatly desired.

In approximately 1 ½ to 2 weeks, you will be mailed a questionnaire. I would be most appreciative if you would provide your input by completing this 10-20 minute questionnaire form.

Thank you for your cooperation. A small token of my appreciation will be enclosed in the questionnaire packet.

Karen Y. Whitmore
Doctoral Candidate at The College of William & Mary
kwhitm@infi.net
APPENDIX F

Second Postcard

November 18, 2002

Dear

As a William & Mary doctoral student, I recently sent you a questionnaire related to your practice of family interventions, including family counseling.

If you have already sent back your questionnaire, I am indeed grateful. **Thank you!** In case you requested a copy of the survey results, it will be sent in approximately three to six months.

If you have not already returned your questionnaire, please consider doing so. Your input is important as it will help give current information on the family work being rendered in our nation’s schools.

Karen Whitmore
William & Mary Doctoral Candidate
E-mail Address: kwhitm@infi.net
APPENDIX G

Results Return Slip

Please send me a copy of the final results of this survey.

Name:

Address:

(please print)
Vita

Karen Y. Whitmore

Birthdate: December 7, 1948
Birthplace: Plain City, Ohio

Education:

2004 The College of William and Mary
Williamsburg, Virginia
Counselor Education,
Cognate: Family Counseling
Doctor of Philosophy

1999 Old Dominion University
Norfolk, Virginia
School Administration
Master of Science in Education

1989 James Madison University
Harrisonburg, Virginia
School Psychology (Level II)
Educational Specialist

1986 James Madison University
Harrisonburg, Virginia
School Psychology (Level I)
Master of Education

1970 Eastern Mennonite University
Harrisonburg, Virginia
Psychology
Bachelor of Arts
Licensures/Certificates:

2002 to present  
School Psychology License – Limited  
Board of Psychology  
Commonwealth of Virginia  
Department of Health Professions  
Richmond, Virginia

1981 to present  
Virginia Collegiate Professional Teacher’s Certificate  
Special Education,  
Endorsement: Mental Retardation  
James Madison University  
Harrisonburg, Virginia

Full-Time Work Experience:

1989 to present  
School Psychologist  
Norfolk Public Schools  
Norfolk, Virginia

1973 - 1988  
Program Coordinator, Instructor  
Pleasant View Homes, Inc.  
Broadway, Virginia

1970 - 1973  
Social Living Instructor, Teacher’s Assistant  
Margaret Sterck School for the Hearing Impaired  
Newark, Delaware

Part-Time Work Experience:

1986  
Instructor  
Psychology Department  
Eastern Mennonite University  
Harrisonburg, Virginia

1985  
Psychological Services Institute  
Harrisonburg, Virginia  
Associate Consultant