CHAPTER 1
INTRODUCTION

It is unlikely the elementary school counselor will be successful in counseling with children unless the children's families, the children's primary social systems, are involved (Amatea & Sherrard, 1997; Carns & Carns, 1997; Lewis, 1996; Rosenthal & Sawyer, 1996). Including the family in counseling is necessary when considering the positive correlation between family interactions and the children's success at school (Walsh & Williams, 1997). Elementary school counselors are in an ideal position to provide family counseling services because their job description involves working as a liaison among children, families and classroom teachers (Nicoll, 1997). Elementary school counselors should take full advantage of their unique position to assist both the school and family systems and improve the relationship between them (Edwards & Foster, 1995; Gerler, 1993; Kraus, 1998; Woody & Woody, 1994).

In support of school counselors incorporating family counseling as part of their interventions, Nicoll (1984) provided a rationale for school counseling programs to provide family-counseling services. He based his argument on the following points: (a) Referred families rarely follow through with counseling outside of the school, (b) Counseling in the school setting may be less threatening than settings unfamiliar to the families, (c) Family counseling is more effective and economical than individual or group counseling, and (d) The school counselor is able to add perceptions and input derived from formal and informal observations of the children's school behavior.

Current literature proposed that families should become the primary focus of treatments by elementary school counselors (Carlson, 1992; Carlson, 1987; Fine, 1992; Fine & Holt, 1983; Plas, 1992, 1986). Many authors advocate school counselor intervention with parents and families (Amatea & Sherrard, 1997; Bowen & Glenn, 1998; Fine & Gardner, 1997; Hinkle & Wells, 1995; Nicoll, 1984; Palmo, Lowry, Weldon & Scioscia, 1988; Peeks, 1997b). In general, elementary school counselors have been reluctant to use family systems counseling in the schools. Three factors account for this: the counselors' lack of training in family counseling techniques, the misconceptions of the significant amount of time required for family counseling, and the view held by many in the schools that family counseling is beyond the scope of services that should be provided by elementary school counselors (Simington, 1996).

Research conducted in settings other than schools has borne out the fact that family systems counseling is a preferred treatment for children with learning disabilities and their families (Hansen & Okun, 1984; Spacone & Hansen, 1984; Kaslow & Cooper, 1978; Klein, Altman, Dreizen, Friedman, & Powers, 1981a, 1981b; Margalit, 1982; Perosa & Perosa, 1981). Considering the influence of the family system upon children with learning disabilities, the role of families in the treatment of children with learning disabilities has become increasingly evident. Elementary school counselors typically provide individual counseling for children with learning disabilities and consult with their parents. Although individual counseling with children with learning disabilities may result in some temporary relief to the family systems, the previous homeostatic balance the family has maladaptively developed is still maintained. Without altering the patterns of family interaction, the children's presenting behaviors will not change (Carns & Carns, 1997; Cerio, 1997; Kraus, 1998).

Children with learning disabilities require more help in social, emotional and academic development, both at home and at school, to be considered a success by society when compared with other children. However, today's stressful and fast-paced society has reduced the amount of time and energy that families of learning disabled children can spend to foster their development at home. As a result, children with learning disabilities typically display more social, emotional and family problems than do children without learning disabilities. Anxiety is identified as a universal problem for children with learning disabilities (Salon, 1981). Poor concentration, short attention span, distractibility, aggressive behavior and depression are concurrent symptoms of a learning disability. Additionally, Salon (1981) identified three maladaptive reactions often displayed in children with learning disabilities: withdrawal, regression and clowning. These symptoms and maladaptive reactions make life changes and daily tasks very threatening for children with learning disabilities.

Many authors (Day & Moore, 1976; Kaslow & Cooper, 1978; Lombana, 1992; Perosa, 1980) determined common family dynamics and patterns of interaction that contribute to learning difficulties. When families react maladaptively to children with learning disabilities, several patterns appear to be prevalent. Overprotection and control on the part of one parent, usually the mother, is a consistent finding. The second parent then becomes distant and left out. The result is strain and discord in the marital dyad and reinforcement of children with learning disabilities and their emotional and social problems. The families become enmeshed and rigid, avoiding conflict and its resolution by deferring attention to the children (Spacone & Hansen,

1984). In order to alter these dysfunctional patterns of interaction, the entire family system needs to be included in interventions.

Public policy makers have also taken an interest in systems theory and the use of family systems intervention for many types of school services and problems (Woody & Woody, 1994). These family systems interventions impact school counseling programs; "virtually every school counseling program can reasonably be expected to adhere to the tenets of family and social systems interventions" (Woody & Woody, 1994, p.20). America 2000 (Doyle, 1991) is a federal education policy utilizing systems theory. Adhering to the systemic belief that children will have a more successful school experience when their parents are involved in their children's education, America 2000 advocates parents' rights and responsibilities to make decisions affecting their children's education. By instituting America 2000, the federal government recognizes the parents' influence and impact on children and endorses systemic interventions in the schools. Children who benefit most from these types of reforms and parent involvement are learning disabled children (Peeks, 1997b). Elementary school counselors must therefore include systems theory and the family system in their counseling programs, especially when intervening with families of children with learning disabilities.

Combining the concepts of school counselors providing family counseling and family counseling being the treatment of choice for families of children with learning disabilities, this study explored the experiences of elementary school counselors while providing family counseling with families of children with learning disabilities. In addition, this study investigated the feasibility of employing a family counseling approach as a part of school counseling programs.

Background of the Problem

Learning Disabilities

Most children with learning disabilities experience academic, social and behavioral difficulties. If these problems become acute, they often result in long-term negative effects on the children's learning, self-esteem, interpersonal relationships and behavior. To prevent such problems from intensifying, elementary school counselors are generally asked to determine what personal and social problems interfere with the children's success at school (Amatea, 1988; Golden, 1983; Shields & Green, 1996; Williams, Robinson & Sinaby, 1988). Diagnosing the nature of these problems requires gathering information about all aspects of these children's

lives. Following this, planning effective interventions for helping the learning disabled children requires that elementary school counselors consider not only the nature of the learning disability but also all of the persons and situations in school and at home which may affect the children's development and learning.

Learning disabilities are often defined as a heterogeneous group of disorders manifested by a range of symptoms and a variety of school related problems (Hamill, Leigh, McNutt, & Larsen, 1981; Pfeiffer, Gerber, & Reiff, 1985). Despite extensive research investigating learning disabilities, the etiology, symptomology, definition and diagnosis are still ambiguous and lack consensus among professionals (Mercer, 1996; Tucker, Stevens & Ysseldyke, 1983). In addition, the lack of clarity surrounding learning disabilities has resulted in diagnoses based largely on underachievement, with little attention to other diagnostic and definitive criteria (Kirk & Kirk, 1983).

Systems Theory

According to Schultz (1984), Bertalanffy, an organismic biologist, developed the general systems theory as a scientific way of thinking about and conceptualizing the world. In systems thinking, the individual is not to be considered in isolation, but as a part of a system that impacts on the individual. The behavior of a person is explained in terms of its relationship with the other parts of the system and its function for the whole system (Schultz, 1984). In using general systems theory to view the family, the family becomes the unit or system, and individual behavior is seen in terms of the family system.

Systems theory requires a reorganization of thinking, involving a shift from linear causality to circular causality (Becvar & Becvar, 1982). In linear causality an event is caused by one, and only one, other event. However, circular causality allows for several cause-and-effect sequences, making circular causality a vital concept for understanding and applying systems theory to the family. For example, in linear causality the husband's drinking causes the wife to nag. In circular causality, the behaviors are reciprocal; the wife's nagging influences the husband's drinking, and the husband's drinking influences the wife's nagging.

Linear etiology has proven ineffective for identifying and clarifying factors related to the etiology, characteristics, symptomology and maintenance of learning disabilities. Therefore, an integrative and ecological approach to the study of children with learning disabilities is necessary. The circular causality of family systems theory emphasizes an interactive process with the

environment, individual family members and the entire family in the development and maintenance of symptoms and problems in children with learning disabilities.

The primary system to which children belong, the family, has great impact on their development and, therefore, should be included in the counseling process. Families play a vital role in the children's success in school (Nicoll, 1997; Mullis & Berger, 1981). Research has demonstrated the relationship between academic achievement in school and the affection, communication and power structure patterns existing within family systems (Nicoll, 1984; Rutter, 1985; Steinberg & Elmen, 1986). Family systems theorists believe that academic, behavioral and social difficulties in children with learning disabilities emanate from within family systems.

Research

Several researchers (Day & Moore, 1976; Ditton, Greene, & Singer, 1987; Kaslow & Cooper, 1978; Perosa, 1980) observed that families with learning disabled children display transactional and relational dynamics different from those of families with non-learning disabled children. The dynamics of families of children with learning disabilities are often characterized by poor communication between the parents (Ditton et al. 1987). Researchers also proposed that the presence of children with learning disabilities in the family can greatly affect parental perceptions and attitudes toward the children and, in turn, affect family dynamics. As a result of these difficulties within families of children with learning disabilities, the associated symptoms of the learning disabled children and the family interaction patterns are maintained or exacerbated.

Many studies addressing the relationship and transactional dynamics of families with children with learning disabilities focus on the mother-child dyad (Dean & Jacobsen, 1982; Humphries & Bauman, 1980; Klein et al., 1981a, 1981b; Kohn & Rossman, 1974; Maestos, 1981; Staver, 1953). Perosa (1980) used Minuchin's (1967, 1978, 1984) structural theory to design a self-report instrument to measure dimensions of family system dynamics. Perosa (1980) found significant differences on several dimensions of family interaction patterns. The dimensions of family interaction patterns are: enmeshment, disengagement, overprotection, neglect, conflict resolution, conflict avoidance, conflict expression- without resolution, flexibility-rigidity, parent-management, triangulation, parent-child coalition and detouring. (See definitions for structural family counseling at end of chapter.)

Pfeiffer, Gerber and Reiff (1985) discussed a rationale for a family systems intervention with families of children with learning disabilities. "The consequences of a learning disability

can cause dysfunction at three interrelated levels: (1) the cognitive and affective growth of the children in school; (2) the cognitive and affective growth of the children in the family; and (3) the psychological 'health' of the whole family. The family systems approach recognizes the dynamic and reciprocal nature of these three levels" (Pfeiffer, Gerber, & Reiff, 1985, p.63). The family environment affects much of the children's school behavior. Children's problems in school will tend to increase at times of strain in the family and will be more amenable to improvement when the family is functioning more smoothly (Pfeiffer & Tittler, 1983).

Statement of the Problem

Intervening with children with learning disabilities is a standard function and practice of elementary school counselors. At present elementary school counselors play a key role in intervening with children with learning disabilities about issues such as poor self-concept, social, behavioral and emotional difficulties. Counselors address these issues primarily by providing individual and/or group counseling for the children with learning disabilities and brief, periodic consultation with their parents and teachers. These approaches can help in assisting the children with their identified problem. However, these brief periodic consultations with parents and counseling the child are too often inadequate interventions for bringing about lasting changes. Research findings suggest that family counseling is effective in helping children with learning disabilities. Literature also supports a systemic approach in counseling children in the schools. In view of the great influence parents and other family members have upon children, it is essential that elementary school counselors include in the counseling process all individuals that impact significantly on the student's life. To be successful in counseling children with learning disabilities in the schools, elementary school counselors need to counsel them and their families as a single system.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) Board now recognizes family counseling as an important part of school counselor responsibilities. The CACREP Board requires accredited counselor education programs to incorporate family systems counseling as part of their program requirements. In order to implement family counseling training in all school counselor education programs, research is needed to explore the feasibility of school counselors providing family counseling.

Purpose of the Study

The purpose of this study is to gain an in-depth understanding of elementary school counselors' experiences and perceptions using family counseling as an intervention with families of children with learning disabilities.

Theoretical Basis

Family dynamics are consistently identified in the research as important factors in the academic and behavioral adjustment of children and adolescents. Milner (1951) observed that early reading success is correlated with family interaction patterns such as direct and frequent verbal communication, open expression of positive affect, parental discipline style and home training in responsibility and cooperation. Johnston and Zemitzsch (1997) summarized the research on children's achievement by stating that most of the research on children's achievement is related to family functioning.

The difficulties experienced by learning disabled children are often viewed in linear, causal, blaming ways (Bergman, 1985; Fine & Holt, 1983). These linear ways of thinking allow individuals to project blame, assign faults and accuse others to take responsibility for their actions (Johnson & Zemitzsch, 1997). Thus, the intervention focus is then on the "emotional crime" rather than making plans for changes in children's behavior (Minuchin, 1974). Instead of a linear perspective, schools and families need to understand that children's behaviors do not occur in isolation. People inadvertently relate in cycles of behavior that maintain problems. In order to understand these cycles of behavior, counselors and family members need to engage in systematic thinking in which events are explained within the context of interpersonal relationships. The focus is no longer on individual children's characteristics, but on the connections and relationships within the family. Circular thinking pertains to each person's functioning within children's milieu and has the potential for changing not only children's misconceptions of reality, but also those misconceptions of parents and teachers (Johnson & Zemitzsch, 1997).

Family systems theory provides an interactive model including the various subsystems impacting upon the children such as school, peer, family and community, and focuses on the change within and among systems. From the perspective of systems theory, dysfunction in children occurs if the two main systems, school and home, clash in their expectations of children and how the children should learn (DiCocco, 1986; Lusterman, 1986; Power & Bartholomew,

1987). A systems perspective of reciprocity and interaction explains how an identifiable personal deficit (e.g., deficit decoding skills and poor vocabulary) may be exacerbated by system difficulties, but without these system difficulties the learning disability would not exist (Fish & Jain, 1997).

Research Questions

1. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to counselors obtaining families to participate in family counseling?
2. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to family members attending counseling sessions?
3. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the procedures and logistics involved in family counseling as a part of the school counseling program?
4. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the changes observed by the counselors in the children and families during the period of family counseling?
5. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the education and counseling experiences the counselors believe necessary in order to provide family counseling as a regular part of the school counseling program?
6. What are the experiences and perceptions of elementary school counselors while providing families counseling to families of children with learning disabilities in regard to continuing to provide family counseling as a regular part of the school counseling program?

Need for the Study

Numerous researchers have focused on the utilization of a systemic approach for resolving children's academic, social, emotional and behavioral problems at school (Amatea & Sherrard, 1997; Carlson, 1992; Carns & Carns, 1997; Cerio, 1997; Donigan & Gilio, 1971; Edwards & Foster, 1995; Fine, 1992; Fine & Gardner, 1997; Fish & Jain, 1985, 1997; Hinkle &

Wells, 1995; Lusterman, 1986; McDaniel, 1981; Mullis & Berger, 1981; Nicoll, 1997; Palmo et al., 1988; Peeks, 1997a, 1997b; Perosa & Perosa, 1981; Pfeiffer & Tittler, 1983; Plas, 1986; Quin & Cowie, 1995; Sawayzky, 1993; Widerman & Widerman, 1995; Wilcoxon, 1986; Wilcoxon & Comas, 1987; Woody & Woody, 1994). A number of articles have also described case studies in which systems principles are used to solve student problems in schools (Amatea, 1988; Amatea & Fabrick, 1981; Carlson, 1987; Margalit, 1982; McComb, 1981; Peeks, 1997a).

Although the number of studies conducted on family counseling has grown tremendously over the last two decades, very little research has been done about school counselors conducting family counseling in the schools, and the research that has been done focused on the use of brief family interventions instead of family counseling (Amatea, 1988; Dewitt, 1980; Gurman & Kniskern, 1981; Peeks, 1997a; Stone & Peeks, 1986; Simington, 1996). In addition, these studies are by individuals from outside the school setting who come into the schools to conduct family counseling interventions and research (Casey & Buchan, 1997; Carlson, 1987; DiCocco, 1986; Evans & Carter, 1997; Fine & Holt, 1983; Millard, 1997; Morrison et al., 1997; Perosa & Perosa, 1981). An important component of this research is that elementary school counselors conduct the counseling for the study.

Significance of the Study

The researcher of this study seeks to gain an in-depth understanding of school counselors' experience while providing family counseling for families of children with learning disabilities in elementary schools. The researcher will look at the procedures and logistics involved in obtaining families to participate in family counseling and in providing family counseling in the schools. If the intervention of family counseling is helpful and feasible, elementary school counselors may consider implementing family counseling programs in their schools. Counselor educators will be able to use the information from this study to implement training and supervision in family counseling as part of their school counseling preparation programs.

Definitions

1. Family – A group of two or more people related by birth, marriage or adoption and residing together (United States Bureau of Congress, 1988; Hartman, 1993). All other household units are considered non-family (Poverny & Finch, 1988). Although this definition rules out many who would define themselves as family, it is probably the broadest of existing public

policy definitions and the one most commonly accepted (Hartman, 1993). For the purposes of this study, the school counselor will determine which family members are to participate in the family counseling. A minimum of one parent/guardian and one child with learning disabilities will be considered a family to participate in the assessment and treatment component of this study.

2. Family Counseling or Family Systems Counseling – The family systems approach to intervention and treatment presents problems and dysfunctions as emerging from a systemic frame of reference. The dysfunctions are maintained by the relationship within the family system, rather than from within the intrapsychic process of the individual (Levant, 1984).
3. General Systems Theory – An organization of principles, constructs, and assumptions used to describe regularities and redundant patterns observed between people and other phenomena (Becvar & Becvar, 1982).
4. Learning Disability – A diagnosis whereby the person's achievement on individually administered standardized tests in reading, mathematics or written expression fall substantially below that expected for age, schooling and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical or written skills. Substantially below is usually defined as two standard deviations between achievement and IQ. In cases where performance on an IQ test may have been compromised by an associated disorder in processing, a medical condition or mental disorder, or ethnic or cultural background, a smaller discrepancy between achievement and IQ may be used. When a sensory deficit is present, the learning difficulties must be in excess of those usually associated with the sensory deficit (DSM-IV, 1994, p.46).
5. Parental Perceptions – When parents generalize the learning disability to the totality of the child, which results in perceptions of the child being weak, bad, or inept (Kaslow & Cooper, 1978).
6. Structural Family Counseling – An interactional counseling perspective that embraces the here-and-now focus of Minuchin's (1967, 1974, 1978, 1992) structural theory. In structural family counseling, the main focus of diagnosis and change are the organizational features of the family and the transactional sequences among family members.

a) Conflict Avoidance and Diffusions – This interaction pattern occurs when family members avoid making decisions, resolving conflicts and settling arguments. Family members deny any conflicts within the family.

b) Enmeshment – The extent of family interactions in which the family members are dependent upon one another.

c) Over-protectiveness – A display of nurturant-protective behaviors and protectiveness-eliciting behaviors in the family.

d) Rigidity – The extent of family interactions in which alliance patterns are flexible in relation to functional or objective tasks and topics rather than remaining fixed or bound regardless of the issue.

7. Supervision – Counseling or clinical supervision that is provided by a trained supervisor of counselors (not administrative supervision provided by the school principal).

CHAPTER 2
LITERATURE REVIEW

This chapter presents literature on the use of structural family counseling in working with families of children with learning disabilities. The literature is discussed in terms of the following categories: family counseling in the schools, family counseling of families of children with learning disabilities, systems theory, structural family theories, the family system of the learning disabled child and learning disabilities.

Family Counseling in the Schools

One emerging trend for schools is an increased emphasis on cooperation between school and family (Keyes, 1997). In the past 10 years, there has been a surge in the literature on school and family partnerships (Chavkin, 1993; Evans, Evans & Schmidt, 1989; Kellaghan, Sloane, Alvarez, & Bloom, 1993; Kindred, Bagin, & Gallagher, 1990; McConkey, 1985; O'Callaghan, 1993; Procidano & Fisher, 1992; Swap, 1993). Three reasons for the increased emphasis on the family are: a) numerous research findings highlighting the important contributions of the home to children's school progress, b) unsuccessful school reform efforts focusing on schools in order to improve student achievement and c) increasing pressures on families resulting in concerns about families' ability to provide the conditions that foster children's scholastic development (Kellaghan et al., 1993). These reasons, in addition to findings showing family interventions have been effective in treating the social, emotional and behavioral problems of children (Amatea, 1989; Carlson, 1992; Fine 1992; Golden & Capuzzi, 1986; Lewis, 1996; Simington, 1996) have led to an increased interest in including families in interventions.

Family Dynamics and Student Adjustment

Several researchers have investigated the importance of the family in student adjustment (Forehand, Long, & Brody, 1988; Rutter, 1985). Rutter (1985) suggested that environmental effects on cognitive development were relatively modest, but that the effects of strong negative family situations were substantial. Forehand et al. (1986) examined the relationship between home variables and young adolescents' school behavior and performance. Results indicate that both academic performance and problem behavior in school are related to the parent-adolescent relationship and/or maternal depression. Data also suggested that both mothers and fathers

were influential in inhibiting or stimulating school performance and adjustment. Working with a sample of almost 1,000 eighth graders, Epstein, Beck, Farkas, Kazdin, Daneman and Becker (1981) investigated the effect of family and classroom environments on student attitudes and academic achievement. Importantly, results suggested that family processes were more powerful than classroom processes in producing change in children.

School-based Family Interventions

Researchers have explored the efficacy of school based family interventions (Goodman & Kjonaas, 1984; Nicoll, 1984; Palmo et al., 1988; Wilcoxen & Comas, 1987; Williams, Robinson, & Smaby, 1988). Historically, school counselors have referred clients with issues needing family counseling to community agencies (Bobele & Conran, 1988; Braden & Sherrard, 1987; Ritchie & Partin, 1994). However, research has shown that only 30% of the families referred to outside agencies actually followed through and only 8% continued beyond two sessions (Bloss, 1995).

According to Nicoll (1984), one of the advantages of school-based family interventions is an equal opportunity for families from all income levels to receive services. A second advantage is that the school counselors' position within the school enables greater communication and consultation with all significant adults involved with child. Getz and Gunn (1988) presented a rationale for incorporating family systems knowledge into the assessment in schools to determine the most appropriate intervention. Factors to consider include family communication patterns, emotional distance between family members and the family role structuring. The authors suggested that families be assessed to determine whether parent education or family counseling would be the most beneficial. The authors concluded that awareness and analysis of family-systems dynamics are very important for school counselors who work with children.

Traditionally, the school counselors' contact with parents whose children have learning disabilities has been to consult with the parents about their child-rearing concerns. Through consultation and parent education programs, school counselors are able to assist with parenting methods. For learning disabled children, this level of home school interaction may not be enough. Lombana and Lombana (1982) have developed a hierarchy of intervention levels between parents and counselors. Parent involvement, parent conferences, parent education and finally, parent counseling represent the increasing levels of interaction between parents and school counselor. Each increasing level requires more time, energy and resources. Family

counseling requires the highest level of interaction but provides the greatest level of effectiveness (Lombana & Lombana, 1982). By involving parents in family counseling, the school counselor can intervene in both the school and family systems to bring about change (Scovern, Bukstel, Kilmann, Laval, Busemeyer & Smith, 1980).

A few researchers (Beck, 1984 ; Bloss, 1995 and Samis et al., 1993) have attempted to identify the school-based family intervention practices of school counselors. Beck (1984) surveyed 117 school counselors (elementary, middle and junior high) and 30 counselor educators in Milwaukee. She found that 78.3% of the responding counselor educators and 81.5% of the responding school counselors saw a need for family counseling in the schools. Furthermore, she found 40.4% of the school counselors believed they should do more family counseling and 69.6% of the counselor educators believed school counselors should do more family counseling. Bloss (1995) surveyed school counselors across the United States and found discrepancies between what school counselors do and what they consider to be appropriate. Bloss (1995) found school counselors would like to use all forms of school-based family interventions. Samis et al. (1993) surveyed 250 British-Colombian elementary school counselors, found that 249 school counselors reported all the following family interventions should be provided; parent education, parent consultation, parent counseling, family consultation, family counseling and family therapy.

Family Counseling in the Schools

As systems theory and family therapy have become more well known in the counseling profession, there has also been an increase in the number of school counselors utilizing these concepts (Kraus, 1998). Donigian and Giglio (1971) reported a counseling program that assigned school counselors to family units rather than to the traditional grade, sex or alphabetical assignments. This program represented one of the earliest uses of general systems theory and family counseling in the school setting. Recognition of the individual in a larger social context was critical to the development of this program and to setting the initial stage for the use of systems theory and family counseling in the school counseling programs.

Widerman and Widerman (1995), expanding on the systems perspective of Peeks (1993, 1997b), stated that "family oriented, systemic, school-based counseling replaces the individual child with the entire family system as the unit of analysis and relocates the locus of change to the classroom and the home, with the family system conceptualized as the source of learning (p.72)." Edwards and Foster (1995) advised school counselors who use family strategies which

involve the family and school systems of their unique position and role in this process. Counselors need to be aware that the family and school systems may hold two very different views of the problem and are committed to different solutions.

A review of the current school counseling literature reveals recognition of the need for family counseling in the schools (Casey & Buchan, 1997; Hinkle, 1993, 1997; Johnston & Zemitzsch, 1997; Kraus, 1998; Millard, 1997). Considering the limited amount of time school counselors have for treatments, Carns and Carns (1997) believe the use of systems theory and family counseling techniques have proven to be a very promising treatment. Carns and Carns (1997) and Lewis (1996) proposed that families become the primary focus of treatments by school counselors. To view children who are experiencing difficulties in school within the context of the family can be most beneficial. School counselors are in a unique position to provide family counseling since they have contact with all aspects of both school and family systems. It is unlikely that the school counselor will have success intervening with a child unless the family, the child's primary social system, is involved (Lewis, 1996).

Employing family systems theory and techniques in analyzing presenting problems has become increasingly popular among school counselors. Nicoll (1997) presented a counseling consultation model to provide school counselors with a practical, step-by-step format for assessment and intervention with student difficulties. The model consists of an average of three sessions, each of which is approximately 45 minutes in duration and which focuses on family dynamics and classroom interaction patterns. Morrison, Olivos, Dominguez, Gomez and Lena (1997) presented a systems approach to resolving school behavior problems. Their approach uses several established family systems models, including Structural-Communication, Strategic, and Solution-Focused, to develop a discipline board to address these problems from a systems perspective. Lastly, Cerio (1997) discussed the use of family systems theory applications by a school counselor assisting a school phobic.

Counselors also need to take a more active role in working with and empowering families (Lewis, 1996). Although individual counseling may bring about temporary relief to the family system, the homeostatic balance in the family is still maintained. Without altering the patterns of interaction, within the family, the presenting behaviors will not change. In order to intervene successfully for more permanent improvements, counselors need to play a role in helping families and schools understand systems and determine how to break cycles of destructive behavior patterns.

There has been increased interest in the use of family counseling by school counselors. (ESGC, 1981). McDaniel (1981) discussed the "unique" use of family systems concepts to help reduce children's problems in the school setting. Amatea and Fabrick (1981) also advocated family counseling as an alternative to more traditional school counselor interventions such as individual and group counseling and consulting with parents. McComb (1981) noted that family counseling in the school setting must be based upon adequately trained counselors, judicious and timely applications of appropriate family counseling procedures and the consent and cooperation of school administrators.

The April 1993 issue of Elementary School Guidance and Counseling, a professsional journal published by the American School Counselors Association, focused entirely on the relationship between parents and schools and the roles of school counselors. Many of the articles in this issue addressed the importance of school counselors providing family counseling. Hinkle (1993, 1997) described a process to train school counselors to do family counseling. He also identified ways for school counselors to receive the necessary training in family counseling, such as in-service training, continuing education courses, conferences, and professional workshops. Peeks (1993, 1997b) cited a need for school counselors to incorporate systems perspectives and Hinkle indicated the increasing need for counselors to include families in their work.

As a part of the growing trend toward full-service schools, some model programs which include family services and family counseling have begun to be implemented in public and private schools across the nation (Fine & Carlson, 1992). These include programs in the Topeka Public Schools in Kansas, the "New Beginnings" program in San Diego, California, "Project Touch" in the Los Angeles beach cities, and the "Murchison Street Family Center" project in East Los Angeles. Although these programs are implemented in the schools, counselors not affiliated with the school systems provide the family counseling.

School counselors have provided brief family counseling and it has been documented. Simington (1996) designed a brief strategic family intervention for school counselors to use in working with middle school children who exhibited behavior problems. Evans and Carter (1997) described a program at California State University in which school-based family counseling has been implemented in an urban school setting. The counselors who implemented the school-based family counseling model were graduate students who were pursuing both their master's degrees in marriage and family counseling and school counseling credentials. This

program improved the success of children in the classroom by maximizing parental and community involvement. The program consisted of classroom-focused interventions and fostered the school-family-community connection. The program however provided only brief family counseling. If more assistance was needed, families were referred out for services.

Role of the School Counselor

The American School Counselors Association (ASCA) defines the school counselor as "a certified professional educator who assists students, teachers, parents, and administrators." Three generally recognized helping processes used by the counselor are counseling, consulting and coordinating (ASCA, 1997). According to ASCA, the primary goal of the school counselor is to assist students in reaching their highest potential (Ginter, Scalise & Presse, 1990). Extending services beyond students to include parents and families is essential for achieving this goal.

A review of the literature indicated a trend toward school-based family interventions and the need for school counselors to develop a working knowledge of systems theory and practice (Amatea, 1989, 1990; Amatea & Fabrick, 1981; Dowling & Osborne, 1985; Fine & Carlson, 1992; Fine & Gardner, 1997; Getz & Gunn, 1988; Golden, 1983; Golden & Capuzzi, 1986; Goldenberg & Goldenberg, 1981; Goddman & Kjonaas, 1984; Shields & Green, 1996; Hinkle, 1993, 1997; Lambie & Daniels-Mohring, 1993; Nicoll, 1984, 1992, 1997; Palmo et al., 1988; Peeks, 1989a, 1989b; Perosa & Perosa, 1981; Sawatzky, Eckert, & Ryan, 1993; Walsh & Giblin, 1988; Wilcoxon, 1986; Wilcoxen & Comas, 1987; Williams et al., 1988). Wilcoxon and Comas (1987). Palmo et al. (1984) demonstrated the growing need for school counselors to be involved in family counseling with their clientele. Three prerequisites for providing effective family interventions were discussed, including additional training and adequate supervision for school counselors and more confidence in their abilities as family counselors. A primary benefit of the family systems approach is that school counselors would be able to explore family dynamics in depth rather than working only with the surface symptoms children present in the classroom (Palmo et al., 1988).

Barriers to School-Based Family Interventions

Various authors have discussed barriers which could prevent school counselors from providing school-based family interventions (Hinkle, 1993; Kraus, 1998; Palmo et al., 1988; Samis et al., 1993). Samis et al. (1993) surveyed elementary school counselors to determine barriers to school-based family intervention and identified the counselors' work load and work

schedule to be the greatest barriers. Other barriers were inadequate administrative support, attitude of school administrators, teacher attitudes, counselors' theoretical orientations, parent reluctance, lack of facilities, and insufficient training. Similarly, Beck (1984) found work-load, lack of training, and time constraints as the barriers most often reported by school counselors. One critical issue is that many school counselors have received little or no training in working with families (Hinkle, 1993; Palmo et al., 1988). In fact, some school counselors may have had little or no supervised experience working with adults.

Palmo et al. (1984) discussed a number of changes which may be necessary to advance school-based family interventions. These changes include: flexibility in scheduling to allow counselors to meet with families during evenings, Saturdays, and summer months; accessibility of counselors to families requesting family services; and availability of counselors as 12-month employees in order to maintain a consistent family counseling program. Samis et al. (1993) further suggested: (a) reducing the counselor/pupil ratio, (b) providing more counseling (rather than non-counseling responsibilities), (c) hiring more counselors, (d) increasing opportunities for training and supervision, (e) providing appropriate facilities for family interventions, (f) redefining and clarifying the counselor's role, and (g) offering more flexible work hours.

Family Systems Theory

Bertalanffy, an organismic biologist, developed the general systems theory as a scientific way of thinking and conceptualizing the world (Schultz, 1984). Although derived from the physical sciences systems theory may be applied to the conceptual framework of counseling. In systems thinking, the individual is not to be considered in isolation, but only as a part of a system that impacts on the individual. The behavior of a person, or the part, is explained in terms of its relationship with the other parts and its function for the whole (Schultz, 1984). In using general systems theory to view the family, the family becomes the unit or system and individuals are seen as a part of the family system. All the concepts of systems theory are applicable to the family system.

Circular Causality

Systems theory requires a reorganization of thinking, involving a shift from linear causality (a cause and an effect) to circular causality (Becvar & Becvar, 1982). In linear causality an event is being caused by one and only one other event. However, circular causality allows for several cause-and-effect sequences, making circular causality a vital concept for understanding

and applying systems theory. For example, in linear causality the husband's drinking causes the wife to nag. But, in circular causality, the behaviors are reciprocal; the wife's nagging influences the husband's drinking, and the husband's drinking influences the wife's nagging. Applying circular causality, individual behavior is seen as being influenced by the individual family members and the family system as well. Circular causality and how it applies and relates to other systems concepts is imperative in understanding this theory.

Boundaries

According to systems theory, boundaries establish invisible limits that influence the other system components. These invisible demarcations between subsystems and systems determine who is considered an insider and who remains an outsider to the system. Boundaries act as psychological limits to help individuals recognize what is acceptable and not acceptable within the system, what one may and may not do within the system. In the family system, boundaries define relationships, roles and patterns of interaction among family members and subsystems to provide the family system and subsystems with its unique identity, function and relationship patterns (Becvar & Becvar, 1982). Boundaries are invisible, but nevertheless delineate individuals and subsystems and define the amount and kind of contact allowable between members of the family (Becvar & Becvar, 1993). In other words, boundaries imply rules of preferred relationships between subsystems in the family (Becvar & Becvar, 1993). For example, parental subsystems and children subsystems are defined and distinguished by boundaries. The roles of the subsystems are unequal, and the rules for interaction place the parental subsystems in charge.

Rules

The rules according to which a system operates are comprised of the characteristic relationship patterns within the system (Becvar & Becvar, 1993). Rules "express the values of the system" and what is acceptable or expected in the system; they become the guiding principles to determine system functioning, conduct and action (Becvar and Becvar (1982). Thus, rules provide structure and establish roles within the system, distinguishing it from other systems (Becvar & Becvar, 1982). In addition, each part, the subsystems, has a unique role that is largely defined by rules determined by the system. Family rules determine a sequence of normative behavior patterns and expectations (Becvar & Bacvar, 1993). The rules are used by individuals within a system as points of reference to guide their role within the family system and to help define the subsystems and the roles of each subsystem. Rules play an important part in

determining the psychological environment of the family system. Rules evolve over time, usually determined by the parental subsystem, to maintain equilibrium and family functioning. Examples of rules may include; family dinner always served at 6:00 p.m., certain expectation about school performance or certain family members responsible for specific chores.

Progressive Segregation

Ackerman (1984) referred to progressive segregation as a "process whereby an organization is built up out of a uniform whole consisting of differentiated parts increasingly independent of one another." Progressive segregation establishes that the system is made up of many independent parts working together for the good of the system. A common example of this concept can be found in the development of organs, where cells exist individually and multiply or reproduce for the larger tissue or organ. Progressive segregation also refers to the differentiation of the system, as it becomes increasingly complex. In family systems, progressive segregation begins with the formation of the basic family unit, the couple, and continues with the many different stages of family development. The family system becomes more complex when children are added to the marital unit, requiring adjustments to maintain the family system as the family progresses from couple in the marriage stage to the stage of families with young children (Carter & McGoldrick, 1989). Initially, the couple must learn to negotiate and determine function and roles in the household for themselves and then re-negotiate with the birth of a child. With the birth of a child, progressive segregation becomes especially important to cope with the changing roles of mother and father while still maintaining the couple. This becomes a critical point in the system as it begins to differentiate into smaller parts while maintaining itself as a whole (Ackerman, 1984). The subsystems instantly multiply; the husband and wife subsystem are now a mother and father subsystem, a wife and child subsystem and a husband and child subsystem.

Centralization

Centralization refers to making changes in the vital parts of the system, which consequently create change in the non-centralized parts of the system (Ackerman, 1984). Since each system has certain central duties required for the continued existence of the system, changing the essential central duties will influence the more peripheral duties of the system as well. Ackerman (1984) defined centralization as the "function of the system where leading parts or central duties of the system form in such a way that small changes in one part produce large changes in other parts" (p.19). Similar to progressive segregation, the initial centralization occurs

when a couple gets married and begins a life together. At this time, the marriage becomes the most important part of their lives. The birth of a child causes the couple to adjust their existing lifestyle to accommodate to all the demanding needs of a newborn. Therefore, the couple has to centralize the new responsibilities entailed in caring for the newborn into the family system.

Equifinity

Equifinity refers to the fact that a given organismic state may have evolved from any of several different initial stages among multiple paths (Schultz, 1984). In other words, there is more than one route or pathway to get to the same destination. In considering systems, numerous possibilities exist for the explanation of how the system evolved. The concept of equifinality within the family system pertains to the influence of parents on children, children on parents and spouse on spouse. Although it is widely acknowledged that parents influence the development of their children, equifinality recognizes the often forgotten effect of children on their parents. This concept is also incorporated into other basic concepts of systems theory. For example, the parents, as a result of interactions with the child, can create boundaries and rules in addition to the commonly held belief that these dynamics are passed to the child from the parents.

Homeostasis

Homeostasis is a self-preservation mechanism that minimizes change and instability in systems in order to maintain a balanced nature (Schultz, 1984). Systems approach a stable state in order to institute the principle of minimal effect. Minimal effect refers to the reluctance encountered when altering the system functioning. In family systems, homeostasis is the family system's regulation or control mechanism. The homeostatic function in the family system is to maintain the status quo and resist change. Whether the system functions well or is dysfunctional, equilibrium is desired. In the family system, this homeostatic function can result in new behaviors to maintain the status quo (Ackerman, 1984). For example, if the problematic behavior of one family member who is viewed as the identified patient, is successfully treated, another member may develop problematic behavior, which maintains the previous patterns of interaction in the family. This typifies the system goal of resisting change and maintaining the status quo.

Family Counseling

Family counseling had its roots in the 1940s and 1950s (Guerin, 1976; Okun, & Rappaport, 1980). Ackerman, a psychoanalytically trained psychiatrist, is considered by some to be the grandfather of family counseling and the first documented as having interviewed a family together (Framo, 1979). This inclusion of the family in the treatment of the individual was the integration of systems theory in looking at the family. Ackerman then began to utilize intrapsychic phenomena and family system dynamics (Brown & Christensen, 1986).

The earliest research on family counseling investigated schizophrenia. The first family theorists and practitioners, the Palo Alto group, led by Gregory Bateson, focused on paradoxical communication in animals and humans (Okun & Rappaport, 1980). Building upon this research, Bateson, Jackson, Haley and Weakland (1956) coined the concept of the double bind. A double bind is defined as the "situation of a person who receives two related but contradictory messages at the same time, the response to either of which is inappropriate (there is no escape)" (Brown & Christenson, 1986). The concept was part of the movement to focus counseling on the interaction of individuals within the family system instead of upon the individual.

"Family counseling is a point of view . . . that finds its focus primarily in work with family systems. It regards problems and dysfunction emanating from the family rather than from the intrapsychic problems of any one individual" (Okun & Rappaport, 1980, p.31). Thus, family counseling is a method of intervening with individuals through treating the family system.

Symptomatic behavior in family counseling is seen as the linkage of an individual's symptoms to the entire family. The behavior of the identified patient serves a purpose in the family system. Regardless of treatment approach in the realm of family counseling, the entire family system must be included in the assessment and intervention of the identified client's problem (Okun & Rappaport, 1980). According to Framo (1979), the family can be viewed as an interacting unit where characteristics of systems, such as rules, alliances and communication patterns, can be witnessed in direct observation. This gives the counselor access to interactional patterns in the family which are usually not privy to an outsider.

Family systems approaches and theories are many and varied. <u>The Handbook of Family Therapy</u> (Gurman & Kniskern, 1995) includes over 15 chapters by authors and practitioners who have different ideas, points of emphasis or terminology for understanding and treating families. Breunlin and Schwartz (1986) argued that the family therapy field has evolved from

discrete models of treatment and understanding to approaches that are compared to identify a common denominator for treatment, understanding and observation.

The common denominator in family systems is that families are patterned and tend to repeat sequences of interactions numerous times. Haley (1976), a strategic theorist, defined a symptom as "a type of behavior that is a part of a sequence of acts between several people" (p.2). Haley (1980) also wrote, "The chief merit of systems theory is that it allows the therapist to recognize repeating sequences and so make prediction" (p.24). The importance of pattern and sequence to family therapy and theory is highlighted by Minuchin and Fishman (1981), structural family therapists, who stated "The family is a natural group which over time evolves patterns of interacting" (p.11).

Structural Family Counseling

Theory and Concepts

Salvador Minuchin, a systems theorist, developed a structural approach to family counseling. Structural family counseling is the approach most closely associated with Minuchin (1974). Minuchin's structural approach to treating families stemmed from his work on the Wiltwych project (Brown & Christensen, 1986). This project was conducted at the Wiltwyck School, a school for delinquent boys in New York City. This project focused on the "structure and process of disorganized, low socioeconomic families that had each produced more than one acting-out (delinquent) child" (Minuchin, Montalvo, Guerney, Rosman & Scumer, 1967, p. ix). Minuchin's work focused on families' structure and organization in relation to the dysfunctional behavior of individual members.

Like other systems theorists, Minuchin (1967, 1974) and Minuchin et al. (1978) viewed the individual within the context of the family and the psychological structure of the individual as interdependent with the person's social structure. Minuchin (1974) noted, "Pathology may be inside the patient, in his social context or in the feedback between them" (p.9). Family structure is the "invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, p.51). The transactional patterns make up the "family structure, which governs the functioning of family members," delineating their range of behavior and facilitating their interaction (Minuchin & Fishman, 1981, p.21). Minuchin postulated a constantly recurring sequence of interactions between the individual and the family environment. These reoccurring sequences and transactions regulate family members' behavior

and determine rules that govern how, when, and to whom to relate. The rules that organize and regulate family interactions define the family structure.

Structure of a family can be viewed as consisting of two general systems of constraint. The first constraint is referred to as generic; an observation that all families everywhere have a hierarchical structure of some form by which parents have more authority than children. An important aspect of this generic structure is the concept of reciprocal and complementary functions. This refers to the label given to family members to describe the roles and functions they serve in the family. For example, if one parent takes on the role of overly competent, the other parent could be described as incompetent. Other examples of parental complements include a parent who is too strict while the other one is seen as too nurturing, or one parent who is overly involved while the other is viewed as peripheral. These complementary and reciprocal functions enable the family to function and maintain equilibrium. Thus, the family roles evolve to balanced, logical complements. According to Becvar and Becvar (1993), "regardless of a member's description, or metaphor (tough, hard, good, healthy, etc.) one can discern another family member whose role in the family logically complements or assumes the opposite role and thus achieves a balance in the family (tender, soft, bad, sick, etc.)" (p. 191). The second constraint is that which is idiosyncratic to the particular family. Rules and patterns evolve with time, often over several generations and become part of the family structure. This structure can only be understood by observing processes within and between subsystems.

The family system differentiates and carries out its functions through subsystems. Subsystems refer to distinctive individuals, dyads, or triads who share unique characteristics in the family system (Schultz, 1984). In order to have a functional family, the rules among these subsystems need to follow hierarchy and appropriate boundaries. The subsystems are based primarily on interactions such as those between husband and wife, parent and child, and sister and brother. Each family member belongs to different subsystems in which the member has a different level of power, and the member learns differentiated skills. For example, a woman can be a wife, mother, sister, aunt or grandmother, each of which places her into a different subsystem. The organization and hierarchy of the family can be observed through these subsystems. Minuchin believed that problems in the family hierarchy contribute greatly to organizational problems in the family system. Hierarchial problems are manifested primarily when the naturally most powerful subsystem or individual is displaced by another subsystem or individual. An example of this is when children have more power in the family than the parents.

The members of the spousal subsystem must be mutually supportive of each other in the development of the other's interest. There should be give-and-take on both sides so that neither one is too accommodating. Each spouse should remain an individual, while they are respectfully bound together as a couple. The parental subsystem is the second subsystem described by Minuchin (1974). The addition of a child transforms the system and requires more negotiation. The demands of a child raise new negotiable issues, such as different parenting styles. The spousal subsystem exists around child-rearing issues and should not involve children. Once again there is a challenge to maintain a mutually supportive structure to ensure that the children get a clear message that the parents are in charge. A family is not a democracy, and children are not equal to parents. Finally, the sibling subsystem allows children to interact with each other. It is the social laboratory in which children can experiment with siblings to negotiate, compete, work out differences and support one another. Coalitions within a subsystem allow interaction with individuals different yet relative to one another. Coalitions within subsystems and clear boundaries between subsystems enhance the security and well-being of the family (Becvar & Becvar, 1993)

The subsystem is defined by boundaries, which are a set of rules concerning who participates and how. Schultz (1984) claimed that the key concept of structural family counseling is that of boundaries. Boundaries are the rules within the system and between individual family members and between the different parts (subsystems) of the family system. Studying the boundaries allows the structural family counselor to gain understanding and evaluate relationships and interactions of system members. Boundaries are used in assessing functioning of the family (Minuchin, 1974). The function of boundaries is to protect and maintain the differentiation of the system. Boundaries of the subsystems must be clear and free from interference from other subsystems for proper family functioning to occur. For example, negotiation skills are first learned in the sibling subsystem with no interference from the parental subsystem. These skills may then be used with peers.

According to Minuchin (1974), the notion of clarity of boundaries within a family is the most important parameter for evaluating family function. Where there is a boundary dysfunction, there will be a family dysfunction. Dysfunctional boundaries are enmeshed, extremely diffused and disengaged or inappropriately rigid (Minuchin, 1974). When a family is extremely disengaged or enmeshed, these dysfunctional boundaries mark areas of pathology (Minuchin, 1974). Members of enmeshed systems are poorly differentiated from the system,

thus losing their autonomy. Although enmeshed members are often characterized by a greater sense of loyalty and belonging, they often lack a sense of individuality. Boundaries are crossed, and roles never clearly differentiated. In this case, everyone is into everyone else's business. There is too much negotiation and accommodation. The spouse subsystem devotes itself almost totally to parenting functions, and as parents they spend too much time with children and do too much for them. As a result, children do not develop their own abilities (Minuchin, 1992). The family system becomes characterized by poorly defined roles and unclear, permeable boundaries.

Conversely, members of disengaged systems function with autonomy, but lack a sense of belonging and loyalty (Minuchin, 1974). Boundaries are rigid and impermeable to the extent that members are separated and isolated from each other (Minuchin, 1974). There is no room for negotiation between subsystems. In this context, children learn to fight their own battles and to negotiate without parents protecting, nurturing and supporting them. Family members are so involved in their own issues that they do not respond when others need them.

Subsystem boundaries may fall on a continuum between rigid and diffuse, with boundaries falling in the middle as the "normal range" (Minuchin, 1974). Ideally, subsystems are defined by clear and firm, yet flexible boundaries. When clear boundaries exist, family members are supported and nurtured yet allowed a certain degree of autonomy. In such cases, there is an ideal balance between support, nurture and inclusion, along with the freedom to experiment, individuate and to be one's own person. Clear boundaries increase communication and negotiation, and accommodation can occur successfully to bring about appropriate change in structure, rules and roles to maintain functional stability. In other words, parents and children belong, yet individuate. To define the clarity of the boundaries, all families can be placed on a continuum, ranging from rigid or disengaged to diffuse or enmeshed. However, the family with clear boundaries is better able to accommodate expected and unexpected change.

The family is seen as a dynamic, living system in constant transformation (Minuchin, 1986). Transformation is regulated by the interplay of homeostasis and change. Homeostasis determines the patterns of interaction which assure the stability of the system and maintain its characteristics at a given point in time. It maintains the status quo. Conversely, change is the accommodation that the system undergoes to adapt to environmental circumstances or developmental needs.

Coping with stress often brings about change in family behavioral patterns. Families may respond to stress by confronting the problem, accommodating the stressor, avoiding the

stressful area, or by repeated struggling among family members about problematic issues. A family's capacity to adapt to stress depends upon its ability to keep the boundaries of the system firm enough to provide security and differentiation of subsystems and roles, yet flexible enough to permit boundaries to be negotiated and realigned. If a family is unable to negotiate and realign boundaries to alter its structure at stressful points, dysfunctional symptoms will emerge.

According to Minuchin (1974, 1984, 1986), a process sometimes involved in adaptation to stress is triangulation. In triangulation, one member of a conflictual dyad (a subsystem of two) moves away from the other and connects with a third individual outside of the dyadic relationship, forming a coalition to gain an ally in conflict. Triangulation also occurs when a third person is sensitized to anxiety in one member of the dyad, or to a conflict in the dyadic relationship. The third person tries to defuse the anxiety or conflict. This is usually accomplished by the third party exhibiting problem behaviors or symptoms. In this way, the attention is directed away from the conflict or anxiety and toward the symptom.

The triangulated member may be a child who diffuses conflict and anxiety in the parental subsystem. The child's symptoms or problematic behaviors, if reinforced, become permanent. The triangulation enables the spouses to avoid their problems by focusing on the child's symptoms in a process called detouring. The spousal subsystem problems are then submerged in the problems of parenting. The role of triangulation, according to Minuchin (1974), was to maintain equilibrium or the homeostatic balance of the family's preferred interactional patterns.

<u>Process</u>

According to Becvar and Becvar (1993), the goals of structural family counseling are to:

- Create an effective hierarchal structure, parents must be in charge. Thus, there must be a generational gap based on parental/executive authority.
- Establish a parental executive coalition in which parents support and accommodation of each other to provide a united front to their children. As the parental/executive coalition forms, the sibling subsystem becomes a system of peers.
- Increase the frequency of interaction and move toward clear rather than rigid boundaries if the family is disengaged. Through this shift there would be an increase in nurture and support to complement the previous independence and autonomy characteristics of families with rigid boundaries.
- Foster differentiation of individuals and subsystems if the family is enmeshed. This

would reflect a respect for differences in developmental stages of the children and permissions for age-appropriate experimentation with independent activity.

- Establish a spouse subsystem as an entity distinct from the parental subsystem (Becvar and Becvar, 1993, p.204).

Minuchin (1974) identified three stages in structural family therapy: the therapist joins the family and assumes a leadership role; the therapist gains an understanding of the underlying family structure and the therapist transforms the family structure. The structural therapist must join the family and build a respect for its members and its way of organizing itself. The therapist acts as a friendly "uncle," offering suggestions, instructions and directives aimed at changing the family structure or patterns of interaction. The mutual acceptance between the family and therapist is essential to restructuring.

Structural family therapy is action-oriented and aims at influencing what happens in the therapy session (Becvar & Becvar, 1993). Even though the discussion is about events outside of the session, the therapist acts on what is going on in the session. The structural therapist respects the hierarchy of the family by asking for the parents' observations first. If the therapist asks for the child's observations first, the therapist might be rejected because of being viewed as siding with the child. The therapist begins modifying while observing and accepting. The therapist listens, reframes and transforms the family events into a systemic, structural framework.

Structural family therapy focuses on the here and now. The therapist may ask for a demonstration to observe the family's sequence of behaviors for dealing with a problem. In structural terms, this role-play is often referred to as an enactment. Enactment describes the process in counseling where the counselor makes specific transactions occur and begins to modify structure in the family. For example, the therapist might observe while he has mother and father discuss an issue regarding their child. If the child joins with one of the parents, this may suggest a parent-child coalition, bridging the generation gap between subsystems, a weak parental subsystem, a diffuse boundary between one parent and child and a rigid boundary between the other parent and child. After observing, the therapist will help the family to alter their enactment. In this example, the therapist might suggest that the parents firmly tell their child he or she may not interrupt since the issue under discussion is between them.

Spontaneous behavioral sequences describe transactions that occur in the family as a part of the system patterns of interaction. When a therapist successfully joins the family, the family

structure becomes evident through family transactions. The transactions are not requested like enactments, but they offer similar opportunities for altering structure.

The structural therapist needs to observe the transactions of the family to understand patterns and structure. One should avoid assumptions based on prior information; however, these assumptions may give clues as to what patterns may be probable. Therefore, hypotheses about structure are constantly being formed and modified. A key to understanding the family is to observe the family in action and not rely on reports from family members about what is happening. Critical issues in the therapist's mind as he or she observes the family are "who says what to whom, and in what way" (Nicols, 1984, p.494). Sequences such as frequent interruptions suggest enmeshment, while a disinterested response by a spouse or parent concerning an emotional crisis suggests disengagement (Becvar & Becvar, 1993).

Minuchin's process of diagnosis centers on his family schemata (Becvar and Becvar, 1993). The therapist joins and probes the family system to map out its framework. Structural maps of the family can be drawn using symbols to denote boundaries as clear, diffuse or rigid and relationship patterns as enmeshed or disengaged between members.

Clear: – – – – – – – – – –

Diffuse: - - - - - - - - - - - - - - - - -

Rigid: ————————

Affiliation: ========

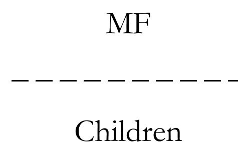
Overinvolvement: ≡≡≡≡≡≡≡

Conflict: ————‖————

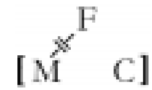
Coalition: **[ ]**

Detouring: ————Λ————

The following symbolises a functional two-parent family that has clear boundaries between the parental (executive) subsystem and the sibling subsystem:



A conflicted marriage in which the mother forms a coalition with the child and thus establishes a cross-generational breach undermining the executive subsystem might be depicted as:



In assessing the families' interactions, the therapist concentrates on systems concepts, the family structure and preferred transactional patterns: enmeshment, disengagement, flexibility, rigidity, boundaries, subsystems, coalitions and conflict adaptation. The therapist then evaluates the system's alliances, coalitions and subsystems in response to changing circumstances. Next, the therapist examines the family system's resonance and sensitivity to individual actions to determine where the family falls on the continuum between enmeshment and disengagement. Finally, the therapist looks at the family life context, developmental stages and the role the identified patient's symptom plays in maintaining the family's preferred transactional patterns.

After observing and identifying problematic patterns, the therapist must begin the challenge of breaking the faulty pattern. There are no specific techniques for doing this. According to Becvar and Becvar (1993), techniques can interfere with the natural flow in the family. The therapist, therefore, must know what he/she wants that say and must say it in a way that gets the family's attention. The therapist creates intense, attention-getting statements by using different communication styles in voice, tone, pacing, volume repetition and word selection. It is the intensity of the delivery that enables family members to hear the therapists message about what is going on and, thus, sets the stage for structural change (Becvar & Becvar, 1993).

Shaping competence is another important tool. This tool refers to helping develop the positive, functional alternatives that the family members may already know (Becvar & Becvar, 1993). For example, praise may help build confidence in family members.

Becvar & Becvar (1993) provided other techniques the structural therapist might use such as:

- Realign boundaries by physically altering the proximity or distance between family subsystems. This can also be accomplished by meeting separately with subsystems or individuals in order to firmly establish or acknowledge boundaries.

- Help members of disengaged families to increase the frequency of contact between them.
- Help specific dyads resolve their own issues without intrusion from other members of the family. This can be sibling to sibling, parent to parent, or parent to sibling. Such activities can be described as allowing each relationship to seek its own level.
- Teach aspects of structural theory to the family so the family can have its own cognitive map to understand the goals and interventions of the therapist better.
- Change the way family members relate to one another so their perceptions of the other person can change. Structural therapists believe that reality is only a perspective. The family members are acting on the validity of the perspective each member has of the other members. The therapist can also provide the family with other cognitive constructions referred to as pragmatic fictions, which provide family members with a different view of their experience (Nicols, 1984, p.500).
- Confuse the family by using paradoxes to help them evolve into different structures.

In structural family counseling, the therapist may employ a variety of techniques called collective restructuring. These techniques are part of the therapeutic process that challenges the family to restructure and change. Minuchin (1974) identified the following frequently-used, encompassing, restructuring techniques: actualizing family transactional patterns, marking boundaries, escalating stress, assigning tasks, utilizing symptoms, reframing, manipulating mood, the use of directives and support, education and guidance.

In summary, the structural family therapy process includes:

- Learning and believing in the concept of structure in families.
- Observing transaction and patterns characterizing these processes, from which the structure may be inferred.
- Having a clear idea of the ideal structure for a family given its constitute members and circumstances.
- Joining, accepting and respecting the family and its efforts to organize itself to achieve the goals while assuming a leadership position.
- Intervening in the family in respectful and yet firm ways to make happen in session what the therapist wants to have occur, consistent with the structural map in order for the family to move toward a more "healthy" family.

- Supporting members, challenging them to try new methods in session and generously give praise when they are successful.

Minuchin's definition of healthy is often associated with an ideal family. Minuchin (1984) considered the traditional family, two parents and their children, as ideal but not the only acceptable family form. He believed that considering single parent, stepparent, or blended families as less than ideal would be detrimental to other families which view themselves as functional. The ideal family is based on a spousal subsystem in which each spouse accommodates, nurtures and supports the other. The couple negotiates complementary roles to deal with changing situations, such as the birth of children. The spouse subsystem maintains itself even when children are born and the parental and sibling subsystems come into existence. The parental subsystem must maintain a balance of authority and nurture, which will support children in becoming increasingly independent within the security of the family. Children consider the family structure in which they are raised as being normal. Therefore, they mourn the lost structure when a divorce occurs because the family structure after the divorce is different. However, this new structure may offer new possibilities for growth which the previous structure did not (Minuchin, 1984). Nuclear families and divorced families are different from each other, but are no better or no worse than each other. Both have potential to either be healthy or dysfunctional (Becvar & Becvar, 1993). Minuchin's ideal family will encounter expected and unexpected crises appropriately by recognizing and facilitating necessary changes in structure.

The efficacy of the structural model is supported by empirical evidence. Structural family therapy is one of the most heavily researched models, and its efficacy has been demonstrated in a variety of difficult families (Becvar & Becvar, 1993). Minuchin et al. (1967), Minuchin (1974) and Minuchin, Rosman and Baker (1978) demonstrated the application and effectiveness of the structural approach in his work with poor families of delinquent children and families with children suffering from anorexia nervosa, diabetes mellitus and chronic asthma. Structural principles and therapy have also been investigated in families with alcoholics (Davis, Stern & VanDuesen, 1977) and in families with a chemically addicted member (Stanton, Todd, Steir, VanDuesen, Marder, Rosoff, Seamen & Skibinski, 1979; Zeigler-Driscoll, 1979).

Play Techniques in Family Counseling

Family therapists have explored numerous techniques for facilitating meaningful communication and interaction among family members in counseling. Minuchin et al. (1967) devised a number of family tasks, family activities in which the family must work cooperatively and allows the therapist to intervene when the family display inappropriate patterns of interaction.

In *Family of the Slums*, (Minuchin et al., 1967) family members were asked to collectively work out a menu with their favorite foods or to come to some agreement on how to spend 10 dollars. Since systems theorists believe human behavior is patterned, observing the process of communication is more important then the content. Watzlawick (1966) suggested counselors ask the family to plan something they could all do together or to ask parents to discuss the meaning of a proverb that they will later teach to their children. Family sculpture (Papp, Silverstein, & Center, 1973; Simon, 1972) is another activity in which family members take turns arranging the other family members to create a symbolic representation of family relationships. This nonverbal technique reveals the family relationships in terms of space, attitude, role, alliances and feelings toward one another.

Safer (1965) used play activities with parents and children. Many art therapy techniques have been used with families (Bing, 1970, Kwiatkowska, 1967, Rubin & Magnussen, 1974, Smith, 1994). Symbolic family drawings could be used to explore areas of family conflict (Kwiatkowska, 1967). The informality and indirectness of drawing techniques in family counseling reduces defenses and controls in communication (Kwiatkowska, 1978).

A technique described by Kwiatkowska (1967) included the "joint scribble technique" in which each member does a quick scribble and the entire family joins in to make a picture, providing a counseling tool for many associations. The counselor will use the associations to get in touch with inner thoughts and feelings of family members. The following directions are used in describing this technique,

> Each of us will have a piece of paper and a pencil. I will draw a squiggle and you will make any kind of drawing you like out of it, then you'll make up a story about your drawing, and I will ask a few questions about it (your drawing and story). Then you will draw a squiggle which I will make a drawing out of, tell a story about it, and you can ask me questions about it (Claman, 1993, p.173).

Family members take turns telling stories and making pictures out of the previous person's

squiggle.

Rubin and Magnussen (1974) provided a variety of drawing techniques including a joint mural and free drawings. Free drawings consist of asking each family member to draw a picture of whatever he/she wishes. Hulse (1951) began to have family members draw a picture of themselves and their family as a counseling tool. Burns and Kaufman (1970, 1972) expanded this concept by requesting the picture be of the family members "doing something together." Bing (1970) also modified the family drawing by recommending family members draw a picture as they "see" themselves as a family. Following each of these drawing exercises, family members are asked to share his/her picture with the family.

Sometimes, it may be most beneficial to have the family collaborate in completing a drawing. This activity provides an opportunity for the counselor to study interaction between family members rather than individual behaviors of family members. Family members contributing to a collaborative family drawing do not have complete freedom in their efforts but must accommodate to each other in some way (Smith, 1994). The directions for Smith's (1994) collaborative drawing technique are as follows:

> Each of you is to select a crayon with which you will begin drawing . . . now that each of you has a crayon, you need to decide in what order you will go; so, who will be first? Second? . . . Now from this moment on, there should be no talking and no effort to communicate with each other. When I say, "start," the first person will sit in the drawing chair and begin to draw whatever he likes. When I say, "next," the person drawing will stop immediately and whoever is next will sit in the chair and begin drawing. We'll continue in order until I tell you to stop (p.72).

Smith (1994) recommended no discussion until the task is completed. The drawing must be one picture, not several different drawings. Thirty second time intervals are to be used and shortened during subsequent rounds to increase the amount of collaboration necessary (Smith, 1994). After completion of the drawing, he recommends that the counselor explore the following: ask family members to describe the picture, the role each member played in drawing it, the colors each family member chose, what individuals would have changed the picture and what they liked and didn't like about the process of drawing the picture and the picture itself.

Landgarten (1981) incorporated into problem-solving tasks for the family. She instructed family members to draw their initials as large as they can, and then to find a picture in the initials by elaborating on them and finally to give a title to their picture. Schaefer and

Cangelosi (1993) teach families to express feelings by pairing feelings them to colors. The family members are then given paper and asked to "fill it up with colors to show the feelings they have in their life" (Schaefer & O'Conner, 1983, p.255). Regardless of the drawing activity, the completed pictures should be analyzed in addition to the process of the drawing activity experienced by the family (Smith, 1994).

Irwin and Malloy (1994) discussed the use of puppet interviews to stimulate communication in a non-threatening manner. The family puppet interviews provides opportunities to observe the visible as well as the covert, ways that families communicate with each other. The puppet choices, any conflicts expressed in the puppet fantasy, the discussion following play, how family members associate to the story and the relationship of the story to the family's functioning all give important information concerning family interactions. Gil (1994) recommended the following script for the puppet interview,

> I brought some puppets today and I am going to ask you to take a few minutes and choose the puppets that you would like to work with. Then I am going to ask you to make up a story with a beginning, a middle, and an end. There are only a couple of rules: you must make up a story, not tell one like Cinderella or Pinocchio, and you must act out the story with your puppets rather than narrate it. I will give you about 30 minutes to make up the story and when you are ready you will tell me the story.' Once introductions of the puppets are made, the counselor may need to say, "Don't tell me about what the puppet says, let the puppets speak for themselves" (p.47).

Gardner (1993) developed and described the mutual story telling technique. This technique is very similar to the puppet interview. The primary difference is that the puppets are not used to tell the story. Instead the family members verbally report an original story with a beginning, middle and an end. With this technique, "the therapist, on hearing a story, surmises its meaning, and then creates a story of his own, using the same characters in a similar setting. However, the therapist's story differs from that of the child in that he introduces healthier resolutions and maturer adaptations" (Gardner, 1993, p.200).

Regardless of the play technique—individual drawings, family drawings, story telling or mutual story telling techniques, puppet interviews, etc.—all serve as a means to explore areas of family conflict in an informal and indirect manner to reduce defenses and controls in communication. These play techniques stimulate verbal and nonverbal communication and reveal in a non-threatening manner how a family interacts and approaches a goal or task.

Learning Disabilities

Definition

Learning disability is a term used to describe a broad range of learning disorders; defining the term is difficult. Numerous authors have proposed and supported definitions which differ significantly from one another. Kirk (1962) defined learning disability in terms of the educational aspects of the disability. Johnson and Myklebust (1967) focused on the neurological symptomology of learning disabilities, and Bateman (1965) focused on developmental imbalances. The National Advisory Committee on Handicapped Children (1969) presented the following definition of learning disabilities to Congress:

> Children who have learning disorders are those who manifest an educationally significant discrepancy between their estimated intellectual potential and actual level of performance related to basic disorders in the learning processes, which may or may not be accompanied by central nervous system dysfunction, and which are not secondary to generalized mental retardation, educational or cultural deprivation, severe emotional disturbance, or sensory loss (p.220).

This definition was incorporated into Public Law 91-230 (United States Department of Education, 1968) and later into Public Law 94-142, The Education for All Handicapped Children Act of 1975 (USDOE, 1977). The legal definition of the term, learning disability as described in the Public Law 94-142, The Education for All Handicapped Children Act of 1975, is as follows:

> Specific learning disabilities means a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily a result of visual, hearing or motor handicaps, of mental retardation, of emotional disturbance or environmental, cultural or economic disadvantage (USDOE, 1977, p.65083).

Dissatisfaction with the definition in Public Law 94-142 led to the formation of the National Joint Committee for Learning Disabilities (NJCLD). In 1981, the NJCLD proposed this definition:

> Learning disabilities is a generic term that refers to a heterogeneous group of disorders

> manifested by significant difficulties in the acquisition and use of listening, speaking, reading, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social or emotional disturbance) or environmental influences (e.g., cultural differences, insufficient or inappropriate instruction, psychogenic factors), it is not the direct result of those conditions or influences (Hammill, Leigh, McNutt & Larsen, 1981, p.336).

The definition of the NJCLD (1990) differs in some respects from the definition in PL 94-142. There are, however, several points of agreement regarding learning disabilities (Eisenhauer, 1991). Both concur on the following as conditions/aspects of learning disabilities:

1. A discrepancy between expected and actual achievement,
2. Manifestations of disorders of speaking, listening, reading, writing, spelling, thinking and/or arithmetic,
3. Presumed etiology of central nervous system dysfunction,
4. The exclusion of other handicapping conditions or influences as causative of the individual's learning problems and
5. The learning disabled as a heterogeneous population.

The range of symptomology and the hetereogeneity of the learning disabled population, however, provide few characteristics upon which to base a diagnosis. Learning disabilities evolved as a diagnostic category to serve children who experience learning difficulties in school and often fail, but do not qualify for services under categories such as emotionally disturbed, mentally retarded and physically handicapped (Mercer, 1983).

The National Institute of Mental Health (NIMH) describes learning disabilities as follows:

> Learning Disabilities is a disorder that affects people's ability to either interpret what they see and hear or to link information from different parts of the brain. These limitations can show up in many ways—as specific difficulties with spoken and written language, coordination, self-control, or attention. Such difficulties extend to schoolwork and can impede learning to read or write, or to do math. Learning disabilities can be lifelong conditions that, in some cases, affect many parts of a person's life: school or work, daily routines, family life, and sometimes even

> friendships and play. In some people, many overlapping learning disabilities may be apparent. Other people may have a single, isolated learning problem that has little impact on other areas of their lives (1993).

Characteristics

A review of the literature (Mercer, 1983; Aldeman & Taylor, 1983) indicates that the characteristics of the learning disabled are as varied, inclusive and unsystematic as the definitions of the disorder. For example, children with a learning disability may be hyperactive, hypoactive or show no disturbance of motor activity. Awkwardness and clumsiness are among diagnostic criteria, but are not necessary to the diagnosis. Characteristics include fine or gross motor difficulties, perceptual-motor incoordination, impulsivity, distractability, attention deficits and preservation as well as a range of perceptual disorders. Disorders of memory, cognition, language, speech and hearing are also possible characteristics, as are neurological signs and electro-encephylagram (EEG) irregularities. Poor self-concept and social and emotional difficulties are frequently cited as secondary characteristics. Mattis, French, and Rabin (1975) noted that every dysfunction is found with greater frequency in learning disabled children than in normal controls. In addition, they find that no child with learning disabilities exhibits all deficiencies and no specific disability can be seen in all learning disabled children. Two factors consistently found are the behavioral and emotional difficulties accompanying the learning problems.

Learning disabilities as a diagnostic entity is also difficult to clearly define. The learning disabled can only be viewed as a heterogeneous population when considering the common link of academic underachievement. Kirk and Kirk (1983) argued that the lack of clarity in definition and diagnosis of learning disabilities has resulted in diagnosis based largely on underachievement, with very little or no concern regarding the other diagnostic criteria. Mann, Davis, Boyer, Metz and Wolford (1983) reviewed national data collected by the Child Service Demonstration Center and funded through Public Law 91-230. The authors found that a majority of children identified and treated as learning disabled did not meet diagnostic criteria. Many of the children appeared to be culturally deprived, slow learners and mentally retarded, but were identified as learning disabled only because they did not perform academically at grade level in school. Ames (1983) and Ysseldyke and Algozzine (1983) reported that underachievement and learning disability are often treated as the same. They find that children identified as learning disabled have normal academic potential but, are simply placed inappropriately at a

more advanced grade level.

According to the Diagnostic and Statistical Manual, IV (DSM-IV, 1994),

> Learning disorders are diagnosed when the individual's achievement on individually administered standardized tests in reading, mathematics and written expression fall substantially below that expected for age, schooling and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical or written skills. A variety of statistical skills may be used to establish that a discrepancy is significant. Substantially below is usually defined as two standard deviations between achievement and IQ. In cases where performance on an IQ test may have been compromised by an associated disorder in processing, a medical condition or mental disorder, or ethnic or cultural background, a smaller discrepancy between achievement and IQ may be used. When a sensory deficit is present, the learning difficulties must be in excess of those usually associated with the deficit. Learning disorders may persist into adulthood (p.46).

According to the DSM-IV (1994), the school dropout rate for learning disabled children and adolescents is about 1½ times the average of non-learning disordered children, approximately 40% of the total drop out population. Deficits in social skills and low self-esteem may be associated with learning disorders. It has also been found that adults with learning disabilities may experience difficulties in employment or social adjustment. Ten to twenty-five percent of individuals with conduct disorder, opposition defiant disorder, attention-deficit/hyperactivity disorder, major depressive disorder or dysthymic also have learning disorders (DSM-IV, 1994). Frequently, there are underlying abnormalities in cognitive processing; visual perception, linguistic processes, attention, memory or any combination of processing difficulties that often exist before or evolve with the learning disorder (DSM-IV, 1994). Although genetic predisposition, prenatal injury, neurological and other general medical conditions are often associated with learning disorders, these are not predictors of an eventual learning disorder (DSM-IV, 1994).

Diagnosis

Individual testing of the child is essential for making an accurate diagnosis of a learning disorder. Psycho-educational assessments and standardized tests are administered to determine the existence of learning disorders. In diagnosing learning disorders, caution must be taken to ensure differentiation of the learning disorders from normal variations in academic attainment

and from scholastic difficulties due to lack of opportunity, poor teaching or cultural factors different from the prevailing school culture (DSM-IV, 1994). Inadequate schooling can result in poor scores on standardized achievement tests.

The lack of clarity regarding the characteristics of learning disabilities is indicative of the discrepancies among estimates of the prevalence of learning disorders; these range from 2% to 10% of the population depending upon which theory/definition of learning disorder is applied (DSM-IV, 1994). Approximately 5% of children in public schools in the United States are identified as having a learning disorder (DSM-IV, p.47). Despite the lack of consensus regarding the definition, characteristics and diagnoses of learning disabilities, Tucker, Stevens and Ysseldyke (1983) concluded that most professionals view learning disabilities as a valid diagnostic category.

Theories of Learning Disabilities

There is as much ambiguity in theories of learning disabilities as exists in the definition and diagnosis of learning disabilities. Although theories of learning disabilities vary, they generally fall into one of the following categories: a medical model, a slow maturation or delayed development model, an inadequate environmental model, or an interactive model (Rouke & Del Dotto, 1994). In the medical model, malfunction of the central nervous system is considered the primary cause of learning disabilities. The slow maturation model is developmental in focus, arguing that learning disabilities are manifestations of delayed development instead of disordered or limited development of mental processes and cognition (Aldeman & Taylor, 1983). Environmentalists focus on the influence of the environment on behavior and minimize the biological, psychological, and developmental factors. The emphasis for environmentalists is on the behavioral/environmental contingencies and reinforcements that explain and modify the problem behaviors. The interactive, more ecological model, views a learning disability as a symptom reflecting a generalized underlying disorder for which there exists no singular, linear cause (Day & Moore, 1976). A linear cause of symptomology is very limiting in considering learning disabilities. It is appropriate, therefore, to take a position of circular causality and look at learning disabilities from the perspective of family systems theory, which offers an interactive approach to conceptualizing the child's difficulties regarding the learning disability (Johnson & Zemitzch, 1997).

Family System of a Child with Learning Disabilities

Characteristics

The psychosocial context of parents of children with learning disabilities is quite complex. Families today live with the stress of personal, family, economic and social systems which, by the very nature of modern society, may contribute to a feeling of isolation and instability of one's role and function as an individual or a parent. It is within this context that parents of learning disabled children have to cope with the added stress of raising learning disabled children. Common parenting skills and parental instincts are generally insufficient for parents of children with learning disabilities, therefore adding more stress to the family functioning. Being unable to deal effectively with children with learning disabilities, these parents may experience feelings of incompetence, anxiety, and alienation from the child, extended family and society. Learning disabled children alter the state and possibly the stability of the family system. Parents' reactions to learning disabilities are initially a negative result of the labeling and special class placement of their children. Therefore, these families often need help in their cognitive, emotional and behavioral adjustment to the changes in the family.

Since the symptomology of learning disabilities typically becomes evident in the school setting, children are usually not diagnosed as having learning disabilities until between the ages of 6 and 11 (Kirk & Kirk, 1983). By this time, the patterns of family functioning have already been established and are often in need of change because the rules, roles and boundaries have already formed unhealthy patterns of functioning.

The different approaches used by professionals in identifying the etiology and treatment of learning disorders create more frustration and confusion, resulting in psychological reactions and maladaptive defenses for these parents (Philage, 1975). After years of living with a child the parents considered to be normal, their usual expectations of a successful child are instantly and dramatically threatened or altered by the diagnosis of a learning disability. This diagnosis may alter the whole family system as the parents try to compensate and adjust to this new situation, experiencing immediate frustrations and adjustment problems. As the parents become the effects of continual failure on an intellectually, emotionally, and environmentally normal child, the parents' anxiety increases with regard to the future of their child who has a learning disability (Cruickshank, 1967).

Research

Much of the early literature on learning disabilities postulates a linear model of development and treatment (Perosa, 1980). The linear approach encompasses all the approaches that focus on the individual. However, within the last decade this has expanded to include multiple components and a circular causality. In this view, the learning disability is considered a symptom reflecting a more generalized, underlying disorder (Day & Moore, 1976; Rabinovitch, 1959).

Kaslow and Cooper (1978) described family reactions and dynamics upon acknowledging a learning disability in a child. The families are compared to those in a process of grief and mourning, experiencing stages of denial, depression, anger and guilt. Kaslow and Cooper (1978) noted parents often try to compensate for their children's disability by becoming overprotective and overindulgent, thereby depriving them of opportunities for growth and development. In turn, the children can become skilled at manipulating their parents and then take a central, powerful and controlling role in the families.

The great amount of time and energy parents devote to their learning disabled children, makes them tired, anxious, angry and sad. Kaslow and Cooper (1978) identified four maladaptive relationships in families with children who have learning disabilities:

1. The parents become irritable, and their marriage may become marred by arguments and reproachments.
2. One parent, usually the mother, may become depressed, and moody.
3. One parent may become the child's protector and form an alliance with the child against the other parent.
4. Both parents may compete for the child's attention and affection.

Day and Moore (1976) noted 10 patterns that they identified from clinical observations of families with learning disabled children:

1. Inhibition of aggressiveness and competitiveness in family members
2. Hostile dependency and fear of growth in family members
3. Passive-aggressive retaliation among family members
4. Negative self-image, depression, self-deprecation and self-punishment among parents and the child with learning disabilities.
5. Guilt in the parent or child which inhibits aggression and opposition
6. Inhibition of conflict because of a fear of evoking rejection

7. Infantilization or overprotection of the child because of parental insecurity
8. Family scapegoating, blaming others to avoid responsibility for behavior
9. Parental projections that are acted out by the child
10. The maintenance of family secrets

Kaslow and Cooper (1978) described the family dynamics associated with having children with learning disabilities. Almost from birth, depending on the severity of the handicap, learning disabled children present problems to their parents. Before diagnosis, parents are confused by their children being "different." Parents often feel frustrated in interactions with them and annoyed at the lack of "normal" responses and behavior. With time, parents become more aware of the discrepancy between their perfect child to the cranky, clumsy child they actually have. A crisis of ambivalence and uncertainty develops. The routine of "doctor shopping" is common as they try to find someone to alleviate their fears. Parents must finally come to acknowledge their children's limitations. They should not focus on false perceptions or on what the child cannot do. Instead, they need to recognize what their child is and see his or her true potential.

The sequence leading toward some acceptance of and the ability to cope with the child's condition can be analogous to the process of grief or mourning. Parents are suffering the loss of the child they had dreamed of in their family. Initially, there is a denial of the problem and a search for a doctor who will give them a more positive diagnosis. Parents experience great sadness when the final diagnosis is made. Feelings of anger build, and thoughts of getting rid of the child may fill the parents. Very few can consciously recognize these thoughts and feelings. Parents act defensively to overprotect and overindulge the child. The child then becomes adept at playing on his parent's guilt and sympathy, altering the hierarchy in the family by becoming a powerful and controlling member (Kaslow & Cooper, 1976).

Frequently, the symptoms begin to permeate the family. The disability is generalized to represent the child instead of a characteristic of the child. The parents become very uneasy and exaggerate the problem by exhibiting overly punitive or indulgent behavior (Kaslow & Cooper, 1976). Each spouse blames the other for the child's difficulties. One of several different patterns of interaction results. The marital relationship is filled with arguments and rapprochement. One parent, usually the mother, might become depressed. Another realignment is that one parent sees him or herself as the child's protector and allies with the child against the other parent. These two become overly attached and enmeshed in a symbiotic sense.

The excluded parent may escape into work, other activities or an affair to offset the disappointment. Another scenario is when both parents become invested in the child and there is a rival for the child's attention.

The child may not have developed a foundation for learning if the parents have fostered too much dependence by not allowing the child to learn by trial-and-error and have downgraded the importance of teachers. On the other hand, if the parents stress school too much, and their affection seems to be correlated to the grades the child receives, the child is placed in a losing situation with unrealistic goals. The child with learning disabilities becomes the scapegoat or "identified patient", with all the other family members projecting their difficulties onto the child with learning disabilities. Resentment and fear often builds in other children in the family as they are kept unaware of what is really wrong with the learning disabled sibling.

Briard (1976) outlined a stage-by-stage analysis in counseling parents of children with learning disabilities. Children with learning disabilities develop secondary emotional problems as a result of their poor self-image. These children's poor opinion of themselves is due to their inability to learn and meet the expectations of others, especially their parents. It is also important to consider how the children's handicaps affects the parents' attitudes of themselves as parents.

In the intake phase of counseling, the most typical reactions of the parents are either denial of the problem and refusal to accept help, or relief that the problem has been identified and that help is forthcoming. But, as treatment progresses, parents feel that they may be responsible for their child's problems, and parental guilt becomes the main treatment issue. Another source of guilt is parental feelings that the parents must have contributed to the child's emotional problems resulting from the learning disability. The parents must form more realistic attitudes and expectations regarding themselves and their child.

The parents may have exacerbated the child's poor self-image by setting unrealistic expectations. Then they make the child more handicapped by affirming the child's inability to complete certain tasks. Negative feelings the parent may have toward the handicapped child is another source of parental guilt. Parents need help in recognizing and accepting these natural, although culturally unacceptable, negative feelings in order to begin dealing with them.

Once parental guilt feelings have surfaced and have been expressed, explored and at least partially neutralized, the counseling process then moves toward parenting issues. A common issue is the problem of limit setting and discipline. Once parents have emotionally accepted

their child's handicap and recognized and dealt with their negative feelings regarding themselves and their child, there is often a tendency for them to baby the child and fail to impose discipline and set limits. This limit-free parenting can create additional problems with siblings who receive different treatment from that of the child. These problems will often intensify sibling rivalry. Parents need to be helped to understand that the child with learning disabilities must follow realistic limits and that consequences must be given when limits are not adhered to. Another issue that surfaces in counseling is whether the parents should tutor the child and/or assist with homework. This is complicated and would depend upon the personality of the parents, the nature of the disability and the opinion of the child's teacher.

Minuchin's theories can be extended beyond psychosomatic families to include families with learning disabilities (Perosa, 1980). Spacone and Hanson (1984) likened the family interactions of children with learning disabilities and other underachievers to the psychosomatic family patterns described by Minuchin et al. (1978). Minuchin's notions of enmeshment and overprotection, rigidity and lack of conflict resolution can all be identified in learning disabled families. Silverman, Fite and Mosher (1995) investigated family or system-level problems in families with learning disabilities. In this study of 35 boys with learning disabilities, the authors concluded that there is usually one parent who is actively involved in the child's problem. Additional findings showed severe sibling rivarly, along with a history of marital discord. The parents were found to hold unrealistic and high expectations for their children's achievement, resulting in unnecessary pressure for the learning disabled children to perform academically. The authors suggested that these characteristics may be related to the development and maintenance of difficulties experienced by learning disabled children.

Research

Few studies have been conducted examining families of learning disabled children from a family systems perspective. Many of the studies of such families take a psychodynamic view and center on the parent-child, usually the mother-child dyad. Perosa (1980) hypothesized that families with learning disabled children would demonstrate structural patterns similar to families with children suffering from psychosomatic disorders, as described by Minuchin et al. (1978). Using the Structural Family Interaction Scale, a self-report instrument was developed by Perosa (1980). Perosa compared 25 families with learning disabled children to 28 families whose children were not learning disabled (or psychosomatic). Nine of the 25 learning disabled children were considered severely handicapped and had been in self-contained classes or

resource classes in school. These children also had emotional problems and were more than one year below expectancy in academic achievement. The remaining 16 were considered to be less severely handicapped, less than one year behind in their achievement and had been mainstreamed into regular education classrooms.

In Perosa's (1980) study, major differences between socioeconomic status and educational levels of the families in the two groups created threats to the internal validity of the study, when considering sex, age and economic status. In the learning disabled group, 4 of the 25 families were classified as upper-middle class, 10 as middle-middle class, 3 as lower-middle class, and 8 as working class. In the non-disabled group, 19 of the families were upper-middle class, 6 were middle-middle class, 1 was lower-middle class and 2 were working class. Furthermore, there was an imbalance regarding gender. The learning disabled group combined 19 males, as opposed to the 12 males in the non-disabled group. Ages for both groups averaged 12 years, with a range spanning 7 to 18 years. Perosa's hypothesis was supported by multivariate analysis of findings demonstrating that families of children suffering from psychosomatic disorders show similar characteristics as families of learning disabled children. These families are characterized by overprotection, rigidity, lack of conflict resolution due to conflict avoidance between parents, and patterns of conflict expression without resolution between parents and children. No differences were noted between disabled and non-disabled groups on measures indicating parent-child coalitions, triangulation, and detouring. Unlike the psychosomatic sample, families with learning disabled children did not reveal strong enmeshment tendencies. Instead, they were placed higher on the scale in disengagement and neglect, particularly by fathers. Perosa's study supported the hypothesis that families with learning disabled children differ from families with non-disabled children in ways that may be important to treatment and understanding of the disorder.

Investigation by Ditton, Green, and Springer (1987) explored the clarity of communication of parents with learning disabled children. Learning disabilities usually influence a child's thinking and ability to maintain attention. Ditton et al. (1987) hypothesized that parents of these children will differ from parents of non-disabled children in the clarity of their communication.

Ditton et al. (1987) compared audiotaped communication samples of 30 parents of learning disabled children to 30 parents of "normally achieving" children. Two raters trained in the use of a communication deviance-coding scheme scored the recordings for communication

deviance. Communication deviance is defined in this study as those oddities of language which blur the meaning of communication and leave the listener confused.

The experimental groups consisted of 12 girls and 18 boys who attended a suburban junior high school. All learning disabled children had received special academic assistance in reading or English, and the non-disabled attended grade-level classes. The learning disabled group had a mean percentile rank of 30.5 on the Comprehensive Test of Basic Skills, with individual scores falling at least one standard deviation below expectancy. On the other hand, the average achieving group had a mean percentile rank of 66.96, with all individuals scoring within one standard deviation of expectancy. The mean verbal I.Q. for the learning disabled children was 98.5, as compared to 102.8 for their normal achieving peers with all children scoring 90 or above. I.Q. was measured with the Wechsler Intelligence Scale for Children. The groups were similar in I.Q., socioeconomic status, parental occupational levels and family configuration. However, the educational level of the parents differed significantly, with parents of learning disabled children reporting 13.77 years of education, and parents of normal achievers reporting 14.70 years of education. The parents determined who the primary caretaker was to participate in the study. Sex and marital status of the parents were not reported.

The experimental task required one-way communication from parent to child. Parents and children were placed in separate rooms and communicated by telephone. The children's phone did not have a mouthpiece so that the children could only listen and not talk to their parents. Five randomly placed Rorschach inkblots were placed in front of each child and the same five inkblots were placed in a pre-arranged sequence. The task involved parents instructing their children on how to arrange the inkblots. The final goal was to have the children's arrangement match the parents' sequence. The parent communication was tape-recorded.

The parental communication samples were scored for communication deviance (CD). The raters, working individually, rated each of the 60 recordings as either low or high CD. The initial ratings showed inter-rater agreement of 0.70 kappa = 0.41, $p<0.001$. The raters then worked together to reassess the recordings until they agreed on placement in high or low category for CD. The raters were blind to the educational placements of the children.

Results showed that parental CD was a good predictor of the level of children's school achievement. Eighty-seven percent of the parents of the learning disabled children were rated high on communication deviance, while 77% of the parents of normal achievers were assigned low CD ratings. The inclusion of parental educational level in the regression equation

significantly increased predictability. Educational level accounted for less than 1% of the variance, as opposed to the CD rating which accounted for 18%.

Failure to report sex of the primary caretaker or parental marital status is a weakness in the study. Despite these weaknesses, the study provides evidence that a relationship exists between language processing/usage difficulties and parental communication deviance. Even though the study does not look at communication deviance in the second parent, or both parents, it provides the possibility that a child's ability to conceptualize may be improved by helping parents learn to communicate in clearer, more direct ways. The findings of this study indicated the ways in which parents use language affects communication patterns and thinking processes in their children. In addition, the authors suggested that the parents' inability to teach their child a new task, or to maintain shared attention long enough for a child to learn tasks, may have a detrimental effect on the child's cognitive development.

Staver (1953) reported case study data on 17 mother-child dyads in which the children were learning disabled. Staver observed that the mothers appear to be preoccupied with fears of separation and illness in their learning disabled children. A mutual attachment results, leaving mothers and their children poorly differentiated and enmeshed.

Guberman, Herwitz, Prentice and Sperry (1962) provided clinical data of 18 fathers of learning disabled children. Although several of the fathers were viewed as having achieved occupational and educational success, these fathers had self-defeating attitudes, attributing their success to luck. Fathers who were less successful occupationally and educationally saw themselves as hopeless and destined for failure. The wives of the unsuccessful fathers tended to view their husbands as inadequate and weak. As parents, the fathers tended to be passive, with tendencies for violent and aggressive outbursts. In conclusion, the authors described the family patterns as marked by unresolved spousal conflict and ineffective parental/executive functioning.

Humphries and Bauman (1980) collected experimental data in their study comparing 35 mothers of learning disabled children to 35 mothers of normal achievers. The mothers were approximately equal in age, educational level and socioeconomic status. The average age of their children was 8, ranging from 6 to 14; the mean grade level in school was third grade, and all children had IQ's of 90 or higher on the Weschler Intelligence Scale for Children. There were more boys in the learning disabled group, but the control group numbers were equivalent. According to the scores on the Wide Range Achievement Test, the learning disabled group of

children was an average of 26.57 months below grade level, and the normal achievers were an average of 2.63 months below grade level.

These two groups of mothers were compared for authoritarian attitudes, hostility, and rejection. Statistically significant differences between the groups were found on all factors. Mothers of learning disabled children were more authoritarian and controlling and scored lower on democratic attitudes, but were less hostile and rejecting. When controlling for the sex of a child, gender did not present as a factor.

Dean and Jacobson (1982) compared the Minnesota Multiphasic Personality Inventory profiles of the parents of 90 children who had been referred for clinical treatment and evaluation. According to behavioral criteria on the Gray problem checklist, the children were considered conduct disordered (CD), learning disabled (LD), or personality disordered (PD). The children had a mean age of 8 and ranged in age from 6 to 12 years. The groups consisted of 30 families randomly selected from volunteers. The results indicated that LD mothers were significantly more defensive and reported more physical complaints than CD mothers, however, no differences were found across groups of fathers. However, these results must be considered with caution due to the diagnostic procedures used for classification.

A study by Klein, Altman, Dreizen, Friedman, and Powers (1981a, 1981b) reviewed case studies involving parents of learning disabled children. Their observations found that these parents held negative attitudes toward their children, as well as negative attitudes concerning authority and responsibility for their child's learning. The authors conclude that such negative attitudes from parents not only exacerbate difficulties but also may even be causative.

Roskin and Pitcher-Baker (1977) studied learning disabled children's perceptions of closeness among family members. One hundred kindergarten and first grade children, 50 of whom were learning disabled and 50 non-learning disabled, who attended the same school, were selected for this study. The two groups were comprised of 52 males and 48 females, with a mean age of 6.2 years. Each child was asked to complete a kinetic family drawing that was scored by two independent specialists. The results suggest that the learning disabled children were more troubled than the non-learning disabled children, with sibling rivalry and feelings of isolation and rejection prevalent in their families.

Silverman et al. (1995) investigated family or system-level problems in families of children with learning disabilities. In this study of 35 boys with learning disabilities, the authors concluded that there is usually one parent who is actively involved in the child's problems related

to the learning disability. Additional findings showed severe sibling rivalry, along with a history of marital discord. The parents were found to hold unrealistic and high expectations for their children's achievement, resulting in unnecessary pressure for the learning disabled children to perform academically. The authors suggested that these characteristics may be related to the development and maintenance of difficulties experienced by learning disabled children.

Using Systems Theory with Families of Children with Learning Disabilities

Traditionally, learning disabilities have been conceptualized within an educational context where interventions have focused on remedial services for children with learning disabilities in school. This approach makes learning disabilities seem purely an academic problem. Pfeiffer (1985) found recent research indicating that learning disabilities undermine affective, cognitive and psychosocial development, and that learning disabilities are not only an academic problem occurring in school, but a heterogeneous disorder affecting the individual's capacity to function in all aspects and settings of life. Thus, to incorporate an ecological perspective and provide effective valuable treatment for the children with learning disabilities, treatments must include the family environment. Clinicians, such as Day and Moore (1976) and Kaslow and Cooper (1978), provided descriptions of themes, issues, feelings and stages which emerge in counseling learning disabled families. However, no theoretical framework for this counseling was described.

The family exerts significant influence upon all aspects of the child's development. Families with learning disabled children usually experience additional stress beyond that often associated with parenting. A family with this added stress often resembles a family experiencing psychological disequilibrium (Pfeiffer, 1985).

In considering a rationale for family systems treatment, one must look at the levels of dysfunction, the cognitive and affective development of the child in school, the cognitive and affective growth of the child in the family and the psychological "health" of the entire family. A family systems approach acknowledges these interrelated levels as well as the dynamic and reciprocal nature of the levels.

The learning disabled child's school behavior is greatly affected by family environment and, conversely, the child's problems in school tend to increase family stress. Pfeiffer and Tittler (1983) concluded that a child's difficulties in school typically increase at times of strain in the

family and become more amenable to improvement when the family is functioning more smoothly. The family systems approach integrates the family system and school system to address this reciprocal relationship and produce more complete interventions.

Pfeiffer (1985) proposed a family systems intervention to improve family functioning and ease difficulties encountered by learning disabled children. According to Pfeiffer (1985), the most significant manifestations of a learning disability occur in the dynamic relationship between learning disabled individuals and their families. Although children spend a major part of the day in school, they spend more time at home—even more than their non-disabled counterparts. Learning disabled children typically become more dependent on family relationships than do other children because of the lack of supportive peer relationships. Thus, from a systems view, families of learning disabled children face pressures that disrupt the family homeostasis and, in an effort to adjust, develop maladaptive coping behaviors. These maladaptive behaviors can range from being mildly dysfunctional to being severely pathologic. Due to deficits in social decoding and encoding, learning disabled children are more vulnerable to dysfunctional family dynamics and parental attitudes (Gerber and Zinkgraf, 1982; Pfeiffer, 1985). Kronick (1978) indicated that learning disabled children are more likely to receive inadequate nurturing, ambiguous communication and unclear expectations than non-learning disabled children. Although some families handle stress with minimal disruption in functioning, others experience significant disruption in family routines and stability. This disorganization exacerbates the learning disability.

According to systems theory, family relationships are constantly changing because of reciprocal influences. Other family members affect learning disabled children, and conversely, these children influence the family members as well. Since the difficulties of one family member can impair the functioning of all the family members, counseling involving only the learning disabled children has very limited impact. Few families escape the disruptive effects that a learning disability can bring (Pfeiffer, 1985).

Many parents deny the existence of the disability and experience uneasiness and anxiety whenever the disability causes disruption (Kronick, 1978). Anger is often displayed as parents discover that their expectations for the children's success cannot be met. Anger and resentment build as the parents come to realize all the additional needs and assistance of their learning disabled child. Maladaptive parenting styles such as overprotection, indulgence, denial and projection are often exhibited (Doleys, Cartelli and Doster, 1976). Learning disabled children

can learn to manipulate parental guilt and, thereby, gain a considerable degree of control over family equilibrium (Pfeiffer, 1985). This alteration of the family hierarchy results in a dysfunctional family structure. Considered within this context, a family with a learning disabled child will often need professional mental health assistance (Pfeiffer, 1985).

The use of a family systems approach in treating families of children with learning disabilities is the most effective intervention (Hanson & Okun, 1984; Perosa & Perosa, 1981; Margalit, 1982; Klein et al., 1981a, 1981b; Abrams & Kaslow, 1977, Pfeiffer, 1985). Working with the family offers the opportunity to intervene using "primary counteracting and buffering forces that can provide growth-producing social interactions" with the learning disabled child (Pfeiffer and Tittler, 1983, p.169).

The family is not only a major force in a child's development but also a powerful influence to create change in the child's life. According to Pfeiffer (1985), in cases of children with learning disabilities, family-oriented interventions enhance the family organization, routine, communication, interdependence, and strategies to optimize the overall treatment process. In working with learning disabled children, the primary goal is to restructure dysfunctional parental attitudes and child-rearing practices that may be interfering with the children's learning. The family system orientation necessitates this active cooperation of all systems/aspects of the child's life.

The long-standing linear and medical model approach to learning disabilities has resulted in little research about the use of family systems treatment of learning disorders, despite the many authors who argue for family therapy to treat learning disability families (Hanson & Okun, 1984; Perosa & Perosa, 1981; Margalit, 1982; Klein et al., 1981a, 1981b; Abrams & Kaslow, 1977, Pfieffer, 1985). These authors reported symptom relief, behavioral and academic gains for children, more effective executive functioning by parents and improved family communication. Unfortunately, these authors cited case examples to support their contentions, but offered no empirical corroboration.

Experimental studies with child-centered problems other than learning disabilities provide the only source of empirical evidence for the efficacy of family treatment when the child is the identified patient. Masten (1979) reviewed 14 studies of family therapy as an intervention for child and adolescent problems. A variety of family therapy approaches and techniques were used in these studies with at least one parent and the identified patient seen in treatment. Masten (1979) reported an overall improvement rate in 71% of the cases, as opposed to 66.4%

for traditional child psychotherapy. These figures compare favorably with those reported by Gurman and Kniskern (1981) in their review of family therapy outcome studies for a range of age groups and problems.

Matsen claimed that the internal and external validity in these studies had been hindered by weaknesses in methodology. Eight studies did not have a control group, and 7 used only one to measure outcome. Only 9 took both pre- and post-measures and 5 did not provide follow up consults. Five studies controlled time during treatment; however, none considered age as a variable related to improvement rate. Measures of improvement across the 14 studies were often subjective and not treated as independent variables. The studies fail to compare treatment approaches and therefore, no conclusions may be drawn of preferred treatment to presenting complaint. In addition, randomization was not utilized, and the clinical populations are poorly defined. Thus, these poor methods leave inconclusive data.

In her dissertation on family systems therapy with learning disabled children, Eisenhauer (1991) studied the efficacy of family systems therapy for families of children with learning disabilities. Baseline data were collected from three volunteer families before they participated in 10 sessions of family therapy in a clinic setting. Measurements were collected weekly from baseline through follow up, affording both outcome and change. Follow up, which was 60 days after the final therapy session.

Findings indicated that each treatment child's average weekly performance in basic academic skills had improved over the course of the study. Pre-treatment and post-treatment behavior ratings by the teachers, using the Devereux Elementary School Behavior Rating Scale (Swift, 1982), revealed perplexing results as teachers' perceptions declined as the study progressed. Pre-treatment and post-treatment parent ratings on a behavioral assessment revealed that the parents' perceptions of their children's behavior improved over the course of the study. Perhaps the improvements seen by the parents had been generalized to the classroom. Measures on family systems and subsystems were accomplished by coding their communication through the Ericson-Rogers Relational Coding System (Ericson & Rogers, 1973). Findings for couples revealed that wives in each couple were slightly more dominant then their husbands at the outset of treatment. Examination of overall communication patterns and relational dynamics of the couples revealed more symmetrical than complementary interactions. This symmetry points to difficulties negotiating control and coming to agreements about concerns or problems. As for interactional patterns within families, Eisenhauer (1991)

noted an apparent competition for dominance within the families. The measures of dominance indicate that children either dominated the families, or that there was little distinction between the levels of dominance between parent and child.

Schools that limit diagnosis of learning disabilities to testing intelligence, memory, visual and audio perceptions, fine and gross motor coordination, speech and hearing do not go far enough (Perosa & Perosa, 1981). The impact on the family of having a learning disabled child also must be assessed, and appropriate intervention strategies undertaken. School counselors should be trained in family counseling and should be important members of any multidisciplinary team working with learning disabled children (Perosa & Perosa, 1981).

Summary

It is unlikely elementary school counselors will be successful in counseling with children unless the children's families, the children's primary social systems, are involved (Amatea & Sherrard, 1997; Carns & Carns, 1997; Lewis, 1996; Rosenthal & Sawyers, 1996). Counselors will need to take a more active role in working with and empowering families (Lewis, 1996). Although individual counseling may bring about temporary relief to the family system, the homeostatic balance is still maintained. Without altering the patterns of interaction, the presenting behaviors will not change. In order to be successful in intervening, counselors need to play a role in helping families and schools understand systems and determine how to break cycles of destructive behavior patterns. In this way, more permanent interventions can be implemented (Carns & Carns, 1997).

A review of the current school counseling literature shows a need for family counseling in the schools (Millard, 1997; Johnston & Zemitzsch, 1997; Casey & Buchan, 1997; Hinkle, 1997). Considering the limited amount of time school counselors have for treatments, the use of systems theory and family counseling skills has proven to be a very promising treatment (Carns & Carns, 1997).

The possibilities for school counselors to use family counseling in the schools are numerous. Despite an increase in the amount of literature pertaining to school counselors providing family counseling, questions concerning feasibility still remain, requiring more research in this area. Many authors (Hinkle, 1993; Magnuson & Norem, 1998) discussed school counselors' changing role in serving families within the schools. Magnuson and Norem (1998) recommended that school counselors become licensed as marriage and family therapists as well.

In view of the potential benefits of this approach, this study will explore the school counselors' use of family counseling with children with learning disabilities as an intervention in the schools.

Family systems counseling is a beneficial and effective counseling technique for treating families of children with learning disabilities and, therefore, the children with learning disabilities themselves. Family counseling has been utilized in many environments and settings but has not been explored previously as an intervention in the schools. This qualitative research explored school counselors' experiences and perceptions when using family counseling as an intervention with families of children with learning disabilities, and provides insight regarding the implementation of family counseling as an intervention by school counselors working with families of children with learning disabilities in the school setting.

CHAPTER 3
METHOD

This chapter contains the procedures employed to investigate the experiences and perceptions of the elementary school counselors who participated in this study. For this study, these counselors conducted family counseling with families of children with learning disabilities. Additionally, the sampling criteria used to select school counselors and families to participate in this study are presented. Finally, this chapter contains a discussion of the data and the methods of data collection and data analysis that were used to address the research questions.

Design

A qualitative approach to data analysis was used to explore the experiences and perceptions of school counselors while providing family counseling to families of children with learning disabilities. The children with learning disabilities attended elementary schools in a large, suburban school district. The experiences and perceptions of 10 counselors were investigated regarding the coordination and implementation of family counseling. The change the counselors observed in the 10 families as a result of family counseling also were investigated. Through this study, the additional supervision, education and experiences that counselors believe are necessary for them to continue providing family counseling as a school counselor intervention are identified. Finally, the intent of the school counselors to continue or cease providing family counseling at the conclusion of this study is identified.

A qualitative approach was appropriate in this study because it involved a set of procedures that focused on human interactions and dynamics, in which informants would be encouraged to discuss their experiences and perceptions (Gilgun, Daly & Handel, 1992). In this type of research, a hypothesis was not necessary for the investigation. The following tools were used to collect data for this study: 1) researcher field notes, 2) Counseling Process Notes, 3) Counseling Progress Notes, 4) Early-in-Process Counselor Questionnaire, and 5) Post-Counseling Counselor Questionnaire. The researcher's field notes cover all correspondence throughout the duration of the study including detailed content of telephone and in-person conversations the researcher has had with the elementary school counselors who participated. The school counselors also submitted written data to the researcher in the form of the

Counseling Progress Notes, the Counseling Process Notes and responses to the Early-in-Process Counselor Questionnaire and the Post-Counseling Counselor Questionnaire.

According to Lee (1993), gaining access to information about personal experiences requires researchers to have a theoretical understanding of the setting they are attempting to enter. As a licensed school counselor with six years of counseling experience in elementary schools and a licensed marriage and family therapist, this researcher has an excellent understanding of school and family systems.

Research Questions

The research questions given below were designed to elicit information concerning elementary school counselors' experiences and perceptions in providing family counseling.

1. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to counselors obtaining families to participate in family counseling?
2. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to family members attending counseling sessions?
3. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the procedures and logistics involved in family counseling as a part of the school counseling program?
4. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the changes observed by the counselors in the children and families during the period of family counseling?
5. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the education and counseling experiences the counselors believe necessary in order to provide family counseling as a regular part of the school counseling program?
6. What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to continuing to provide family counseling as a regular part of the school counseling program?

Selection of Counselor Participants

The elementary school counselors who participated in this study were employed by a large, suburban school system in Northern Virginia that employs more than 175 elementary school counselors. Each of these elementary school counselors is assigned approximately 500 students. According to required enumerative data reports the counselors submit to the school system, these school counselors generally counsel 35 students per year in individual and/or group counseling, in addition to providing classroom guidance. The counselors also consult with parents and provide parent education and other preventative programs unique to the individual school counseling program.

Prior to the official beginning of the school year, the researcher introduced the study to the prospective school counselors at a counselor in-service program. During the in-service program, the researcher explained the need, purpose and significance of the study. At the in-service meeting, 175 elementary school counselors completed a Family Counseling Survey form which the researcher developed to determine the counselor's qualifications and interest in participating in the study (see Appendix A). Sixty-five school counselors designated an interest to participate in the study by checking an interest box, item number seven on the survey form. Of these 65 counselors, only 38 met the criteria for participation in the study.

The researcher, in collaboration with a university professor of marriage and family therapists, developed the following criteria for selecting the counselors who would participate in the study:

1. The counselor had successfully completed at least one course in family systems counseling from an institution of higher education.
2. The counselor had attended conferences or workshops in family counseling authorized by a professional organization.
3. The counselor had a minimum of two years of counseling experience, with at least one year in an elementary school.
4. The counselor had obtained permission from their respective school principal to participate in the study.

The 38 potential school counselor participants who met the selection criteria were invited to one of two information meetings about the study (see Appendix B). To ascertain the extent of the perspective school counselor participant's knowledge and competencies in family counseling, the researcher asked all 30 counselors who attended the information meetings to

complete the Counselor Screening Form (see Appendix C). The eight counselors who did not attend the information meeting were unable to participate in the study. A Counselor Protocol with detailed information about procedures of the study, screening the family, informed consent and supporting research, was provided to the school counselors and reviewed at the information meetings (see Appendices K and L). Included with the Counselor Protocol was a copy of the American Counseling Association Code of Ethics. The Code of Ethics was also reviewed with the perspective school counselor participants to encourage their strict adherence to professional ethical standards as they participate in the study.

The researcher, a Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT) and a Licensed School Counselor, then identified 10 school counselors to conduct family counseling for this study. The school system's research committee approved only 10 counselors to participate in the study. The permission of the principal of each counselor's school was required for counselors to conduct family counseling as part of this study. The researcher met with principals to obtain the principal's written permission for their schools to participate in the study (Appendix D). Considering the voluntary nature of counseling and the possibility of drop out of counselors providing family counseling and/or families receiving family counseling, the researcher required a minimum of two school counselors to complete this study.

Procedure

Procedure for Data Collection

Each elementary school counselor who participated in the study conducted family counseling with a family of a child with a learning disability. The research period began when the researcher recruited, identified and screened prospective school counselors. The researcher spoke about the study at the first counselor in-service at the beginning of school year. The researcher explained the need, purpose and significance of the study to 175 elementary school counselors who attended the meeting. The researcher had all the counselors at the inservice complete a Family Counseling Survey form. This form was developed by the researcher to determine the counselor's qualifications and interest in participating in the study (see Appendix A). Sixty-five school counselors indicated on the forms that they were interested in participating in the study. Although 65 counselors expressed interest in the study, 38 met the criteria for participation in the study (see Selection of Counselors in previous section).

The 38 potential school counselor participants were invited to attend one of two information meetings about the study (see Appendix B). The researcher asked all 30 counselors who attended the information meetings to complete the Counselor Screening Form (see Appendix C). The information on this form was compiled by the researcher to ascertain the extent of the perspective school counselor participant's knowledge and competencies in family counseling. Those counselors who were unable to attend the information meeting were unable to participate in the study. At the meeting, the researcher provided each potential participant with the Counselor Protocol, a detailed information about procedures of the study. Included in the protocol were complete instructions for the family counseling procedures and the procedures (see Appendices K and L). The researcher reviewed the School Counselor Code of Ethics to encourage the participants' strict adherence to professional ethical standards as they participate in the study. The researcher reviewed informed consent and had the counselors sign the Informed Consent Forms.

The researcher then identified 10 school counselors to conduct family counseling for this study. Ten counselors were selected to participate in the study. This was the number approved by the school system's research committee. The school's principal needed to give permission for the counselor to participate in this study. The researcher met with the principals to obtain a signed permission for their school counselor to provide family counseling as a part of this study (Appendix D).

Once the counselors began family counseling, the researcher required them to provide her with the counseling progress notes and the counseling process notes of each counseling session (see Appendix G and H). These notes and all correspondence for this study were kept confidential. The names of school counselors and names of families were changed, and all information identifying the families was destroyed to ensure client confidentiality. The counselors kept a copy of the counseling notes for their records, and a copy was forwarded to the researcher after each family counseling session. The school counselors were able to send the counseling notes, intake report and informed consent directly to the researcher via a dedicated facsimile machine. The counseling notes were reviewed regularly by the researcher. In addition to being available at any time for consultation with the school counselor participants, the researcher contacted each of the school counselors by telephone a minimum of three times during the study.

Two structured questionnaires were given to the school counselors to enable them to provide feedback and information on their experiences and perceptions conducting family counseling in their schools. The Early-in-Process Counseling Questionnaire was completed by the counselors after the second or third session of counseling, and the Post-Counseling Counselor Questionnaire was completed after the eighth session (see Appendix J). These questionnaires allowed the researcher to collect descriptive information about the counselors' experiences and perceptions while providing family counseling and their participation in the study.

Procedure for Counseling Process

Principal permission was received from eight of the ten schools. Once principal permission was obtained, school counselors were asked to begin selecting a family to participate in family counseling. The school counselor participants consulted with the resource teachers for the children receiving learning disability services to identify perspective families. These families had a child who qualified as learning disabled and who received special education services (Appendix K, Selecting a Family in the Counselor Protocol).

The following criteria were used in selecting families to receive family counseling in this study:

1. Only families with a child diagnosed as having a learning disability and no other primary or secondary diagnostic classification.
2. Only families with a child receiving special education services for at least one year.
3. Only families presently receiving no other family counseling were considered as prospective subjects.

After identifying potential families, the school counselors contacted each of the families by telephone to provide them with information about the study, and to offer them the opportunity to set up an appointment to learn more about the study. The counselors screened the families to determine their counseling histories and to determine their dedication to the family counseling process (see Appendix K, Screening Families in the Counselor Protocol).

The counselors then received a completed Family Informed Consent form from their respective families. As part of the informed consent, the counselors reviewed procedures for maintaining confidentiality in the study and the legal and ethical exceptions to confidentiality. Prior to the meeting with the family, the counselor reviewed the child's social case history report. During the family screening, the counselors clarified any questions they may have had from the

social case history report and finished completing the intake report with the parents (see Appendix F). The counselor then scheduled a time for the first counseling session.

Each school counselor determined which family members were to participate in the counseling sessions. However, as a minimum, one parent and the child with learning disabilities must have committed to attend all of the counseling sessions. The counseling period included eight one-hour sessions that were scheduled on days and at times convenient for the families. Family counseling sessions were conducted before, during or after school hours. If an appointment for a session was cancelled and could not be rescheduled within the week it had originally been scheduled, the counseling period continued for an additional week to ensure that eight counseling sessions had been provided for each family. The researcher required the school counselors provide her with the counseling progress notes and the counseling process notes of each session (see Appendix G and H).

As a part of the counseling process, counselors asked the participating parents to complete a Structural Family Interaction Questionnaire at the beginning and at the end of the eight-week sessions. At the conclusion of the eighth counseling session, the parents were also asked to complete the Family Counseling Evaluation Form in which they evaluated their family counseling experiences (Appendix I). Since these forms contained information pertaining to the school counselors, each of these evaluation forms was put in an envelope and sealed by the family member. The Structural Family Interaction Questionnaire and Family Counseling Evaluation form were collected as part of the counseling process and are not reported as part of the results in this study.

Research Instruments for Counselor Experiences and Perceptions

Early-in-Process Counselor Questionnaire. (Appendix J) The Early-in-Process Counselor Questionnaire was designed by the researcher to obtain information on the experiences and perceptions of elementary school counselors while providing family counseling in the schools. The questionnaire consists of seven questions designed to explore the procedures and logistics involved in providing family counseling as a part of the school counseling program. In addition, the questions provided a structured format, which enabled the school counselors to indicate the degree of cooperation they received from the families.

Post-Counseling Counselor Questionnaire. (Appendix J) The Post-Counseling Counselor Questionnaire was designed by the researcher to explore the experiences and perceptions of elementary school counselors while providing family counseling in the schools.

The questionnaire consists of 14 questions designed to identify changes the counselors observed in children and families during the period of family counseling, the level of training and education the school counselors believe is necessary for providing family counseling in the schools, and the intent of the school counselors to either continue or discontinue to provide family counseling.

Counseling Progress and Process Notes. (Appendices G and H) The researcher created the format for the counseling progress and process notes. The counseling notes were submitted after each session to ensure that the school counselors were using systems theories and techniques in counseling families for this study. The progress notes require the counselor to identify the presenting problem and provide a diagnostic impression and treatment plan. The counselors were also required to provide a detailed summary of each counseling session and any additional related comments. The six-question counseling process notes allowed the school counselors to identify counseling techniques and interventions they used, as well as to rate their impressions of their counseling and the counseling process.

Research Instruments for Descriptive Data of Counselors

Family Counseling Survey. (Appendix A) The Family Counseling Survey is a seven-question checklist in yes/no format designed by the researcher. The survey provides the researcher with an initial screening of the counselors and a list of counselors who are interested in participating in the study. The survey allowed the researcher to collect information on the school counselors' education, training and interest in family systems counseling.

Counselor Screening Form. (Appendix C) The Counselor Screening Form is a 14-question, short-answer form designed by the researcher. The Counselor Screening Form was used to collect more detailed information about the school counselors' education, training and interest in family systems counseling. The counselors responded to questions specific to their experiences and supervision in family counseling. The Counselor Screening Form also explores the counselors' theoretical orientations and preferred counseling theories and techniques.

Instruments for Description of Families and as a Part of the Counseling Process

Intake Report. (Appendix F) The Intake Report was used to provide the counselors and the researchers with background information on the children and families. The intake provided demographic information about the families, descriptions of the children, information on the health of the children, family background, family relationships, the progress of the children in school and the children's relationships with peers. The school counselors completed the intake

using information from the children's social case history report in their special education records and information from the parents and teachers.

Family Counseling Evaluation Form. (Appendix I) The Family Counseling Evaluation Form is a seven-question, short answer evaluation form created by the researcher. The families completed the Family Counseling Evaluation Form after their final counseling session. The family evaluation has the parents rate their satisfaction with family counseling, identify what they liked best about family counseling, describe what they learned about themselves and family members during the sessions, and describe changes in them and their family that may be a result of the family counseling. The families were also asked in the evaluation if they would recommend to others at the school participating in family counseling. This instrument was used to provide feedback to the researcher and the counselors on the family counseling and was not be used for data collection in this study.

The Structural Family Interaction Questionnaire. The Structural Family Interaction Questionnaire (Perosa, 1980) was administered to the parents prior to and following the family counseling. The information obtained prior to the family counseling aids the counselor in gaining a better understanding of the family patterns of interaction. The information obtained from this questionnaire was used as part of the counseling process and was not used for data collection in this study. The Structural Family Interaction Questionnaire incorporates the Family Environment Scale (1974), the Family Interaction Scale (1965) and the Family Concept Test (1960), and measures the major constructs postulated in Minuchin's general model of structural family functioning.

Perosa (1980) reports using these tests because they have good reliability and validity. A pool of 100 items were generated to measure the following family interaction patterns: enmeshment, disengagement, overprotection, neglect, conflict resolution, conflict avoidance, conflict expression—without resolution, flexibility, rigidity, parent-management, triangulation, parent-child coalition and detouring. Perosa developed this instrument to investigate whether Minuchin's specific model of psychosomatic family functioning applies to families with learning disabled children.

To determine content validity and construct validity, six family counselors were given construct definitions, questionnaire items, and directions to rate the fit between the two. The overall inter-judge reliability for the content of the items was 0.950. Most promising in terms of construct validity is the fact that the interscale correlations do fall into patterns set out by

Minuchin. The instrument appears to be tapping into concepts indicated in Minuchin's theory. Although one step has been taken toward establishing construct validity, Perosa (1980) reported no real progress in determining criterion-related validity.

Research Questions Matched with Data Collection Sources

Table 3-1 shows the instruments used to collect the data and the specific items used to answer each research question.

Table 3-1 Research Questions Matched with Data Collection Sources

Research Questions	Early-in-Process Counselor Questionnaire	Post-Counseling Counselor Questionnaire	Counselor Progress Notes	Counselor Process Notes
What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to:				
1. counselors obtaining families to participate in family counseling?	1) What did you encounter in the process of obtaining a family to participate in this study? 2) How did you gain cooperation from the families in scheduling sessions?			
2. family members attending counseling sessions?	3) What days and times were sessions scheduled? 4) Who attends or will attend the counseling session?	2) How many total sessions did the family attend? 3) How many sessions needed to be rescheduled and why?	Attendance at each session	

Research Questions	Early-in-Process Counselor Questionnaire	Post-Counseling Counselor Questionnaire	Counselor Progress Notes	Counselor Process Notes
3. the procedures and logistics involved in family counseling as a part of the school counseling program?	5) What adjustments, if any did you have to make to your regular schedule or program in order to offer family counseling? 6) What procedures and logistics did you encounter as you conducted family counseling in your school?			
4. the changes observed by counselors in the children and families during the period of family counseling?		4) On a scale of 1-6, where 1 is the goals not completed to 6 is all goals completed, how close do you think your clients came to meeting their counseling goals? 5) What changes, if any, occurred in the child that may be related to their participation in family counseling? 6) What changes, if any, occurred in the parent(s) that may be related to their participation in family counseling? 7) What changes, if any, occurred in parent-parent interaction that may be related to their participation in family counseling? 8) What changes, if any, occurred in the parent-child interactions that may be related to their participation in family counseling? 9) To what extent did family members modify their expectations regarding their child?		1, 4 Additional comments or observations

Research Questions	Early-in-Process Counselor Questionnaire	Post-Counseling Counselor Questionnaire	Counselor Progress Notes	Counselor Process Notes
		10) What about the counseling process seemed to have the greatest impact on the family you counseled?		
5. the experience and education the counselors believe necessary in order to continue to provide family counseling as a regular part of the school counseling program?		11) What specific education (i.e., course work, practicum, internships) do you believe is necessary for you to continue to provide family counseling? 12) What specific training (i.e., work experience, supervision) do you believe is necessary for you to continue to provide family counseling?		
6. continuing to provide family counseling as a regular part of the school counseling program?	7) Discuss the benefits of offering family counseling as part of your school counseling program.	1) Use five single descriptors to indicate your experiences in conducting family counseling. 13) Will you continue to provide family counseling? 14) In your opinion, should family counseling become a regular part of the school counseling program?		

Data Collection

Numerous means of data collection were utilized in this study. Information to describe counselor participants was obtained from the Family Counseling Survey and the Counselor Screening Forms. Information to describe family participants was obtained from the counseling progress and process notes, the Intake Report, the Structural Family Interaction Questionnaire

and the Family Counseling Evaluation Form. Actual counselor and family names have been replaced with fictitious names and each family has been assigned an identification number. All information collected on the families and counselors were kept confidential in all oral and written communication associated with this study.

Understanding the school counselors' experiences and perceptions in providing family counseling in the schools required verbal and written interactions between the counselors and the researcher. The researcher met at least once with each counselor and principal to explain the study and obtain consent from the principal. The researcher also made regular telephone contacts with each counselor. All verbal interactions occurring as part of this study were documented in researcher field notes. The school counselors completed and submitted their counseling notes to the researcher and also responded to two questionnaires about their experiences during the study. The two questionnaires, the Early-in-Process Counselor and the Post-Counseling Counselor Questionnaires, were designed by the researcher to elicit responses from the school counselors about their experiences and perceptions during the entire process of providing family counseling in the schools. The researcher reviewed all counselor responses to the questionnaires, and, when necessary, the researcher responded to the counselors with probing questions for clarification, or to gain more details of the counselors' experiences in this study. In turn, the counselor responded with more detailed responses.

Researcher Bias

According to *Websters New Dictionary* (1991), a bias is defined as a leaning of the mind. Three types of researcher biases in this study will be reviewed. These biases are those resulting from the following: 1) the researcher's attributes and attitudes, 2) the researcher's experiences and expectancies, and 3) the procedures for the study.

Researcher biases in this study result from the personal attributes of the researcher, e.g., the researcher's enthusiasm and commitment to the research. Another bias results from the researcher's role as a professional school counselor, counselor educator of school counselors and a licensed marriage and family therapist. These roles contributed to the researcher's bias toward a systems approach to school counseling. To offer the best help for children with learning disabilities, the researcher believes that counselors must work with the entire family and that the ideal place to provide this assistance is in the schools. Therefore, the researcher is an advocate for school counselors to provide family counseling to children and their families.

Researcher expectancies are beliefs and desires about how the participant should perform or how the study should turn out (Heppner, Kivlighan, & Wampold, 1999). Kazdin (1980) noted that the effect of these expectancies have been referred to as an "unintentional expectancy effect." Even though researchers may not intentionally try to influence the participant, they actually do so unconsciously through a range of verbal and nonverbal behaviors such as head nods, smiles, or subtle comments. Although some authors have argued that the effect of researcher bias has been overstated, it is generally concluded that investigators and researchers can and do influence participant responses (Christensen, 1980). Expectancies can be either positive or negative and occur in many different ways during participant recruitment, and data collection, or even after treatment interventions (Heppner et al., 1999). Most of the data from the counselors in this study were obtained in written form to minimize the influence of the bias caused by researcher expectancy.

Researcher bias may also result from procedural imprecision. Procedural imprecision occurs when the activities, task and instructions of the study are not specifically defined. Researchers introduce bias into a study because of variability in procedures. Even if a researcher has carefully specified the procedures for a particular study, variability in the researcher's performance, such as fatigue or researcher drift, might bias participant responses (Heppner et al., 1999). To account for this bias, clear procedural guidelines were established early in the research proposal for this study, and structured questionnaires were used to control counselor participant's interactions with the researcher.

Participant Bias

According to Heppner et al. (1999), participants' prior knowledge of a researcher may make it easier for the participants to respond to questions, whereas others who have no prior knowledge of the researcher may feel much less likely to disclose personal information. Christensen (1980) stated, "The perfect participant is an honest, naïve person who comes to a study without any preconceived notions, willingly accepts instruments, and is motivated to respond in as truthful and helpful as possible." Such participants would not be afraid to be seen in a negative light and would be willing to disclose information. Perfect participants would be aware of both their subjective experiences and the influences of their world around them and could, thus, reliably describe their internal and external worlds (Heppner et al., 1999). Unfortunately, we know that participants often come to research with preconceived notions (Christensen, 1980). The school counselors in this study brought with them many opinions,

preferences, fears, motivations and abilities that may or may not have affected their experiences in providing the data.

Demand characteristics refer to cues within a study that may influence participants to respond in a particular way (Heppner et al., 1999). These characteristics are usually subtle and unintentional, and may or may not be consistent with a researcher's expectancies. Demand characteristics may have occurred at any point in this study, such as during the recruiting of school counselor participants, during researcher interactions with the school counselors, during implementation of the family counseling, during completion of the counseling questionnaires and during the debriefing period following the family counseling. Demand characteristics are often difficult to identify. Although researchers intend to be objective and conduct a rigorous study, they may be unaware that specific instructions on an instrument might influence participants to withhold information (Heppner et al., 1999). Examples of demand characteristics in this study may be questions on the counselor questionnaires that give the impression the counselor must only respond to certain topics while omitting others. Allowances for this bias in the questionnaires have been incorporated in the qualitative design of the study that allows for open-ended questions on the questionnaires and multiple sources of written and verbal data collection. The instructions on the questionnaires also included an explicit statement that, " there are no right or wrong answers," as a means to eliminate demand characteristics and any implications associated with the questions.

Participant characteristics may affect how participants respond to the demand characteristics, but on a broader level. Christensen (1980) suggested a consistent self-presentation theme among participants to present themselves in the most positive light possible. He posited that participants use available demand characteristics to identify the types of responses which make them appear most positively and respond in a way they believe is consistent with the researcher's desires. In this study, some of the counselor participants may have begun to feel threatened if they believed their performance was inadequate or their responses were wrong and, therefore, the counselors may have been reluctant to disclose negative information about themselves or their performance. To reduce performance pressure and fears of their identity being revealed, counselor participants were reminded often that all data would be kept anonymous and confidential and code names had been used instead of the counselor's names.

Method of Data Analysis

The Early-in-Process Counselor and Post-Counseling Counselor Questionnaires were the primary means employed to obtain data from the school counselors. The structured questions were designed to elicit considerable information about the experiences and perceptions of the school counselors. Other data were gathered from the counseling progress and process notes written by the counselors after each counseling session and from researcher field notes compiled during the study. The data were reduced and organized into a descriptive framework.

The specific procedures used in analyzing these data were adapted from Heppner et al., (1999), Miles and Huberman (1994), Seidel, Fiese and Leonard (1995), Stones (1979) and Wolcott, (1994).

List of Data Reduction Procedures

1. Read counselor responses to questionnaires.
2. Organize data by each counselor and by individual questions.
3. Analyze counselor responses to discover global aspects of data.
4. Analyze words, sentences and paragraphs to determine natural meaning units.
5. Give natural meaning units idiographic themes.
6. Idiographic themes occurring two or more times were grouped into nomothetic themes.
7. Use natural meaning units to validate the nomothetic and idiographic themes.
8. Define patterns and trends in the data themes.
9. Interpret the data and themes.

Each of the data reduction procedures is identified and described below. The description contains the source of the procedure and how it was adapted.

1. Read counselor responses to questionnaires. The researcher read the counselor responses numerous times to obtain an overall essence of the data. According to the model of qualitative data analysis given by Seidel et al. (1995), the first step in the data analysis, 'noticing', included making observations, writing researcher field notes, and reviewing counselor screening forms, counseling notes and structured questionnaires. In this study, 'noticing' included the researcher reviewing all the data sources. This initial read allowed the researcher to gain an overview and holistic view of the raw data.

2. Organize data by each counselor and by individual questions. The researcher then organized the counselor responses by each counselor and by individual questions. The

transforming and sorting of the data into counselor and question categories is the beginning of the data reduction process of Miles and Huberman (1994). The categories of data were then organized into matrices, graphs and charts to allow the researcher to see patterns in the data. This process of data organization and display simplifies and transforms the data and begins the process of data reduction. The process of data reduction occurred throughout the study and included writing summaries, coding, developing and sorting themes, making clusters of themes, making partitions and writing memos. After counselor responses were submitted, the data reduction for this study began and continued throughout the study until a final report of the data was compiled.

3. Analyze counselor responses to discover global aspects of data. The researcher again read and analyzed the data to gain a more complete understanding of the data. Wolcott (1994) discusses thick description, a thorough presentation of the data, to analyze data and present results. Wolcott (1994) recommends using a "zoom lens" to zoom in and pull back to present a richer picture of context and detail. To present a thick description in this study, an in-depth analysis of the questionnaire data as well as descriptions of the participating counselors and families were presented in chapter 4. In this way, "the data speak for themselves" and provide a rich account of the counselor's experiences (Heppner et al., 1999).

4. Analyze words, sentences and paragraphs to determine natural meaning units. To continue reducing the data, the researcher studied the counselor responses to identify the essence and characteristics of each response. These responses, in the form of direct quotations from the counselors, were reduced to their natural meaning units. Natural meaning units are unique counselor statements expressing a single aspect of the counselors' experience. The natural meaning units, each conveying a specific meaning, spontaneously emerged from the data (Stones, 1979). The researcher then labeled counselor responses by meaning, categorized equivalent responses and divided direct quotations from the counselors' sentences and paragraphs into natural meaning units.

5. Give natural meaning units idiographic themes. The researcher assigned each natural meaning unit for each counselor's response an idiographic theme. Idiographic themes, according to Vogt (1993), are used to describe research that deals with the individual. Idiographic themes were used in this study to express the data in as accurate form as possible, using the counselor's own terminology whenever possible so that the data may speak for themselves. Themes were first generated from the counselors' direct quotes on a word-by-word,

sentence-by-sentence, paragraph-by-paragraph reading of the natural meaning units, then written into the transcripts. This procedure was repeated several times to ensure accurate identification of themes.

6. Idiographic themes occurring two or more times were grouped into nomothetic themes. The idiographic themes that occurred two or more times or containing similar words were grouped into nomothetic themes. According to Vogt (1993), nomothetic research attempts to establish general, abstract principles and describe relations among variables as well as the research that tries to discover them. The idiographic themes not grouped as a nomothetic theme were closely examined. Relevant idiographic themes were represented as idiographic themes and irrelevant ones were eliminated. The nomothetic and idiographic themes represent condensed summaries of the original data. As these themes emerged from the data, the essence of the counselor's experiences became apparent (Stones, 1979).

7. Use natural meaning units to validate the nomothetic and idiographic themes. The researcher reviewed the natural meaning units and extracted direct quotes to support the nomothetic and idiographic themes. Nomothetic themes were created using exact or similar terminology from the idiographic themes of which they were composed. According to Stones (1979), the shared nature of our world allows us to understand meanings of others. With this shared understanding of meaning, the researcher may designate central themes to reduce natural meaning units into words other than those used by the subject so as to clearly express the intended meaning. In this way, the richness of the data is maintained. This implies that regardless of how clearly meanings are differentiated from one another conceptually through the questioning of the data, there is an inseparable relatedness of all the meaning units (Stones, 1979).

8. Define patterns and trends in the data themes. The researcher used the themes to identify patterns and trends in the data. According to Neuman (1991), categories and patterns in the data can lead to explanations of the subject under study. Through development of themes, recurrent patterns in the data, and relationships among these patterns, the essence and prevalent points of the counselors' experiences was revealed. According to Heppner et al., (1999), as the researcher progresses through the data, the explanatory power of the various themes becomes apparent. The themes are revised and refined until a clear theme is developed. When the theme is relatively robust, the researcher reexamines the data to understand how the theme functions with the phenomenon (Heppner et al., 1999).

9. Interpretation of the data and themes. The researcher extracted meanings and identified context from the emerging patterns, and began to address more global issues concerning the counselors' experiences and perceptions in this study. Wolcott (1994) noted that "at interpretive extreme, a researcher-as-writer may seem merely to swoop down into the field for a descriptive morsel or two and then retreat once again to the lofty heights of theory or speculation" (p.11). Wolcott (1994) also noted that interpretation "is well suited to mark a threshold in thinking and writing at which the researcher transcends factual data and cautious analyses and begins to probe into what is to be made of them" (p.36). From the beginning, the researcher determined meanings of the data, noting patterns, themes, explanations and possible configurations. The process of interpreting was continual so that themes and patterns evolved and became more defined as the study progressed and more data were gathered. As findings reported as themes emerged from the data, they were reviewed for their plausibility and conformity.

Summary

This study focused on the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities. Data were collected through the use of questionnaires, counseling notes and field notes. These data were analyzed using qualitative procedures adapted from several theoretical perspectives.

CHAPTER 4
RESULTS OF THE STUDY

The results of the data analysis described in chapter 3 are provided in this chapter. The first section presents demographic information about the subjects; i.e. the counselors who participated in this study. The second section provides a brief description of the group of families who participated in the study. In the third section, the themes and other information obtained from the counselor questionnaires, counseling notes and interviews using probing questions are presented.

The names given in this study are fictitious. All names have been changed to ensure the anonymity and confidentiality of the counselor participants and members of the families with children with learning disabilities.

As noted in chapter 3, this study started with 10 counselors, each of whom worked with one family, with expectations of completing the eight weeks of family counseling. Of those ten, only five counselors actually completed the eight weeks. Therefore, the following sections include only the data pertaining to the five counselors and five families completing the eight family counseling sessions for the study.

Description of the Counselors

Five different elementary school counselors from five different elementary schools in a large suburban school district in Northern Virginia were the subjects for this study. All five of the school counselors have earned the M.Ed. in school counseling and are licensed as elementary school counselors by the Commonwealth of Virginia. The counselors have had from three to nine years of experience, with a mean of 4.8 years of experience counseling in the schools.

Only one of the counselors has had previous experience working in a setting other than in the schools. All of these counselors have had experience counseling students from diverse populations within their schools, including African, Hispanic and Asian Americans. They also have had experience working with populations of all socioeconomic levels; lower, middle and upper class in urban, suburban and rural areas.

However, most of their experience has been in suburban schools working with middle class children regarding school-related issues. Other counseling issues with which they have had experience include developmental problems in children, family related concerns, changing family structures, parenting and marital issues, substance abuse and violence related to school-age gangs.

Each of the five counselors belongs to one or more professional organizations, with each being a member of the Virginia Counselors Association. Four of the counselors hold membership only in professional associations at the state level while one is a member of professional organizations at both the state and national levels.

Each of the five counselors has had at least one course in family counseling, with two counselors having had two and three family counseling courses, respectively. Only two of the five counselors have had clinical supervision in family counseling, with a range from 100 to 200 hours of supervision.

The five counselors all indicated an eclectic theoretical orientation. Three of the counselors indicated a preference for an Adlerian theoretical approach and three indicated Client-centered approaches. One of the counselors indicated behavioral and solution-focused as well. The counselors noted a preference for the strategic, structural and Bowenian schools of family therapy. The counselors indicated a preference for using all or some of the following family counseling techniques: joining, reframing, altering boundaries, altering patterns of communication and creating alliances. Four of the counselors indicated utilizing structural family maps, family genograms and family sculpting in counseling.

Reasons for Non-Completion of the Study by Some Counselors

Ten counselors were originally identified to participate in this study. In granting permission for the study to be conducted in this school district, the districts research committee specified that counselors would be allowed to participate. Of the 10 original school counselors identified to participate in this study, five completed the eight weeks of family counseling and five did not. Two of the five counselors began the family counseling but were unable to complete the required number of sessions. In one case, the family receiving family counseling had to relocate to another home in a different school area due to a fire that completely burned

down their house in December of 1998. This family had two family counseling sessions prior to the fire and a third termination session afterward during which the counselor referred the family for family counseling services in another setting. In the second case of the second counselor who did not complete the required eight family counseling sessions, the family met with the school counselor three times until a scheduling conflict arose. The family was unable to attend the Thursday evening sessions due to changes in the father's work schedule and wanted to re-schedule for Saturday mornings. The counselor, however, was not willing to work on Saturday mornings without receiving compensatory time from the school. Since this was not possible, the counselor terminated the family counseling and counseled instead only with the child during the school day. The family was also referred for family counseling in a non-school setting.

The other three counselors who did not complete the study were unable to receive permission from their school principals to participate in the study. One principal did not see family counseling as part of the counselors' role in her school. The second principal thought it would be too much work for the school counselor and indicated that the counselor's help was needed instead for other programs within the school. The third principal who did not grant permission for counselor participation stated that the school counselor "already had too much on her plate and does not have time for much counseling." (See Appendix M for more information pertaining to each of the school counselor participants.)

Overview of the Families

The following information collectively describes the families. The information was compiled from intake reports completed by the counselors and the social case history reports initially compiled by the school social worker as part of the eligibility process. The intake report and social case histories were mostly written from information provided by the child's parents and when relevant, school records.

Three of the five children with learning disabilities whose families participated in the study were in grade two and two were third grade students. Two of the five children were female and three were male. All of the children had been receiving special education services for at least two years prior to the beginning of the study, one child having received services for three years, with a mean 2.2 years of special education services. All of the children presented multiple diagnoses for special education. These diagnoses include difficulties in reading skills, written expression, oral expression and listening comprehension, with processing deficits in at least one

area of auditory, visual or motor integration. The referral sources and reasons for the family counseling referrals for these children and families varied. Almost all of the children exhibited academic difficulties and frustration when trying to complete their school work. Some of the following behaviors were also noted in each child: withdrawal, lying, stealing, immature acts, temper tantrums and episodes of anger.

The births of two of the five children were not normal and these same children also have difficulties in sleeping. Three of the five children suffer or have suffered from chronic ear infections. Three of the five children are bilingual and these three children are also first-generation Americans whose families are of Hispanic, Italian and Lebanese decent. Two of the participating families are Catholic, one is Muslim, one is Protestant and one is Jewish.

The current ages of the five mothers range from 33-45 years old, with a mean age of 36.8 years. Three of the mother's have a high school diploma or equivalent, and two have earned bachelor degrees. The fathers range in age from 37-45 years old with a mean age of 41.4. Two of the fathers have high school degrees while three have earned college degrees. All the fathers are employed full-time, and three of the five fathers are self-employed. Four of the five families are dual-career working families, with two mothers working part time. All of the parents are married and living with the family with the exception of one father who lives outside the family residence. Prior to participating in the study, three of the five mothers had received counseling for parenting and/or personal issues.

All of the children participating in this study have siblings. Four of the five children have older siblings. Their parents described them as having poor sibling relationships prior to the study. The sibling relationships typically are marked by much fighting, disagreements and unresolved conflict. According to the parents, all of these children are emotionally closest to their mothers. Intervention and discipline methods used by parents also vary, with all parents using some form of time out, as a disciplinary method.

None of the five children with learning disabilities who participated in the study like attending school. Four have poor social skills, lack peer friendships and often alienate classmates by acting inappropriately. Only one of the five is reported as having a good relationship with the teacher. The other four children tend to avoid the teacher and express negative feelings toward the teacher. Prior to their participation in this present study, all of the five children had previously been counseled by the school counselor for short term (less than five sessions) individual counseling. In addition to the academic assistance specified in each

child's Individual Education Plan and special education accommodations, interventions used by the school in response to the inappropriate behavior included behavior modification contracts and time outs. None of the five children seemed able to take responsibility for their actions and frequently blamed others. At the intake, all of the parents were unable to identify opportunities where they encourage responsibility in their child. (See Appendix N for more information pertaining to each of the families receiving family counseling in this study.)

Results

As described in chapter 3, the counselors' responses to The Early-in-Process Counselor Questionnaires and Post-Counseling Counselor Questionnaires and all interactions of the researcher with the school counselors were compiled into transcripts and divided into natural meaning units. Natural meaning units are direct quotations of unique counselor experiences, each conveying a specific meaning and spontaneously emerging from the data (Stones, 1979). These natural meaning units were given codes and analyzed for idiographic themes. The idiographic themes are identified as unique and specific to each counselor's individual responses (Vogt, 1993). These two or more idiographic themes expressing the same meaning were grouped together and identified as nomothetic themes. Nomothetic themes are universal general ideas or concepts identified in two or more counselor responses (Vogt, 1993). These Nomothetic themes along with relevant idiographic themes which could not be grouped into a Nomothetic theme became the structure of the school counselors' experiences. These themes allowed the researcher to organize the data with similar content to address each research question. Following each research question, the nomothetic themes are identified and listed from the highest to the lowest frequency. The letter "f" is used to indicate frequency (e.g., f=5). In addition to the themes, all of the natural meaning units are presented to validate each designated nomothetic theme.

Nomothetic Themes (NT)

NT-1. Families were initially apprehensive about participating in family counseling (f=4).

NT-2. Counselors needed to be flexible in scheduling sessions (f=4).

NT-3. Families were very interested in participating in family counseling (f=3).

NT-4. All parents and siblings committed to attending family counseling sessions (f=5).

NT-5. Counselors and families met at least eight sessions (f=5).

NT-6. Counselors met with the families during non-school counselor hours (f=3).

NT-7. Counselors did not have a regularly scheduled weekly time to meet with families (f=3).

NT-8. Counseling sessions were scheduled to accommodate parents' work schedules (f=3).

NT-9. Almost no counseling sessions needed to be rescheduled (f=3).

NT-10. Counseling sessions were rescheduled because of fathers' work (f=2).

NT-11. Counselors reported few or no adjustments to their current programs and schedules (f=5).

NT-12. Counselors reported the need to notify staff and faculty of the new program and schedule (f=3).

NT-13. Counselors reported the need for flexible work hours (f=2).

NT-14. Counselors rated the counseling goals were completed at an average of 4.9 on a scale of 6.0.

NT-15. Parents' gained a better understanding of their child's learning disabilities (f=5).

NT-16. Parents improved communication between one another (f=5).

NT-17. Parents changed their academic expectations of their child (f=5).

NT-18. Parents improved their social expectations of their child (f=5).

NT-19. Cooperative parenting was improved (f=4).

NT-20. Regular weekly family time at the counseling sessions had a great impact on the family (f=3).

NT-21. Parents spent more time together in counseling and strengthened the parental subsystem (f=3).

NT-22. Children showed better social skills and interactions with others (f=3).

NT-23. Children were more confident and interested in school (f=3).

NT-24. Children showed fewer episodes of frustration and anger (f=3).

NT-25. Parents were more patient with their child with learning disabilities (f=3).

NT-26. Parents learned new parenting techniques (f=3).

NT-27. Fathers indicated that they will spend more time with their children (f=3).

NT-28. Parents learned strategies for helping their children with homework (f=3).

NT-29. Parents learned to listen and respond to their children (f=2).

NT-30. Parents talked more openly about their child with learning disabilities and parenting issues (f=2).

NT-31. Parents learned the parenting technique of rule setting (f=2).

NT-32. Children improved their communication skills (f=2).

NT-33. Greater parent involvement positively influenced the children (f=2).

NT-34. Counselors reported that counseling supervision is necessary in providing family counseling (f=5).

NT-35. Counselors wanted additional experience conducting family counseling (f=3).

NT-36. Counselors reported that they need more family counseling experience with opportunities to consult with family counselors (f=4).

NT-37. Counselors reported that they were able to provide more effective help to the family and children through the use of family counseling (f=5).

NT-38. Counselors reported that they will continue to provide family counseling after the conclusion of the study (f=5).

NT-39. Counselors reported that family counseling should become a regular part of the school counseling program (f=5).

NT-40. Counselors reported that family counseling is beneficial to families (f=3).

NT-41. Counselors reported that parents better understand the child and the child's symptoms (f=3).

NT-42. Counselors used the descriptors rewarding, challenging, successful, beneficial and active to describe their experiences in family counseling.

NT-43. Families who had been unable to receive family counseling privately were able to benefit from family counseling in the schools (f=2).

Idiographic Themes (IT)

IT-1. Parents concerned about children missing class.

IT-2. Scheduling was an issue due to the availability of the counseling office.

IT-3. Parents concerned others will see the family going into the counselor's office.

IT-4. Compensatory time needed for family sessions scheduled after school counselors' regular work hours.

IT-5. Scheduling problems regarding access to the counseling office.

IT-6. Parental denial of the learning disability was eliminated.

IT-7. Parents gained greater hope regarding their child's ability to cope with the learning disability.

IT-8. Parents spent more time with their children.

IT-9. Improved communication among all family members.

IT-10. Parents established the hierarchy within the family by enforcing the parental subsystem.

IT-11. Counseling provided a safe place for the family to discuss family issues.

IT-12. Family counseling in schools provided help to families who would otherwise not seek help.

IT-13. School counselors reported a need for clinical supervision and consultation to provide family counseling.

Research Question Number One

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to counselors obtaining families to participate in family counseling?

Data from Early-in-Process Counselor Questionnaire: Questions #1 and #2.

Nomothetic Themes.

Nomothetic Theme 1. Families were initially apprehensive about participating in family counseling (f=4).

Counselor 1. "Two families were apprehensive because [of] . . . the uncertainty associated with change. One family was apprehensive and would not give a reason."

Counselor 3. "Father did not think [counseling] was necessary. Mother convinced father . . ."

Counselor 4. "Parents were concerned about the effect family counseling would have on their child and on interaction among family members . . . that their regular appearance in the school counselor's office would have negative impact on their child, such as child embarrassment and peer ridicule."

Counselor 5. "Parent's reactions . . . were diverse, ranging from a severe negative reaction to apathy on the part of three parents . . . . Some parents were apprehensive because they would be the only family involved with family counseling; they stated they would be comfortable if other families were involved."

Nomothetic Theme 2. Counselors need to be flexible in scheduling sessions (f=4).

Counselor 1. "The only requests were for me to be extremely flexible on the schedule . . ."

Counselor 3. "They seemed eager to cooperate as long as we were able to accommodate their work schedules."

Counselor 4. "I had to be flexible for scheduling times to meet for sessions."

Counselor 5. "The family could meet only after regular school hours."

Nomothetic Theme 3. Families were very interested in participating in family counseling (f=3).

Counselor 1. "One family was very enthusiastic . . ."

Counselor 3. "The family I chose was very willing to receive free counseling services."

Counselor 5. "Parent's reactions . . . were diverse . . . [I received reactions of] gladness on the part of two families . . ."

Idiographic Themes.

Idiographic Theme 1. Parents concerned about children missing class.

Counselor 2. "We agreed on a time when the children would not be pulled from class."

Research Question Number Two

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to family members attending counseling sessions?

Data from Early-in-Process Counselor Questionnaire: Questions #3 and #4.

Data from Post-Counseling Counselor Questionnaire: Questions #2 and #3.

Nomothetic Themes.

Nomothetic Theme 4. All parents and siblings committed to attending family counseling sessions (f=5).

Counselor 1. "All family members will attend each session."

Counselor 2. "Mother, father, [and children] will attend . . ."

Counselor 3. "Immediate family members [will attend family counseling session]."

Counselor 4. "The [children] and at least one of the parents [will] attend regularly."

Counselor 5. "The child, mother and father attended . . . The sister attended most sessions."

Attendance records compiled from the counseling notes indicate that a minimum of one parent and the child with learning disabilities attended all the sessions. Both parents attended most sessions and some of the siblings missed a few sessions.

Nomothetic Theme 5. Counselors and families met at least eight sessions (f=5). (see Figure 4-1)

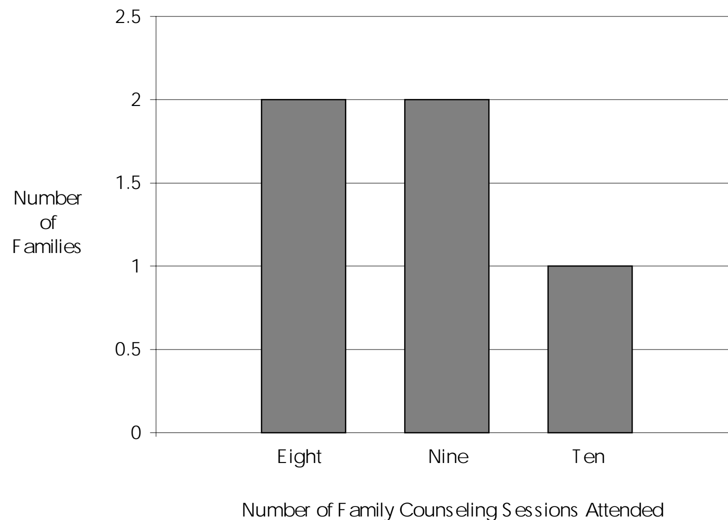


Figure 4-1. Family Counseling Sessions Attended (Average Number of Sessions is 8.8).

Nomothetic Theme 6. Counselors met with the families during non-school counselor hours (f=3).

Counselor 1. "The sessions were in the morning, 7:00 or 8:00 a.m., and midweek, Tuesday or Wednesday."

Counselor 3. "After school on Thursdays."

Counselor 5. "Family counseling sessions were held on Wednesdays at 5:00 p.m. Alternate days and times were always scheduled with little notice and included two Saturday sessions."

Nomothetic Theme 7. Counselors did not have a regularly scheduled weekly time to meet with families (f=3).

Counselor 1. "The schedule for all sessions could not be made in advance . . ."

Counselor 4. "[Counseling] times had to be flexible due to parents' work schedule. . ."

Counselor 5. "A few sessions had to scheduled for alternate days and times, dependending upon the father's schedule."

Nomothetic Theme 8. Counseling sessions were scheduled to accommodate parents' work schedules (f=3).

Counselor 3. "Mother was able to arrange to go into work early and skip lunch so that she was able to leave work early to attend the sessions."

Counselor 4. "Scheduled times had to be flexible due to parents' work schedule . . ."

Counselor 5. "Sessions had to be scheduled for alternate days and times dependent upon the father's schedule."

Nomothetic Theme 9. Almost no sessions needed to be rescheduled (f=3).

Table 4-1 Number of Counseling Sessions Rescheduled

	# of sessions rescheduled
Counselor 1	0
Counselor 2	2
Counselor 3	0
Counselor 4	0
Counselor 5	3

Nomothetic Theme 10. Counseling sessions were rescheduled because of father's work (f=2).

Counselor 1. "Two family counseling sessions needed to be rescheduled because of the father's work schedule."

Counselor 2. "Three sessions had to be rescheduled. All changes were because of the father's work."

Research Question Number Three

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the procedures and logistics involved in family counseling as a part of the school counseling program?

Data from Early-in-Process Counselor Questionnaire: Questions #5 and #6.

Nomothetic Themes.

Nomothetic Theme 11. Counselors reported few or no adjustments to their current programs and schedules (f=5).

Counselor 1. "There was minimal impact on my schedule."

Counselor 2. "It did not disrupt my regular schedule, but required a few adjustments."

Counselor 3. "Changes to my program included the coordination of parent volunteers to supervise the homework club . . . this cleared my schedule so I would have time after school to meet with the family. Homework Club parent volunteers are now a permanent change and have

been positively received by the school community. This small change has allowed me to clear my schedule to do more counseling."

Counselor 4. "My schedule was slightly impacted by the parents' schedule . . . my program was not affected."

Counselor 5. "None. The counseling did not interfere with my regular program since it was after regular working hours."

Nomothetic Theme 12. Counselors reported the need to notify staff and faculty of the new program and schedule (f=3).

Counselor 1. "The staff needed to be informed that I would not be available for consultation on the mornings [I was meeting with families]. Faculty and students were not accustomed to my door being closed so early in the morning."

Counselor 2. "I had to let the faculty know I would not be available for scheduling and consultation on the early dismissal days anymore. I had to make the teachers aware of the times families would be in my room for sessions."

Counselor 3. "I sent out an e-mail message notifying faculty and staff of the change in my schedule and the exciting addition to the counseling program."

Nomothetic Theme 13. Counselors reported the need for flexible work hours (f=2).

Counselor 1. "School counselors need flexible work hours in order to accommodate family schedules."

Counselor 5. "If counselors were to provide ongoing family services, we would need flexible work schedules."

Idiographic Themes

Idiographic Theme 2. Scheduling was an issue due to the availability of the counseling office.

Counselor 2. "Due to confidentiality in counseling, teachers would no longer be able to enter my office Monday afternoons to use the phone."

Idiographic Theme 3. Parents concerned others will see the family going into the counselor's office.

Counselor 2. "I had to 'covertly' escort the parents and siblings to my office. This was done so that the child's peers did not see what the parents called 'the show' of them and their child entering my office. I had to walk by the parents, who were waiting near one of the side

entrances with the child, and they would then walk behind me at a distance and slip into my office."

Idiographic Theme 4. Compensatory time needed for family sessions scheduled after school counselors' regular work hours.

Counselor 5. "I would have liked to receive some 'comp' time as this took away from personal time."

Idiographic Theme 5. Scheduling problems regarding access to the counseling office.

Counselor 5. "I needed to have keys to the school . . . to have access to the building after school hours and on weekends . . . Also, I had to arrange with the janitors to clean my office at an alternate time on Wednesdays because I was meeting with the family during the janitor's usual rounds."

Research Question Number Four

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the changes observed by the counselors in the children and families during the period of family counseling?

Data from Post-Counseling Counselor Questionnaire: Questions #4, #5, #6, #7, #8, #9, and #10.

Nomothetic Themes

Nomothetic Theme 14. Counselors rated the counseling goals were completed at an average of 4.9 on a scale of 6.0. (see Figure 4-2)

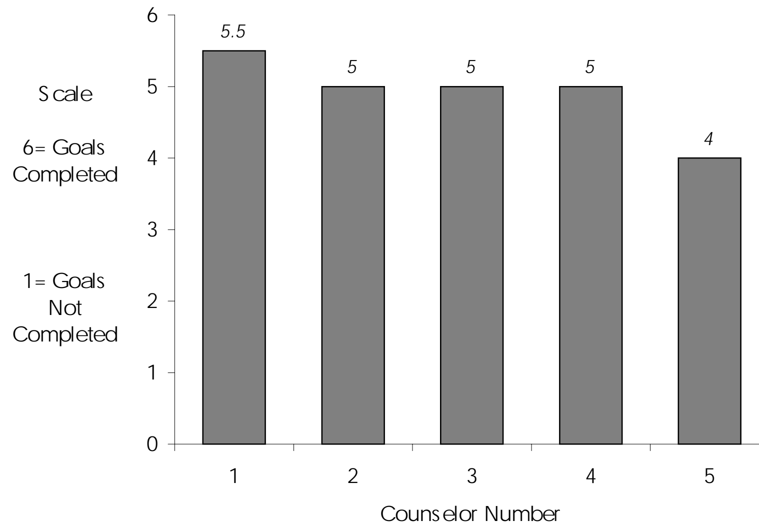


Figure 4-2. Perceptions of elementary school counselors with regard to ratings of goals completed while providing family counseling to families of children with learning disabilities.

Nomothetic Theme 15. Parents gained a better understanding of their child's learning disabilities (f=5).

Counselor 1. "The parents have a better understanding of their role in helping their child cope with academic difficulties and the challenges associated with a learning disability."

Counselor 2. "The parents were not as nervous and uncomfortable with their child's condition. Their comfort level increased markedly when they started to learn more about their child's learning disability and the respective programs available to help him cope with the LD."

Counselor 3. "The parents gained a better understanding of how to help their child to cope with the LD."

Counselor 4. "Both parents have a better understanding of their child's disability. The mother is more compassionate with the child's disability and how the disability manifests itself in the child's life in school and at home."

Counselor 5. "According to the parents, for the first time they have realized fundamental changes could be made in their son's school life."

Nomothetic Theme 16. Parents improved communication between one another (f=5).

Counselor 1. "They were able to strengthen the parenting subsystem by improving communication between them."

Counselor 2. "By the last session the parents were talking more with each other about their LD child and appropriate parenting techniques. The open discussions have led to more frank discussions on this and numerous other family matters. The parents were better able to communicate, although much more work is necessary."

Counselor 3. "They were making an effort to work together and communicate."

Counselor 4. "The parents are better able to communicate with each other with regard to their LD child's disability and how to cope with the disability. Parental communication and collaboration in parenting improved."

Counselor 5. "The parents noted that they are doing a better job of communicating with each other."

Nomothetic Theme 17. Parents changed their academic expectations of their child (f=5).

Counselor 1. "The father is expecting the child to do better academically although he understands the LD and the role he and his wife play in helping the child deal with the LD. The mother states she is withholding raising expectations; however, she does wish for the child to do better academically and socially."

Counselor 2. "Appears as if the parents, especially father, have more realistic expectations concerning their child's ability to perform academically."

Counselor 3. "The child is no longer expected to complete all her work on her own."

Counselor 4. "The parents have changed their expectations that their son will easily succeed in school, realizing academic tasks are more challenging for him than for his older brother."

Counselor 5. "The parents do not expect him to be as perfect as his sister in school. [Thus,] he will not have to spend more time locked in his room studying . . ."

Nomothetic Theme 18. Parents improved their social expectations of their child (f=5).

Counselor 1. "The mother states she is withholding raising expectations; however, she does wish for the child to do better academically and socially."

Counselor 3. "The parents have renewed their expectations that their child will gain new social skills and stop acting out in an aggressive manner."

Counselor 4. "First, the parents expect their child to stop lying and stealing from his classmates,

but they have a better understanding that these behaviors are a sign that the child needs help. They will support and encourage his interaction with other children, but realize they will need to help him foster these friendships."

Counselor 5. "The parents realize he will not be as popular in school as his sister, but they will get him more involved in extra-curricular activities where he can make new friends."

Nomothetic Theme 19. Cooperative parenting was improved (f=4).

Counselor 1. "They are better able to work together to solve problems . . . Although mother has been for individual counseling in the past, regarding parenting issues, she needed the benefits of family counseling in order to gain father's cooperation in implementing parenting techniques."

Counselor 3. "They realized the support and encouragement of both parents is necessary to best help their child. The most important aspect was that the parents learned parenting is not an individual task, but requires teamwork."

Counselor 4. "They learned ways to work collaboratively to parent and set limits. Mother and father start working together to set rules and enforce rules within the family. Mother would help father in setting limits and making parenting decisions, too. This involvement strengthened the parent subsystem."

Counselor 5. "The parents are doing a better job of parenting and setting rules . . . parents were more active (much more active) with the counseling process and their son's life."

Nomothetic Theme 20. Regular weekly family time at the counseling sessions had a great impact on family (f=3).

Counselor 1. "Having all members of the family in one place at one time made the greatest impact on the family. The family became more of a cohesive entity, while retaining their individualism."

Counselor 2. "The fact that the family was together each week for a period of time had an enormous impact on the family. Before the family counseling started, the family rarely met together, even for breakfast or dinner."

Counselor 3. "Providing a neutral place for the parents to meet and discuss their children and other family matters has made an enormous impact on the family."

Counselor 4. "Having the parents and the child on a weekly schedule of sessions—almost a ritual—has had the greatest impact on this family. The family began to look forward to each session, not only for the knowledge they acquired and the skills they learned in each session, but also for the planned time they would spend together."

Nomothetic Theme 21. Parents spent more time together in counseling and strengthened the parental subsystem (f=3).

Counselor 1. "Because the parents have busy schedules, in the past they were not able to discuss their child's LD at length with each other. The family counseling sessions brought them together in a setting where discussions could be held, and these discussions continue outside of the family counseling sessions."

Counselor 3. "Interaction between spouses has been limited. The parents do not live together . . . Change through regular attendance at the family counseling sessions has brought the parents in contact with each other more. They are making an effort to work together and communicate."

Counselor 5. "This is, in part, due to their being together for longer periods of time, both in the family counseling sessions and making time together at home to discuss parenting issues."

Nomothetic Theme 22. Children showed better social skills and interactions with others (f=3).

Counselor 2. "He has improved peer interactions and appears to be doing better socially due to less school outburts."

Counselor 3. "She has started to be more mature behaviorally while in the family counseling sessions. She is learning social skills through the counseling sessions."

Counselor 4. "He is fostering friendships with peers and improving relationships with parents and teachers."

Nomothetic Theme 23. Children were more confident and interested in school (f=3).

Counselor 1. "This has given her confidence that makes her less frustrated and better able to handle the pressure of new schoolwork."

Counselor 2. "The child has become more interested in school and motivated to learn."

Counselor 5. "He appears more confident . . . and expresses more comfortable feelings about coming to school."

Nomothetic Theme 24. Children showed fewer episodes of frustration and anger (f=3).

Counselor 2. " . . . her confidence that makes her less frustrated and better able to handle the pressures of new school work."

Counselor 3. "[He] has learned some anger management strategies and has less-frequent episodes of losing control."

Counselor 4. "The child's frequency of anger and tantrums has decreased."

Nomothetic Theme 25. Parents were more patient with their child with learning disabilities (f=3).

Counselor 1. "When their child gets frustrated and acts out this frustration in an inappropriate manner, the parents are better at handling these situations with an appropriate response."

Counselor 2. "The parents, especially father, showed much more patience with their child."

Counselor 4. "The mother is more compassionate with the child's disability and how the disability manifests itself in the child's daily life in school and at home. She is not getting as frustrated due to a change in expectations and rule setting."

Nomothetic Theme 26. Parents learned new parenting techniques (f=3).

Counselor 1. "Also, when the child exhibits periods of low self-esteem, the parents have better skills to help their child by giving her opportunities to take on more responsibilities."

Counselor 2. "Father also began to replace his disciplining methods with more effective methods using natural and logical consequences."

Counselor 4. "[Parents learn] he responds better to the organization and more structured schedule at home."

Nomothetic Theme 27. Fathers indicated they will spend more time with their children (f=3).

Counselor 3. "Father is going to try to take on more of a parenting role by planning to spend quality time with his children."

Counselor 4. "The father is making more of an attempt to spend time with all of his children."

Counselor 5. "The father spends more time with the child, especially at night, rather than spending time with his business."

Nomothetic Theme 28. Parents learned strategies for helping their children with homework (f=3).

Counselor 3. "They participate more actively in her life, e.g., oversee her homework time more closely. Mother has learned new techniques to build the child's self-esteem while helping her with her homework."

Counselor 4. "[Parents realize] he responds better to the organization and more-structured schedule at home."

Counselor 5. "The mother will be stricter enforcing rules with regard to keeping her son on a schedule that includes homework assignments and activities."

Nomothetic Theme 29. Parents learned to listen and respond to their children (f=2).

Counselor 2. "At the end of the study, both the father and the mother were more considerate when talking with their child about issues related to school and learning."

Counselor 3. "The parents are more responsive to their daughter's needs. Mother is listening to her daughter more, and this has fostered a better mother-daughter relationship."

Nomothetic Theme 30. Parents talked more openly about their child with learning disabilities and parenting issues (f=2).

Counselor 1. "Because the parents have busy schedules, in the past they were not able to discuss their child's learning disability at length with each other. The family counseling sessions brought them together in a setting where discussions could be held and these discussions continue outside of the family counseling sessions."

Counselor 5. "This is, in part, due to their being together for longer periods of time, both in the family counseling sessions and making time together at home to discuss parenting issues."

Nomothetic Theme 31. Parents learned the parenting technique of rule setting (f=2).

Counselor 4. "They learned ways to work collaboratively to parent and set limits. Mother and father start working together to set rules and enforce rules within the family."

Counselor 5. "The parents are doing a better job of parenting and setting rules. The mother has recently started a strict schedule for the child including supervision of school homework and activities."

Nomothetic Theme 32. Children improved their communication skills (f=2).

Counselor 2. "When he experiences negative feelings, he is better able to discuss his feelings with his parents, his teachers, and with me instead of acting them out."

Counselor 5. "The child is more open to discussing his feelings, especially his frustration with school work and friends with his parents."

Nomothetic Theme 33. Greater parent involvement positively influenced the children (f=2).

Counselor 1. "The child is happier now that the parents are much more intimately and actively involved with the daily happenings of her life."

Counselor 2. "The child was better able to communicate with his parents because the parents showed more of an active interest in the child's life at school."

Counselor 5. "He appears more confident because his parents are more involved in his life."

Idiographic Themes

Idiographic Theme 6. Parental denial of the learning disability was eliminated.

Counselor 2. "Father was in denial before participating in the counseling. He felt his son was just not applying himself."

Idiographic Theme 7. Parents gained greater hope regarding their child's ability to cope with their learning disability.

Counselor 4. "The parents have more hope for their son maturing and succeeding in his life."

Idiographic Theme 8. Parents spent more time with their child.

Counselor 5. "The father vowed to spend more time with his children at night rather than doing business work throughout the night . . . Parents were more active with the counseling process and their son's life."

Idiographic Theme 9. Improved communication among all family members.

Counselor 5. "Teaching the family how to communicate with each other has had the greatest impact on the family. The family now know appropriate manners of communication such as 'I messages,' as well as inappropriate manners of communication – manners to avoid."

Idiographic Theme 10. Parents established the hierarchy within the family by enforcing the parental subsystem.

Counselor 3. "The parents are working on establishing the hierarchies within the family."

Idiographic Theme 11. Counseling provided a safe place for the family to discuss family issues.

Counselor 3. "My office served as both a neutral place and a change of venue when compared with their 'split' home."

Research Question Number Five

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to the education and counseling experiences the counselors believe necessary in order to provide family counseling as a regular part of the school counseling program?

Data from Post-Counseling Counselor Questionnaire: Questions #11 and #12.

Nomothetic Themes

Nomothetic Theme 34. Counselors reported that counseling supervision is necessary in providing family counseling (f=5). (see Figure 4-3)

Counselor 1. "Supervision would be extremely beneficial."

Counselor 2. "Supervision in family counseling would also be extremely beneficial."

Counselor 3. "I will require supervision in order to continue family counseling."

Counselor 4. "I believe this supervision would give school counselors the support and confidence necessary to provide family counseling on a regular basis."

Counselor 5. "I will require more extensive supervision in family counseling to ensure all issues that arise are dealt with in an appropriate manner."

Nomothetic Theme 35. Counselors wanted additional experience conducting family counseling (f=3). (see Figure 4-3)

Counselor 1. "I believe an additional practicum or an internship including family counseling would be beneficial."

Counselor 2. "For me, the best way to learn is by doing; therefore, an internship in family counseling would be most beneficial."

Counselor 5. "More opportunities to practice and master family counseling techniques."

Nomothetic Theme 36. Counselors reported that they need more family counseling experience with opportunities to consult with family counselors. (f=4). (see Figure 4-3)

Counselor 1. "[I will continue to provide family counseling] but only with opportunities to consult a counselor with experience in family counseling."

Counselor 2. "The more work experience the better. This would be the only means for being able to deal with the session-specific issues that arise when the whole family is in the office."

Counselor 4. "I would like to have the opportunity to consult with other family counselors regarding details of case studies . . . [Family counseling needs to be incorporated into the program] but school counselors will need opportunities for supervision and consultation."

Counselor 5. "More work experience and more interaction with family counselors would be helpful."

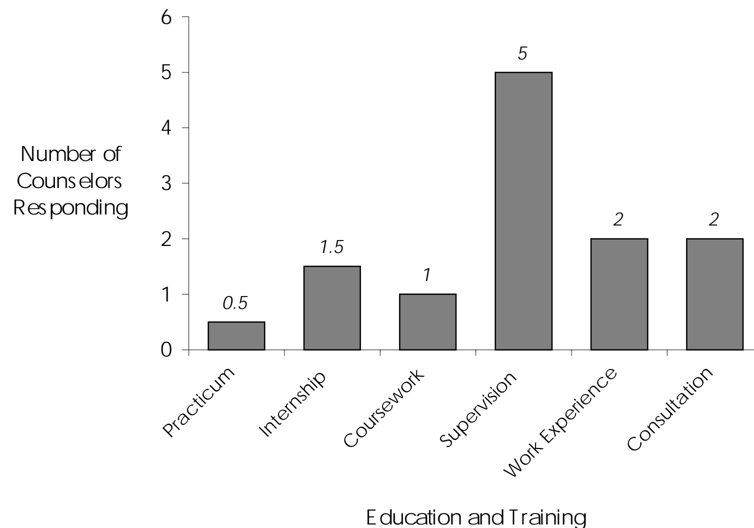


Figure 4-3. Education, training and work experience elementary school counselors need to continue providing family counseling to families of children with learning disabilities.

Research Question Number Six

What are the experiences and perceptions of elementary school counselors while providing family counseling to families of children with learning disabilities in regard to continuing to provide family counseling as a regular part of the school counseling program?

Data from Early-in-Process Counselor Questionnaire: Question #7.

Data from Post-Counseling Counselor Questionnaire: Questions #1, #13 and #14.

Nomothetic Themes

Nomothetic Theme 37. Counselors reported they were able to provide more effective help to the family and children through the use of family counseling (f=5).

Counselor 1. "Family counseling will mean less time for me spent addressing the child's problem with the parents via telephone and additional meetings. Thus, I will be able to spend more time with the child or with additional children."

Counselor 2. "The family counseling has already enabled the school to develop a better relationship with the family and has improved the child's attitude toward school."

Counselor 3. "The family was able to receive counseling within the convenience of the school."

Counselor 4. "Parents were better able to cope with child's learning disability and thus were better able to help the child in coping with the learning disability. Significant improvement in the child's functions was apparent in a relatively short period of time."
Counselor 5. "The child has a better sense of caring because of the involvement of the parents, and this better sense of caring has led to positive changes."

Nomothetic Theme 38. Counselors reported that they will continue to provide family counseling (f=5).

Counselor 1. "Yes."
Counselor 2. "Yes, I hope to continue to provide family counseling for this family, and I have discussed the possibility of family counseling with other families."
Counselor 3. "I will continue to provide family counseling as a part of my program."
Counselor 4. "I hope to continue to provide family counseling to this family . . ."
Counselor 5. "Yes."

Nomothetic Theme 39. Counselors reported that family counseling should become a regular part of the school counseling program (f=5).

Counselor 1. "Most definitely! Yes."
Counselor 2. "Yes [because] family counseling is beneficial to the families . . ."
Counselor 3. "Family counseling should become a regular part of school counseling programs."
Counselor 4. "Yes . . . family counseling proved beneficial . . ."
Counselor 5. "Yes."

Nomothetic Theme 40. Counselors reported that family counseling is beneficial to families (f=3)

Counselor 2. "Family counseling is beneficial to the families . . ."
Counselor 3. "Family counseling has benefited this family enormously and will benefit other families."
Counselor 4. "Family counseling proved beneficial for this family."

Nomothetic Theme 41. Counselors reported that parents better understand the child and the child's symptoms (f=3).

Counselor 1. "The parents left each session with a clearer understanding of their child's problem and program than if I met with them to discuss the issues."
Counselor 4. "The most immediate benefit was for parents to understand the symptoms and diagnosis for their child."

Counselor 5. "The needs of the child were more clearly identified and understood by the family."

Nomothetic Theme 42. Counselors used the descriptors rewarding, challenging, successful, beneficial and active to describe their experiences in family counseling.
(see Figure 4-4)

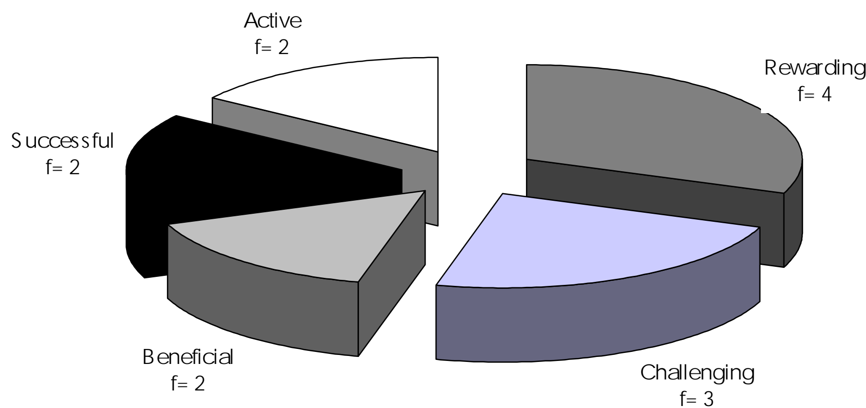


Figure 4-4. Descriptors used by elementary school counselors to indicate their experiences and perceptions while providing family counseling to families of children with learning disabilities.

Nomothetic Theme 43. Families who had been unable to receive family counseling privately were able to benefit from family counseling in the schools (f=2).
Counselor 2. "This family needed a tremendous amount of help. [They] would not have sought family counseling privately.
Counselor 3. "This family does not have the money to seek family counseling that they would never have been able to [afford], and they desperately needed."

Idiographic Themes

Idiographic Theme 12. Family counseling in schools provided help to families who would otherwise not seek help.

Counselor 2. "[Family counseling in the schools] creates an opportunity for families who would otherwise not seek professional assistance."

Idiographic Theme 13. School counselors reported a need clinical supervision and consultation to provide family counseling.

Counselor 4. "School counselors will need opportunities for supervision and consultation."

Probing Questions

Probing questions were used to elicit more information pertaining to each counselor's individual experiences. The following questions were asked to clarify information contained in the counselor responses to the Early-in-Process Counselor and Post-Counseling Counselor Questionnaires.

Probing Question Number 1.

Researcher: "You mentioned that families were apprehensive because of a change in program. To what program were you referring?"

Counselor Number 1: "The families were apprehensive to participate because of the change in the counseling program. The parents were aware of the individual and group counseling services provided as a part of my program, but they were surprised when I offered family counseling as an option. They had some concerns about confidentiality and the purpose of the research. I was able to relieve their concerns by explaining anonymity in any correspondence and research."

Probing Question Number 2.

Researcher: "You used the word, 'intimidating,' as a descriptor of your experience. Tell me more about what was intimidating for you."

Counselor Number 2: "I had never done family counseling prior to this study. I just don't feel comfortable with it yet. It reminds me of the insecure feelings I had when I first began counseling. I need more practice."

Probing Question Number 3.

Researcher: "What methods did you employ to gain cooperation from a father who was in denial concerning the need for counseling?"

Counselor Number 2: "I convinced the father the cost in time for his son and the family participating in family counseling is minimal when compared with the potential rewarding improvements for his son and the family. In addition, he had spent so much time in parent-teacher conferences that this could be an opportunity to create more positive interactions with the school, with collaboration among school and family. I also solicited the mother's help in promoting an idea of teamwork between the parents."

Probing Question Number 4

Researcher: "What methods did you employ to gain cooperation from a father who seemed to be in denial concerning the learning disability of his child?"

Counselor Number 2: "The father had thought his son was simply being lazy and not applying himself. Each time the child's learning disability presented a problem in school or in his social life, I explained to the father the scenario and how the LD manifests itself in his son's actions. The explanations were given in layman's terms and were very discrete, rather than lumping the whole diagnosis together and applying it to his son. I also provided dad with literature and a video of adults and children talking about their LD experiences."

Probing Question Number 5

Researcher: "After dealing with father's denial, it seems as if you may have encountered some resistance from father. Describe how you were able to deal with this resistance."

Counselor Number 2: "Father became very resistant when I challenged his parenting techniques. He was very defensive and trying to gain power. There was an outburst that greatly frightened me, but I was able to remain composed and empathize with his experience. In a very non-threatening manner, I was able to allow him to realize the relationship of his anger management to that of his children. We were then able to work on him modeling and teaching his children better ways of handling their anger."

Probing Question Number 6.

Researcher: "You mentioned coursework, an advanced techniques course, in order to continue to provide family counseling, and then you would require supervision. How would you like to receive this supervision?"

Counselor Number 3: "I would like to receive continued education and training at night. Ideally, a course in family counseling techniques, preferably taken with other counselors who are just starting with family counseling, would be beneficial."

Probing Question Number 7

Researcher: "You mentioned the family would not be able to receive family counseling privately. Did they seek services elsewhere? Your notes indicated a recommendation for family counseling. Who had recommended family counseling?"

Counselor Number 3: "This family was unable to afford family counseling. Mom has had many hospital bills and medical expenses not completely covered by insurance. In addition, this family is paying for two homes—one with a mortgage and the other through rent. The family went to community agencies where they were given fees on a sliding scale, but these were still not manageable to them. Their health insurance covered individual counseling for mother's condition, but not family counseling."

Probing Question Number 8.

Researcher: "How did you address the parents' concerns regarding child embarrassment and peer ridicule?"

Counselor Number 4: "I explained that the child might initially be embarrassed and have fears, and these would subside quickly as part of the family counseling program, especially with active parent involvement. The child will see that his parents are not embarrassed to attend the sessions and, therefore, he will most likely be less embarrassed about attending. Most children are eager to seek help from the counselor as the school counseling program is portrayed in a very positive light."

"Regarding peer ridicule, I explained to the parents the confidentiality of any counseling program. So many children see the counselor for many different reasons that being observed in the counselor's office is an ordinary occurrence."

Probing Question Number 9

Researcher: "Describe any changes in the parents' concerns about being 'noticed' in the counselor's office."

Counselor Number 4: "The parents became more comfortable with regard to their concerns about being noticed in my office. However, a slight concern remained even to the end of the study."

Probing Question Number 10

Researcher: "You mentioned wanting to continue family counseling, and you were discussing this with your principal. How did your principal respond?"

Counselor Number 4: "I feel very strongly about continuing to provide family

counseling. I have seen a marked difference in this family, the LD child and the parents, and I look forward to providing the same services to other families and not just LD families. I do not believe my principal would say 'no.' However, if she did, I would elicit the support of the parents to influence her decision."

Probing Question Number 11

Researcher: "How did you address the parents' apprehension about being the only family to participate in family counseling?"

Counselor Number 4: "I explained the nature of the study and the possible benefits of family counseling versus individual counseling, and I explained they would be the only family in this school, but the study involved other families in different schools."

Probing Question Number 12

Researcher: "Tell me why you used 'draining' as a descriptor of your experience?"

Counselor Number 5: "The family counseling sessions at times seemed like group counseling sessions. During these sessions I had to keep track of each person, rather than one person—the child—and I had to exert more 'control' over the dynamics of the group. This was more challenging and tiring for me."

Summary

The results of the data analysis were provided in this chapter. The first section provided demographic information about the counselors who participated in this study. The second section provided a brief description of the group of families who participated in the study. In the third section, the themes and validations of themes identified from the counselor questionnaires, counseling notes and interviews of probing questions were presented.

CHAPTER 5
FINDINGS AND DISCUSSION

The results of the study are summarized and discussed in this chapter. The proposed findings and supportive nomothetic and idiographic themes are presented and described with supporting references. Following the discussion are sections on recommendations for further research and implications of the study for school counselors, counselor educators and the school counseling profession. The final section is a summary of this study.

Discussion of Results and Findings

The findings below are proposed from the supporting nomothetic and idiographic themes identified from the results of the ten school counselors selected for the study and the five school counselors who completed the study.

Nomothetic Themes (NT) *Idiographic Themes* (IT)

Finding 1. School counselors will continue to provide family counseling.

NT-38. Counselors reported that they will continue to provide family counseling after the conclusion of the study (f=5).

NT-39. Counselors reported that family counseling should become a regular part of the school counseling program (f=5).

NT-42. Counselors used the descriptors rewarding, challenging, successful, beneficial and active to describe their experiences in family counseling.

Counselors describe positive experiences in providing family counseling as a part of this study (NT-42 and NT-43). Through the use of family counseling, school counselors believe they were able to provide more effective help to families and children (NT-37). School counselors found family counseling to be the best way to work with children with learning disabilities even though initially it takes more energy and time to schedule than does individual counseling. In the end, counselors report that they actually have more time to work with other children and families. The parents participating in family counseling understand the learning disability and, therefore, the parents prevent later crises by properly employing constructive parenting techniques in rearing their children. As a result, the school counselor spends less time consulting with these parents and has more time to work with other families. Lombana and Lombana (1982) state that family counseling requires the highest level of interaction with

families but also provides the greatest level of effectiveness.

The school counselors participating in this study indicate that they will continue to provide family counseling as a part of their school counseling program (NT-38). After participating in this study and providing family counseling, the school counselors state that family counseling should become a regular part of the school counseling program (NT-39). Numerous researchers have focused on the utilization of a systemic approach for resolving children's academic, social, emotional and behavioral problems at school (Amatea & Sherrard, 1997; Carlson, 1992; Carns & Carns, 1997; Cerio, 1997; Donigan & Gilio, 1971; Edwards & Foster, 1995; Fine, 1992; Fine & Gardner, 1997; Fish & Jain, 1985, 1997; Hinkle & Wells, 1995; Lusterman, 1986; McDaniel, 1981; Mullis & Berger, 1981; Nicoll, 1992, 1997; Palmo et al., 1988; Peeks, 1997a, 1997b; Perosa & Perosa, 1981; Pfeiffer & Tittler, 1983; Plas, 1986; Quin & Cowie, 1995; Sawayzky et al., 1993; Widerman & Widerman, 1995; Wilcoxon, 1986; Wilcoxon & Comas, 1987; Woody & Woody, 1994).

Recent literature has proposed that families should become the primary focus of treatments by elementary school counselors (Carlson, 1987, 1992; Fine, 1992; Fine & Holt, 1983; Fischer 1986; Kraus, 1998; Plas, 1992, 1986). Many authors advocate school counselor intervention with parents and families (Amatea & Sherrard, 1997; Bowen & Glenn, 1998; Cerio 1997; Fine & Gardner, 1997; Hinkle & Wells, 1995; Morrison et al., 1997; Nicoll, 1984, 1997; Palmo et al., 1988; Peeks, 1997).

A review of the literature indicates a trend toward school-based family interventions, and the importance for school counselors to acquire a working knowledge of family systems theory and practice (Amatea, 1989, 1990; Amatea & Fabrick, 1981; Dowling & Osborne, 1985; Fine & Carlson, 1992; Fine & Gardner, 1991; Getz & Gunn, 1988; Golden, 1983; Golden & Capuzzi, 1986; Goldenberg & Goldenberg, 1981; Goddman & Kjonaas, 1984; Hinkle, 1992, 1993; Kraus, 1998; Lambie & Daniels-Mohring, 1993; Nicoll, 1984, 1992, 1997; Palmo et al., 1988; Peeks, 1989a, 1989b; Perosa & Perosa, 1981; Sawatzky et al., 1993; Shields & Green, 1996; Walsh & Giblin, 1988; Wilcoxon, 1986; Wilcoxen & Comas, 1987; Williams et al., 1988).

Amatea and Sherrard (1997), Carns and Carns (1997), Lewis (1996), and Rosenthal and Sawyer (1996) noted the improbability of elementary school counselors being successful in counseling with children unless the children's families—the children's primary social systems—are involved. Nicoll (1997), Edwards and Foster (1995), Gerler (1993) and Woody and Woody (1994) believe that school counselors are in an ideal position to provide family counseling

services because their job description involves working as a liaison among children, families and classroom teachers. This present study supports Nicoll's (1984) rationale for school counseling programs to provide family counseling services. School counselors in this study found family counseling to be more effective and economical with regard to time than are individual or group counseling.

In a survey of school counselors across the United States, Bloss (1995) found that 40.4% of the school counselors and 69.6% of the counselor educators believe school counselors should do more work with families, in particular family counseling. Family counseling is a vital component in an emerging trend for schools to increase emphasis on cooperation between schools and families (Keyes, 1997).

<u>Finding 2. School counselors need flexible schedules in order to provide family counseling.</u>

NT-2. Counselors needed to be flexible in scheduling sessions (f=4).

NT-6. Counselors met with the families during non-school counselor hours (f=3).

NT-7. Counselors did not have a regularly scheduled weekly time to meet with families (f=3).

NT-12. Counselors reported the need to notify staff and faculty of the new program and schedule (f=3).

NT-13. Counselors reported the need for flexible work hours (f=2).

IT-4. Compensatory time is needed for family sessions scheduled after school counselors' regular work hours.

In order to provide family counseling, school counselors need to be flexible with their schedules (NT-2), and the counselors could not set up regular weekly meeting times with the families (NT-7). This required counselors to alter their family counseling sessions to different days and times to gain cooperation from the family. The school counselors' main concern in scheduling was to accommodate the parents' work schedules. For this reason, most often counselors were not able to meet with families during regular school hours (NT-6 and NT-8). To involve parents in family counseling and provide the best help to children, school counselors will need flexible work hours (NT-13). Flexible schedule and compensatory time (IT-4) will permit school counselors to shift their schedule to work some evenings and possibly weekends if necessary.

This finding helps to confirm the hypothesis of Palmo et al. (1984) about necessary changes to advance school-based family interventions. Changes in school counseling programs

will need to include the following: 1) flexibility in scheduling to allow counselors to meet with families during evenings, Saturdays, and summer months, 2) accessibility of counselors to families requesting family services, 3) and availability of counselors as 12-month employees to maintain a consistent family counseling program. To allow for entrance to the building during non-school hours, school administrations should provide school counselors with keys to the school (IT-5).

Staff and faculty need to be notified of the change in the school counselor's program and schedule with the addition of family counseling (NT-12). This supports Simington's (1996) view that school counselors are not conducting family counseling due to the view held by many that family counseling is beyond the scope of services provided by school counselors. This seems to indicate that school counselor's roles will need to be redefined and clarified to include family counseling (Samis et al., 1993). The results of this study show a trend for school counselors to publicize and better educate the school community of the family counseling services available as part of the school counseling program. In addition, there may be a need to convince boards of education at the state level to have family counseling included in the school counselors' roles and job descriptions.

<u>Finding 3. School counselors need opportunities for training, consultation and clinical supervision.</u>

NT-34. Counselors reported that counseling supervision is necessary in providing family counseling (f=5).

NT-35. Counselors wanted additional experience conducting family counseling (f=3).

NT-36. Counselors reported that they need more family counseling experience with opportunities to consult with family counselors (f=4).

To provide family counseling as a regular part of the school counseling program, counselors report that they will need clinical supervision (NT-34), practice conducting family counseling (NT-35) and opportunities to consult with other family counselors (NT-36).

In general, elementary school counselors have been reluctant to use family systems counseling in the schools due to the counselors' lack of training in family counseling techniques (Simington, 1996). One critical issue is that many school counselors have received little or no training in working with families (Hinkle, 1993, 1997; Palmo et al., 1988). In fact, some school counselors may have little supervised experience working with adults.

Three prerequisites Hinkle (1993, 1997) identified for school counselors to conduct

family interventions are additional training, adequate clinical supervision and more confidence in their abilities as family counselors. Hinkle (1993, 1997) identified ways for school counselors to receive the necessary training in family counseling, such as in-service training, continuing education courses, conferences, and professional workshops. Schools and families would benefit from opportunities for school counselors to receive training in family counseling.

Finding 4. Families are committed to family counseling.

NT-3. Families were very interested in participating in family counseling (f=3).

NT-4. All parents and siblings committed to attending family counseling sessions (f=5).

NT-5. Counselors and families met at least eight sessions (f=5).

NT-8. Counseling sessions were scheduled to accommodate parents' work schedules (f=3).

NT-9. Almost no counseling sessions needed to be rescheduled (f=3).

NT-10. Counseling sessions were rescheduled because of fathers' work (f=2).

The families were very interested in participating in family counseling (NT-3), and all family members were able to commit to participating in family counseling (NT-4). All families in the study attended at least eight family counseling sessions (NT-5).

These findings support Nicols' (1984) belief that counseling services in the school setting may be less threatening than settings unfamiliar to the families. Since the families in this study were committed to the family counseling, this supports family counseling as a part of the school counseling program. Research shows that only 30% of the families referred to outside agencies by school counselors actually followed through with the referral, and only 1% continued counseling beyond two sessions (Bloss, 1995). Considering these findings, if referred for family counseling, these families would not have received the counseling.

The fact that most sessions did not need to be rescheduled indicated the families were committed to family counseling (NT-9). The sessions that did need to be rescheduled were due to father's work and not necessarily in complete control of the family (NT-10). Since fathers were the major providers for these families and were most likely unable to leave work, employers may need to recognize the importance of fathers' roles in families and facilitate more time to attend to family matters (Levering & Moskowitz, 1993).

Finding 5. Family counseling is beneficial to the families.

NT-14. Counselors rated the counseling goals were completed at an average of 4.9 on a scale of 6.0.

NT-37. Counselors reported that they were able to provide more effective help to the family and children through the use of family counseling (f=5).

NT-40. Counselors reported that family counseling is beneficial to families (f=3).

Finding 6. Time spent in family counseling has a positive impact on the families.

NT-20. Regular weekly family time at the counseling sessions had a great impact on the family (f=3).

NT-27. Fathers indicated that they will spend more time with their children (f=3).

NT-21. Parents spent more time together in counseling and strengthened their parental subsystem (f=3).

NT-33. Greater parent involvement positively influenced the children (f=2).

IT-8. Parents spent more time with their children.

Entire Family

The family participants came very close to successfully completing all of their goals in at least eight family counseling sessions (NT-14). Family counseling is beneficial to families of children with learning disabilities (NT-40). Parents seem to understand their children better (NT-41). The greatest impact upon the families were the regular weekly family time at the family counseling sessions (NT-20). Trends in the results of this study show that bringing the families together each week to participate in family counseling in and of itself has been a positive experience for the families.

Researchers found school based family interventions successful (Goodman & Kjonaas, 1984; Nicoll, 1984; Palmo et al., 1988; Wilcoxen & Comas, 1987; Williams et al., 1988). Family systems counseling is a preferred treatment for children with learning disabilities and their families (Eisenhauer, 1991; Hansen & Okun, 1985; Spacone, 1984; Kaslow & Cooper, 1978; Klein et al., 1981; Margalit, 1982; and Perosa & Perosa, 1981). Without altering the patterns of family interaction within the family system, the children's presenting behaviors will not change (Carns & Carns, 1997; Cerio, 1997). Counselors will need to take a more active role in working with and empowering families (Lewis, 1996).

The use of brief family interventions indicates overwhelming success in working with children (Amatea, 1988; Dewitt, 1980; Gurman & Kniskern, 1981; Peeks, 1997a; Stone & Peeks, 1986; Simington, 1996). Other family counseling studies in the schools show positive results,

but the school counselors did not conduct the counseling and research. Individuals from agencies outside the school setting conducted the counseling and research in these studies (Casey & Buchan, 1997; Carlson, 1987; DiCocco, 1986; Evans & Carter, 1997; Fine & Holt, 1983; Kramer, 1977; Merril et al., 1991; Millard, 1977; Morrison et al., 1977; Perosa & Perosa, 1981). Walsh and Williams (1997) noted family counseling is necessary when considering the positive correlation between family interactions and the children's success at school.

As a result of the positive influence increased family time and greater parent involvement has on the child (NT-33), fathers declare they will spend more time with their children (NT-27). The fathers appeared to be taking a passive role as in Kaslow's (1976) theory and the theories of Guberman et al. (1962). Through participation in family counseling, the fathers became more aware of their role in parenting and decided to increase the amount of time spent with their children. Not only is there an increase in the amount of time fathers spend with their children, but an improvement in the quality of time.

Finding 7. Family counseling improves communication within the family.

NT-16. Parents improved communication between one another (f=5).

NT-32. Children improved their communication skills (f=2).

NT-29. Parents learned to listen and respond to their children (f=2).

NT-30. Parents talked more openly about their child with learning disabilities and parenting issues (f=2).

IT-9. Improved communication among all family members.

Finding 8. Family counseling allows parents to gain a better understanding of learning disabilities.

NT-15. Parents gained a better understanding of their child's learning disabilities (f=5).

NT-17. Parents changed their academic expectations of their child (f=5).

NT-18. Parents improved their social expectations of their child (f=5).

NT-25. Parents were more patient with their child with learning disabilities (f=3).

NT-41. Counselors reported that parents better understand the child and the child's symptoms (f=3).

IT-7. Parents gained greater hope regarding their child's ability to cope with the learning disability.

IT-6. Parental denial of the learning disability is eliminated.

Finding 9. Family counseling improves parenting with children with learning disabilities.

NT-19. Cooperative parenting was improved (f=4).

NT-26. Parents learned new parenting techniques (f=3).

NT-28. Parents learned strategies for helping their children with homework (f=3).

NT-31. Parents learned the parenting technique of rule setting (f=2).

IT-10. Parents established the hierarchy within the family by enforcing the parental subsystem.

Parents

Parents have the opportunity to spend more time together in the family counseling sessions and as a result the parental subsystem is strengthened (NT-21). Parent-to-parent interactions improved with better communication between parents (NT-16). The improved interaction allowed parents to talk more openly about the learning disability as well as other parenting issues (NT-30).

Kaslow and Cooper (1978), Day and Moore (1976), Lombana (1992) and Perosa (1980) determined change was needed in maladaptive relationships, family dynamics and patterns of interaction in families with children who have learning disabilities. The improved communication, parenting and the strengthening of the parent subsystem found in this study coincides with these areas of change. As a result of family counseling, the counselors reported that parents were less irritable and better able to communicate with each other and discuss parenting issues with fewer arguments. Both parents recognized the need to work together as a parenting team in lieu of one parent taking on all parental responsibilities.

Through participation in family counseling, parents had the opportunity to learn new parenting techniques (NT-26). The new techniques focused on setting and enforcing rules (NT-31) and strategies for helping their child with homework (NT-28). As in Briard's (1976) counseling stages for working with parents of children with learning disabilities, parents explored feelings of denial and guilt so that the counseling process was able to move toward parenting issues. The common parenting issue among families participating in this study was the problem of limit setting and discipline, especially concerning homework and daily routines. Through family counseling, parents gained an understanding that, even though expectations have changed, their child must follow realistic limits, and that consequences must be given when children do not adhere to limits.

Trends appearing in the results of this study indicate a need for school counselors to provide more family counseling and parent counseling. It will be beneficial for school counselors to assist parents and families with communication skills, parenting techniques and parenting methods. The counseling and education services may be offered during the eligibility process.

Parents and Child

After participating in counseling, parents gained a better understanding of their child's learning disability (NT-15) and were more patient with their child (NT-25). The resulting changes in the families, due to a greater understanding of the learning disability, compliment the primary goals of restructuring dysfunctional parental attitudes and child-rearing practices identified by Pfeiffer (1985). According to Pfeiffer (1985), the learning disability is generalized to represent the child instead of a characteristic of the child. Prior to participating in family counseling, the parents in this study were frustrated in interactions with their child and annoyed at the lack of "normal" responses, achievement and behavior of their child. These patterns of frustration experienced by the parents were similar to the patterns of interaction within families of children with learning disabilities determined by Kaslow and Cooper (1976).

The understanding of learning disabilities the parents gained through family counseling and the change in parental attitude supports findings by Klein et al. (1981a, 1981b). These authors determined that parents of children with learning disabilities hold negative attitudes toward their children, as well as negative attitudes concerning authority and responsibility for their child's learning. Although Klein et al. (1981a, 1981b) concluded that negative attitudes from parents not only exacerbate difficulties but also may even be causative, this study seems to indicate that poor parenting styles exacerbate difficulties.

From the understanding of a systems theory perspective, dysfunction in children occurs if the two main systems, school and home, clash in their expectations of children and how the children should learn (DiCocco, 1986; Lusterman, 1986; Power & Bartholomew, 1987). The greater understanding of learning disabilities from a family systems perspective appears to have helped the parents to change their expectations for the child and in turn allow them to better assist their child.

The improved communication skills reported within the families supports the findings of Ditton et al. (1987) that patterns of language in families of children with learning disabilities often blur the meaning of communication and leave family members confused.

In cases of denial of the learning disability (IT-6), parents finally began to acknowledge the disability through participation in family counseling. Many parents deny the existence of the disability and experience uneasiness and anxiety whenever the disability causes disruption (Kronick, 1978). The stages of dealing with the acknowledgement of a child with learning disabilities resemble the stages of grief and mourning; the parents experience stages of denial, depression, anger and guilt (Kaslow & Cooper, 1978). The greater understanding of their child's learning disability allowed the parents to recognize and cope with their negative, angry attitudes in order to be more patient with their children.

Once the parents became more aware of the learning disability and its effects, parents changed their academic expectations (NT-17) for their child while improving their social expectations for their child (NT-18). These findings support the hypothesis of Silverman et al. (1995) that parents of children with learning disabilities hold unrealistic and high expectations toward achievement, which result in unnecessary pressure for the children to perform academically. They suggested that these characteristics relate to the development and maintenance of difficulties experienced by children with learning disabilities.

This change in academic and social expectations the parents hold for their child becomes an integral part of child development. The parents participating in this study supported the findings of Silverman et al. (1995) that fostering too much dependence on the parents makes the child very dependent upon the parents and incapable of responsibility. Conversely, because the parents in the study stressed school too much, they may have placed the child in a losing situation with unrealistic goals. The unrealistic expectations of parents may have exacerbated the child's poor self-image. Supporting Briard's (1976) concepts, the parents make the child more incapable by affirming the child's inability to complete certain tasks and by not allowing the child to have opportunities to build responsibility. The results of this study indicate that parents must form more realistic attitudes and expectations regarding themselves and their child.

Through family counseling, parents were able to realize that their expectations for their children's success may not be met. They were able to deal with the anger and resentment that result when acknowledging the permanency of the disability. The maladaptive parenting styles identified by Doleys et al. (1976)—overprotection, indulgence, denial and projection—changed in family counseling by strengthening the parental subsystem and enforcing the family hierarchy.

Finding 10. Family counseling in the schools increases the likelihood that children are better able to cope with the effects of their learning disability.

NT-22. Children showed better social skills and interactions with others (f=3).

NT-23. Children were more confident and interested in school (f=3).

NT-24. Children showed fewer episodes of frustration and anger (f=3).

Child

Through family counseling, children show better social skills and interactions with others (NT-22). The children were able to improve their communication skills (NT-32), and they exhibited fewer episodes of frustration and anger (NT-24). The children showed more confidence and improved relationships at home and in school. With the change in parental expectations, the enforcement of rules and improved communication and social interactions that the children exhibit, one can infer the child will take more responsibility for him or herself and will show an improved self-concept.

Johnson and Zemitzsch (1997) claim that families can do systemic thinking. By the school counselors including the family in systemic thinking, the focus is no longer on the characteristics of individual children, but on the connections and relationships within the family. In systemic thinking, parents and school counselors have the potential for changing not only the children's misconceptions of reality, but also the misconceptions of the parents and teachers. Systemic thinking replaces linear ways of thinking which allow children to project blame, assign faults and accuse others to take responsibility for their actions (Johnson & Zemitzsch, 1997).

This study supports other case studies in which systems principles are used to solve student problems in schools (Amatea, 1988; Amatea & Fabrick, 1981; Carlson, 1987; Margalit, 1982; McComb, 1981; Peeks, 1997a).

Other Findings

Although the findings in the following section were rare in the data, these findings include profound and surprising information and are mentioned in this section.

1. School counselors need appropriate facilities to conduct family counseling.

IT-5. Scheduling problems regarding access to the counseling office.

IT-2. Scheduling was an issue due to the availability of the counseling office.

IT-3. Parents concerned others will see the family going into the counselors' office.

School counselors indicated a need for private offices dedicated for counseling purposes. A private office or proper counseling facility would be necessary to avoid scheduling conflicts when the counseling office is unavailable to the counselor (IT-2 and IT-5). Proper facilities would also help to ensure client confidentiality (IT-3). These themes validate Samis' (1993) suggestion for school systems to provide appropriate facilities in order for school counselors to conduct family interventions.

2. Family counseling provides help to those who otherwise would not seek help.

NT-43. Families who had been unable to receive family counseling privately were able to benefit from family counseling in the schools (F=2).

IT-12. Family counseling in schools provided help to families who would otherwise not seek help.

Families that are unable to afford and receive family counseling elsewhere were able to benefit from family counseling in the schools (NT-43). According to Nicoll (1984), one of the advantages of school-based family interventions is an equal opportunity for families from all income levels in the school to receive services.

3. Family counseling may help a family with a child with learning disabilities over many years.

School counselors are able to work with a family for the duration of the time a child is enrolled in school. In an elementary school this is usually seven years. If the child with learning disabilities has older and younger siblings who attend the school, the time the counselor may work with the family may be greater than seven years. The counselor can have regular, ongoing contact with the child and family, even when the family is not participating in family counseling sessions with the school counselor. In this way, school counselors may be available to provide preventative support to the families in addition to crisis interventions. Counselors in outside agencies tend to come and go in the lives of clients, whereas school counselors usually become a consistent part of the school community.

4. Some school counselors are unable to complete the study due to time constraints and workload.

Of the ten counselors selected to participate in this study, only five were able to complete the study. Five counselors did not complete the study due to the time constraints imposed by their school principals and their regular work schedules. This finding supports Samis et al. (1993), who determined counselors' workload and work schedule to be the largest barriers to school-based family intervention. Similarly, Beck (1984) found workload, lack of

training, and time constraints as the barriers most often reported by school counselors.

5. Some school counselors are unable to complete the study due to no principal permission.

Of the ten counselors selected to participate in this study, three were unable to complete the study because the principals would not grant permission. Since three principals did not see the counselor's role as providing family counseling, the school counselors were unable to continue in the study. This finding suggests principals need training in family systems. New principals will need to have systems theory and school counseling coursework as part of their curriculum. School systems will need to provide systems training in in-service programs for administrators already employed within the school district.

Recommendations for Further Study

The findings in this study have established the need for further research. This study may be replicated using school counselors with more diverse levels of experience and training. This study may also be replicated using more families and a different population of families. An investigation looking at families other than those with learning disabilities will allow the results to be generalized to families with children who do not have learning disabilities. A follow up study may also be conducted on the school counselor participants to monitor their long-term progress conducting family counseling. A follow up study may also be conducted on the family participants to monitor their long-term progress while participating in family counseling. Further study may examine the perceptions of the child, family and school with regard to family counseling as part of the school counseling program. In addition, further investigation may be conducted concerning exactly what training and clinical supervision school counselors will need so they are adequately trained in family counseling. This information will be useful to counselor education programs and school systems incorporating family counseling within their programs.

Future Implications of the Study

School counselors spend much of their time working with children with learning disabilities. School counselor training has traditionally focused on counseling approaches, which lend themselves to individual and group counseling in which the identified patient is the child. In order to create lasting changes, school counselors must work with the family.

School counselors must begin to incorporate family counseling into their regular programs. If family counseling were to become a standard practice for school counselors,

counselor education programs would need to incorporate family counseling courses in their school counseling program curriculum. Counselor education programs must also begin to provide training and offer opportunities for appropriate coursework and clinical experience in family systems counseling. Since family counseling is typically not offered as a part of school counseling programs, school counseling students have to obtain family counseling training by enrolling in family counseling courses as electives to their program or in addition to the program requirements. Practicing school counselors may also obtain family counseling training through workshops, consultation and clinical supervision (Hinkle & Wells, 1995).

School systems may need to implement the following changes:

1) Provide flexibility in scheduling that allows counselors to meet with families during evenings, Saturdays, and summer months,
2) Arrange for accessibility of counselors to families requesting family services,
3) Provide availability of counselors as 12-month employees in order to maintain a consistent family counseling program,
4) Reduce the counselor-to-pupil ratio by hiring more school counselors,
5) Redefine the counselor's role and job description to include providing more counseling services, specifically family counseling,
6) Increase opportunities for training and clinical supervision in family counseling,
7) Provide appropriate facilities for family counseling in the schools, and
8) Provide training in family systems theory for school administrators and personnel.

The results of this study seem to indicate that school counselors may need to engage in public relations activities so that children and families may be better informed of the variety of counseling services available, including family counseling. By making others aware that counseling is not only for crisis situations but also to help all children and families with developmental issues, schools and school counselors may be given the opportunity to provide more preventative services before crises services become necessary.

Summary

Family systems counseling is a beneficial and effective counseling technique for treating families of children with learning disabilities and, therefore, the children with learning disabilities themselves. Family counseling has been utilized in many environments and settings, but it has not been explored previously as an intervention by school counselors in the schools. Many

children with learning disabilities are referred to school counselors. However, in order to resolve many of their issues in school, counselors must work with the entire family.

This qualitative research explored the experiences and perceptions of school counselors while using family counseling as an intervention with families of children with learning disabilities. This study provides insight regarding the implementation of family counseling as an intervention by school counselors working with families of children with learning disabilities in the school setting. This study helps to establish the use of family counseling as an alternative to individual counseling of children with learning disabilities and consultation with parents by school counselors.

Families in the study received at least eight sessions of family counseling from their child's school counselor. Results of this study support the use of family counseling in the school setting to foster change in family dynamics and patterns of interaction that contribute to learning difficulties. Families participating in the family counseling experienced improved family functioning including better patterns of communication within the family, a change in academic and social expectations for their child and improved parenting skills including setting and enforcing family rules. Parents were able to strengthen the parental subsystem, and the children with learning disabilities appeared to exhibit improved social interactions.

A qualitative analysis of counselor experiences showed counselors had a very positive experience in providing family counseling. All counselor participants would like to continue to provide family counseling as a regular part of their school counseling program. School counselors will need to take an active part in redefining the role and job description of the school counselor. The school systems will need to provide counselors with appropriate facilities and flexible work schedules. In addition, school counselors will need to seek the appropriate training and clinical supervision, and counselor education programs will need to provide opportunities for school counselors and school counseling students to obtain the necessary experiences in family counseling.

Since school counselors spend much of their time working with children with learning disabilities and family counseling is necessary to bring lasting changes in children and families, school counselors must work with family systems. The results of this study indicate family counseling needs to be incorporated in school counseling programs to resolve the issues of children with learning disabilities.

Family counseling continues to increase in popularity in the field of counseling. School counselors are ideally situated and often the only source of help available to assist families and schools. To meet the growing needs of children, families and schools, school counselors' providing family counseling is an area to be studied more fully. The findings in this study support the use of system's approach to school counseling. This study has also contributed to the possibilities that exist for the school counselors' use of family counseling in the school setting.

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