# DEVELOPING A SCHOOL-BASED REFERRAL SYSTEM: COMPARISON OF FACTORS CITED BY SCHOOL COUNSELORS AND THERAPISTS

by

Stephen C. Lemon

Thesis submitted to the Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE
in
Marriage and Family Therapy

APPROVED:

Linda F. Little, Chairman

C. James Scheirer

Sandra M. Stith

December, 1987

Blacksburg, Virginia

# DEVELOPING A SCHOOL-BASED REFERRAL SYSTEM: COMPARISON OF FACTORS CITED BY SCHOOL COUNSELORS AND THERAPISTS

by

Stephen C. Lemon

Committee Chairman: Linda F. Little
Family and Child Development

(ABSTRACT)

When school-based behavior problems are not solvable in short-term school counseling, referrals are often made to community therapists. The school-based referral process is described in the literature as an informal process aimed at matching clients' needs with therapist skills but the literature also suggests that the referral process is based even more so on the relationship of the school counselor to the therapist. A survey of 19 school counselors was conducted to measure the importance of six factors identified in a pilot study that are used in selecting a referral source; Therapist Accessibility, Therapist Commitment to School, Therapist Philosophy and Belief System, Therapist Reputation, and Therapist Credentials. In addition, 19 community-based therapists were surveyed to measure their ranking of these same factors. When the scores were analyzed it was found that school counselors rated two scales, Therapist Accessibility and Therapist Reputation, significantly higher than did therapists. Surprisingly, Therapist Reputation was rated least important by both groups. This research has the potential to help strengthen the engagement between the school system and the mental health system by first identifying the factors used for school-based referrals and then identifying the differences in how the two systems perceive the importance of these factors.

ACKNOWLEDGEMENTS

As I looked at the process of developing this thesis it became clear that it too was a systems approach. Many things influenced me during my program at Virginia Tech, and they are included in this thesis is the form of information, values, attitudes, expectations, relationships, and a strong appreciation for systems theory in its broadest sense.

My committee has been particularly helpful and supportive in the development of this thesis. Dr. Linda Little, in addition to being a mentor, has provided a model of excellence in therapy and academics. Dr. James Scheirer provided invaluable guidance and a practical approach to research methods. Dr. Sandra Stith's knowledge of family systems and her editing skills helped make this thesis more concise.

Colleagues at Virginia Tech provided a stimulating environment and shared their experiences. Special thanks to who helped set up a pilot study with school counselors, that represented a broad cross section of counselors, to help develop the research questionnaire.

The Prince William County Mental Health Center provided a strong foundation in family systems counseling during my practicum and created an interest in the community referral process.

The Fairfax County Public School System showed interest and support for this thesis through the participation of the Administrative Area lll Elementary Counseling Resource Teachers. These Counseling Resource Teachers freely gave their time and shared their experience without which this thesis could not have been done.

As usual, the family is the last to be acknowledged. In this case it is not the last to be appreciated. My wife, , has been my sounding board, my editor, and my love; providing support in all areas when it was needed most.

TABLE OF CONTENTS


| | Page |
|---|---|
| ABSTRACT | i |
| ACKNOWLEDGEMENTS | ii |
| TABLE OF CONTENTS | iii |
| LIST OF TABLES | v |
| LIST OF FIGURES | vi |
| ARTICLE: Developing a School-Based Referral System: Comparison of Factors Cited by School Counselors and Therapists | 1 |
| Methodology | 6 |
| Pilot Study | 6 |
| Test Instrument | 10 |
| Subjects | 10 |
| Procedure | 11 |
| Results | 12 |
| Discussion | 14 |
| General Impressions from Interviews | 15 |
| Implications of the Study | 17 |
| Limitations | 17 |
| References | 19 |

APPENDIX A: Review of Related Literature ---------- 23

Characteristics of Healthy Families ---------- 24

Families Under Stress ---------- 25

Systems Theory ---------- 27

Schools: A Major Subsystem ---------- 28

Dysfunctional Behavior in the Classroom ---------- 29

Conceptual Interpretation of Classroom Behavior ---------- 30

Multidemensional Role of the School Counselor ---------- 30

Therapist Dimensions and Effectiveness ---------- 31

Interdependence of Counselor and Therapist ---------- 32

In-School Treatment ---------- 33

Referral Concepts ---------- 33

Post Referral Colaboration ---------- 34

APPENDIX B: Additional Results ---------- 36

APPENDIX C: Research Questionnaire ---------- 46

REFERENCES ---------- 53

VITA ---------- 58

LIST of TABLES


| Table | | Page |
|---|---|---|
| 1 | Comparison of t-tests, means, and standard deviations | 13 |
| 2 | Gender of Respondents | 39 |
| 3 | Education Level of Sample Respondents | 40 |
| 4 | Education Field of Sample Respondents | 41 |
| 5 | Median of Responses of Sample Respondents for Years in Profession, Number of School Referrals, and Estimated Treatment Period of Billy | 42 |
| 6 | Scale Composition with Scores for School Counselors | 44 |
| 7 | Scale Composition with Schores for Therapists | 45 |

LIST of FIGURES


| Figure | | Page |
|---|---|---|
| 1 | The School-Based Referral Process | 3 |
| 2 | Process Flow Chart: School Counselor Pilot Study | 8 |
| 3 | Process Flow Chart: Therapist Pilot Study | 9 |
| 4 | Response Data: Graphical Comparison of Combined Scale Scores | 43 |

# DEVELOPING A SCHOOL BASED REFERRAL SYSTEM: FACTORS CITED BY SCHOOL COUNSELORS & THERAPISTS

Few school counselors have direct contact with therapists. Yet, school counselors, by the nature of their position in the school system, find themselves as referral agents to community therapists when school-based problems are beyond the scope of treatment in the school setting. McDaniel (1981) sees the schools and mental health agencies as disengaged systems, each working in their own way to help clients. Millard (1981) uses the term "fragmented" to describe the disengaged systems and states that the resulting confusion between systems sometimes prevents clients from seeking help.

The issue of disengaged systems raises a concern about the linkage between the school system and the therapy community in solving school-based dysfunctional behavior. Of particular concern in this process are the factors used by school counselors in selecting therapists to participate in the referral process. What follows is an in-depth look at the pivotal role school counselors have in assessment, referral and the therapeutic processes that occur when children's behavior emerges as problematic in the classroom.

Families under stress reach out for help directly and indirectly in the community where natural contacts exist. If the problem manifests itself in the school, it is quite natural for the school counselor to become involved. The following example illustrates this point and sets the stage for discussion of the school referral process.

> Billy, age 10, has experienced several major changes in the past year. His father suffered a severe financial loss and had to sell his business and the family home. The family is now renting a home, in the same school district, while father continues to look for another career. Mother has gone back to work and is the primary financial supporter of the family. Both parents have expressed grave concern about the

> decline in Billy's academic performance over the past year. In addition, his school counselor has telephoned the parents twice about disruptive behavior in the classroom. With a continued decline in the school situation, the counselor asked for a parent conference. In the conference, the parents sternly criticized the school for not being able to control Billy in the classroom or to motivate him academically. When asked about Billy's behavior at home, the parents seemed vague and defensive.

The process of moving a problematic child like Billy into therapy is shown in Figure 1. The School Process box suggests that the school's involvement begins with observation of dysfunctional behavior. The conceptual interpretation of the identified behavior determines how counselors proceed (Fine, 1982; Worden, 1981; Young, 1979). If the child is viewed as sick, psychotherapy and even hospitalization may be the preferred treatment. If the child is viewed as bad, the school may work with teachers and parents to set up consistent discipline procedures or a behavior modification program. Referrals for psychotherapy interventions with behavior dysfunction are usually made by the school counselor in a parent/school meeting where the school counselor, using his/her conceptual interpretation of the observed behavior typically gives the names of several providers who offer the therapy modality that fits the counselor's assessment of the problem.

A popular and growing therapy modality, based on systems theory, looks at behavior in the broader context of the environment and the interactions between the client and significant others (Goldenberg & Goldenberg, 1981). An important part of the systems model is concern about how the symptoms affect and are affected by people close to or around the symptom bearer. Rather than seeing the client as an individual, systems oriented therapists see the client as the entire system (Amateau & Fabrick, 1981; Goldenberg & Goldenberg, 1981; Worden, 1981). Systems-oriented therapists are interested in not only how the

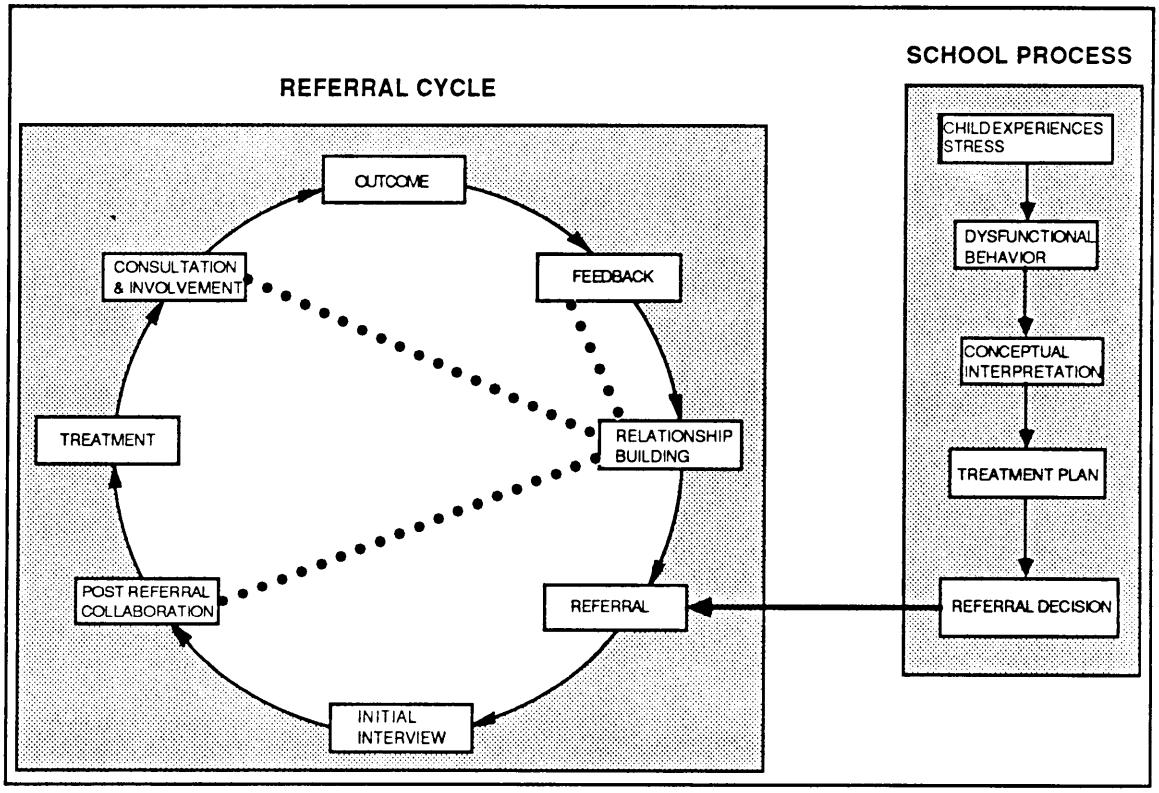


Figure 1. The School-Based Referral Process showing the Integration of the School Process and the Referral Cycle and Relationship Linkages ( •••••••• )

family members interact but also in the quality of interaction with other pertinent systems in the family's larger context. Goldenberg & Goldenberg (1981) includes hierarchy and power as important elements in systems and states "Behavior must be evaluated in system terms (transactions, relationships) in order to be fully understood." For example, children often become symptomatic in school. In the systems theory model, the family system is seen as having a powerful link with the child's school performance, therefore the school counselor must include the family in the early stages of evaluation and treatment planning (Fine, 1982; Goldenberg & Goldenberg, 1981 ). For example, when using a systems approach to the problem behavior of school truancy, it is important to evaluate the interactions of the significant others in the child's environment. Significant others include family members, school personnel, and peers (Little & Thompson 1983; McDaniel, 1981).

The school is a major system that influences children's functioning. In addition to being an academic experience, the school is also a social laboratory and a rehearsal for real life (DiMattia, 1984). In an everyday educational setting, the counselor can initiate assessment and treatment with the child who exhibits problematic behavior (Nicole, 1984). The counselor can focus interventions on just the child, the child within the family context, or the counselor can include all major systems (child, family, and school). Teachers and counselors, through their school positions, have a natural access to families. The counselor also has a critical role in moving the child/family/school into therapy when traditional school based counseling does not work (Amateau & Fabrick, 1984). The counselor can also assume a public relations role (Cole, 1987) for the school in working with the families of dysfunctional children, thus strengthening the relationship between family systems in general and the school system. In a time of family stress the counselor represents the school and its actions, and communicates to the family the degree to which the school wants to be involved. Do they want to help, attack the parents, or just get rid of the problem

child?

Therapists in private practice and community mental health agencies become a temporary part of the child/family/school system when called on to help solve a problem. When working with the school system, therapists are often evaluated by school counselors and judged on a number of variables such as trustworthiness, attractiveness, and expertise (Heppner & Heesacker, 1982; Kaul & Schmidt, 1971), skill level competency (Bergan & Tombari, 1976; Dustin & Ehly, 1984; Heesacker & Heepner, 1983; Epperson & Pecnik, 1985), and other measurable factors like warmth, climate, comfort, satisfaction and appeal (Scheid, 1976). Since client expectations have an impact on client satisfaction in the early stages of therapy ( LaCross, 1980; Tinsley, 1980 ), the school counselor, by means of referrals made, plays a key role with the child/family in setting the stage for effective treatment.

While school counselors and therapists have common goals and objectives as members of the helping profession, the professional relationship between the two is built more on similar philosophies and communication than therapy outcome (Berkman & Rosenblum, 1982; Perlman, 1979). In building an interdependent relationship, therapists should be aware that school counselors see themselves as a part of the therapy process and that school counselors look favorably on therapists who consult with them and keep them informed of progress.

We have now completed the full circle described in the Referral Cycle box (Figure 1). Having started with the child experiencing stress and exhibiting dysfunctional behavior, the process has moved through the referral step and finally into feedback and relationship building. Relationships built on variables previously described (trustworthiness, attractiveness, competence, satisfaction, etc.) appear to be the glue that holds the multi-step referral/therapy process together.

The disengaged and fragmented systems described by McDaniel (1981)

and Millard (1981) suggest that it is an informal process that brings the therapist into the school-based referral process shown in Figure 1. It is the purpose of this thesis to investigate this informal process and in particular to identify and measure the importance of the factors used by school counselors to select a specific therapist for referral. How does the relationship between school counselors and community based clinicians begin? What keeps it going? Why does a school counselor continue to make referrals to a specific therapist? These questions are the basis for generating the research question: "What factors are used by school counselors to select a specific therapist as a referral source for school-based problems? In addition, will therapists agree with the relative importance of the factors used by school counselors to make referrals?"

Continuing with the disengaged and fragmented systems approach described by McDaniel (1981) and Millard (1981), the research hypothesis is: School Counselors and Therapists will not be in agreement on the importance of the factors used by school counselors in making referrals for school-based problems.

This research is seen as having the potential to help engage the school system and the mental health system by first identifying the factors used by school counselors to select therapists in the referral process and then identifying the differences in how the two systems perceive the importance of these factors.

## Methodology

### Pilot Study

This cross sectional study was conducted in a large metropolitan area school district in Northern Virginia that is divided into four administrative areas . A pilot study was used to identify the factors used in making a school based referral. Information was solicited from five therapists and five school counselors in a geographic area adjacent to the research site. Face-to-face interviews with school counselors used open-ended type questions to get a

broad range of input data. The interviews were highly structured using the flowchart shown in Figure 2. The first question asked was "When you think counseling is needed, how do you become involved?" and proceeded to " What factors or criteria , about the therapy provider, do you consider when making a referral?" The factors/criteria were recorded and shown to the school counselor to select the five-top factors. The top five factors were then evaluated for degree of importance by dividing 100 points among them, and giving the more important factors the most points.

The interview process with therapists was a similar process as shown in Figure 3. The first question was "What is your understanding of the school referral process and how does it work?" and proceeded through "What factors or criteria, about the therapy provider, should the schools consider when making a referral?" Therapists also weighed the importance of their answers with the 100 points method previously described.

School counselor's and therapist's responses from the pilot study were reviewed for similarity of content and meaning. These responses appeared to form a pattern and were grouped into six referral factors of five questions each. These factors were then evaluated by Virginia Tech colleagues, who determined them to have face validity. These referral factors and content area, shown below, were used to develop the questionnaire shown in Appendix C.

1) Therapist accessibility (location, hours, case backlog, fees, works with second party payment).

2) Therapist commitment to school (considers school an important information source, provides feedback, attends school meetings, collaborates with school counselor, provides information on availability to school).

3) Therapist philosophy and belief system (works with the family, short term problem solving approach, systems approach, respects family, flexible).

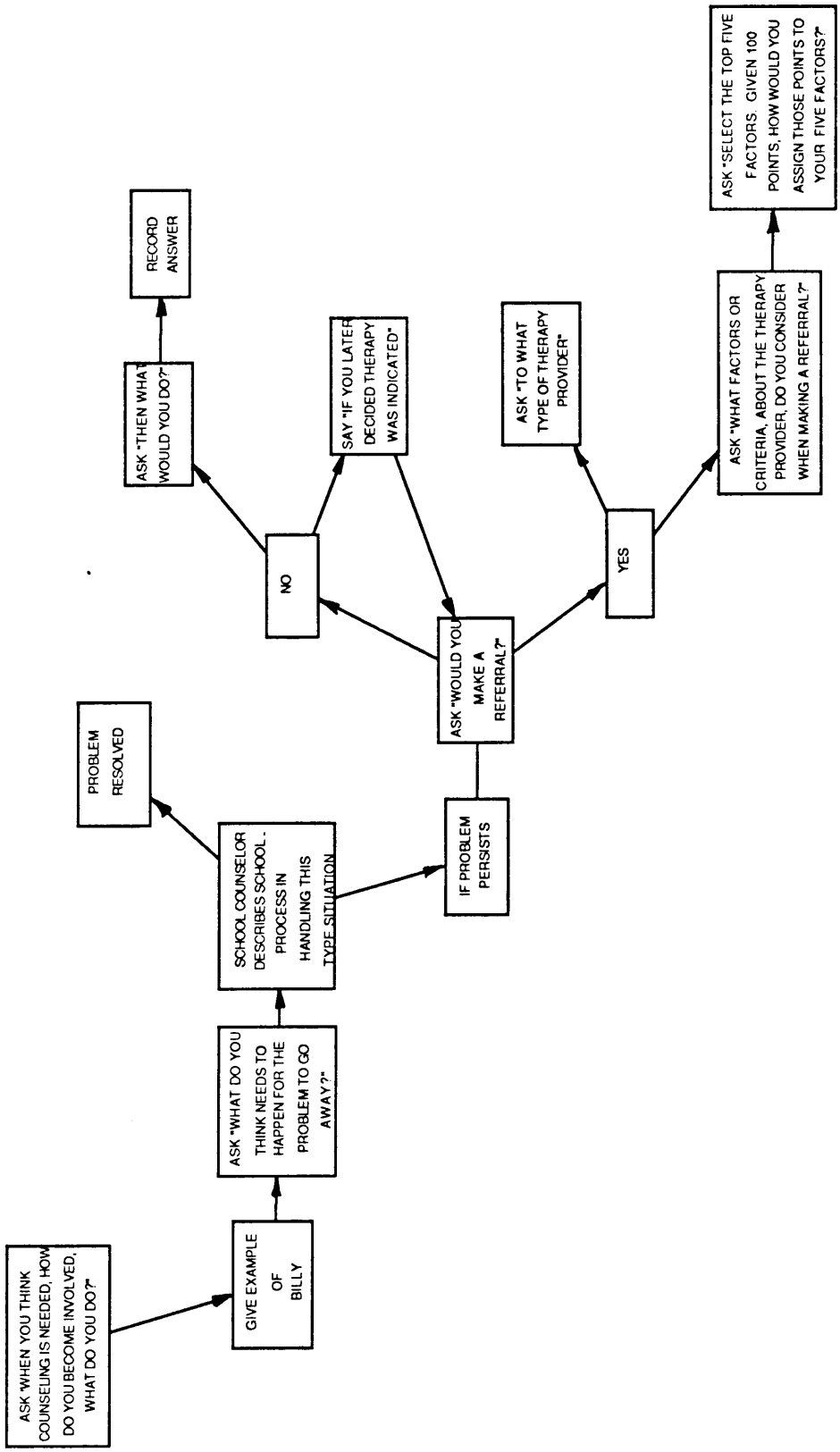


**Figure 2. Process Flow Chart of School Counselor Pilot Study Interview.**

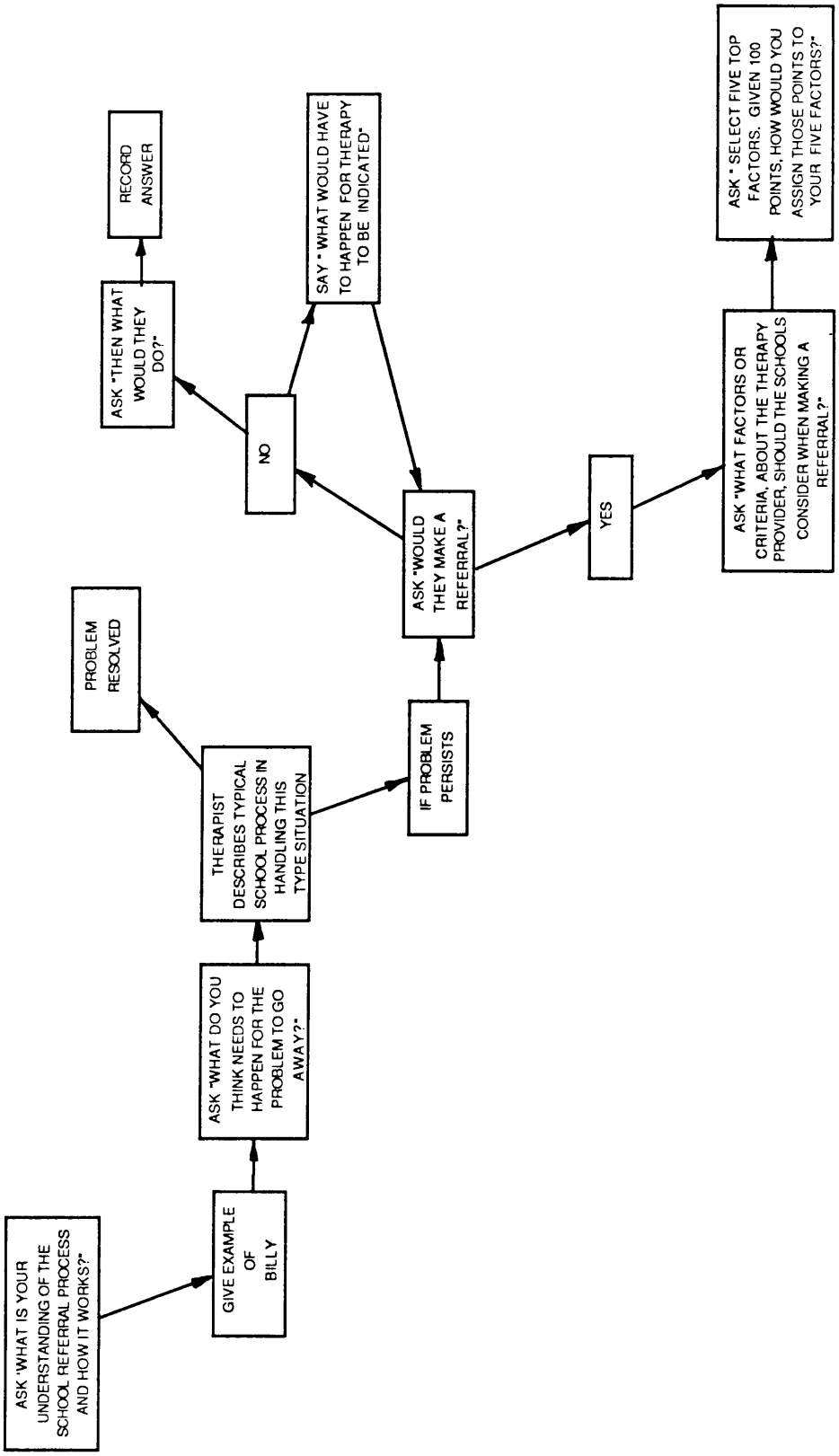


**Figure 3. Process Flow Chart of Therapist Pilot Study Interview.**

4) Therapist reputation (referred to by name, specialized in children's problems, prior experience with school, listed in school counseling guide).

5) Therapist style (friendly, client-therapist match, respects the school, empathy, provides hope).

6) Therapist credentials (education level, specialty area, licensed, professional affiliations, experience).

Test Instrument

The Research Questionnaire was developed using information gained in the pilot study with school counselors and therapists in a school area adjacent to the research area. The Research Questionnaire utilized a six point Likert-type scale to measure how "unimportant" to how "important" each statement was, as perceived by each research participant. Scale questions were mixed to avoid all scale questions being grouped together.

Subjects

School counselors in this study were in-school counselors whose primary role was problem prevention. School counselors typically meet students in individual sessions, in the classroom, and in small group discussions that center around developmental and adjustment issues. Short term individual counseling is provided for emotional and academic issues that could usually be resolved in one to three sessions. Longer term remedial counseling is typically referred outside the school to community therapists.

The Counselor population was defined as the 19 school counselors in one administrative area. Elementary school counselors were selected because they were the largest single group of school counselor in the total school system and because they had a sharp focus on working with behavioral problems that were not predominately developmental in nature (eg., adolescent, career choices, etc.).

Therapists in this study were in private practice either as sole proprietors or as associates of a larger therapy practice. Most saw clients for a wide range of problems and did not limit their practice to school-based problems.

The therapist sample was defined as all of the therapists listed in the Northern Virginia yellow pages under the heading of "Marriage, Family, Child & Individual Counselors." This population was reduced in size by restricting the address listed to a geographical area within the school area boundaries or adjacent to the targeted school area. A simple random sample of therapists was obtained using a table of random numbers.

The education level and field of study varied widely for school counselors and therapists. School counselors were predominately Masters level graduates with a degree in counseling and guidance. Therapists were predominately Ph.D. level graduates with a degree in Psychology . Another area that varied widely was the gender and length of experience. The school counselors were all female with a median experience of two years and a range of 1-10 years of experience. The therapists were 12 females and 7 males with a median experience of six years and a range of 1-21 years of experience.

Procedure

School counselors were notified in writing that this research project had been approved by the school system. School counselors were telephoned for an appointment in their school office. In the interview, subjects were given an overview of the thesis and the research question before the research questionnaire was administered. Questions on the meaning and interpretation of individual instrument items were discussed when requested by the respondent. After completing the questionnaire, demographic data were collected for each subject.

Therapists were telephoned for a screening interview. In this interview, therapists reporting five or more clients with school-based problems were asked to participate in the research study. An appointment was made for a face-to-

face interview that followed a process identical to the one used for school counselors.

## Results

Data were analyzed using StatWorks (Cricket Software, 1985). Questionnaire responses from school counselors and therapists were tested for normality and were found to be significant at the $p>.05$ level using the Kolmogorov-Smirnov one sample test. A Students $t$-test, selected because of the small sample size, was then used to test the research hypothesis at a $p<.05$ level of significance using a two tailed test for unpaired samples.

The hypothesis that school counselors and community-based therapists would not be in agreement on the factors used by school counselors to make referrals was accepted with a 95% level of confidence. School counselors (M=25.34) rated the factors significantly higher than did therapists (M=23.89).

An analysis of the referral factors suggest that Therapist's Accessibility and Therapist's Reputation were the major factors separating school counselor and therapists in their perception of how school referrals are made. The six referral factors were analyzed using the same t-test criteria to measure differences in how the school counselors and therapists perceived the importance of each factor. School counselors ($M = 5.50$) see "Therapist's Accessibility" as significantly more important than do therapists ($M = 5.07$). In addition school counselors ($M = 4.59$) rated Therapist's Reputation significantly higher than did therapists ($M = 3.77$). Therapist commitment to School, Therapist Philosophy & Belief, Therapist Style, and Therapist Credentials could not be rejected at the .05 level of significance, suggesting that school counselors and therapists are in agreement on the relative importance of these factors. Table 1 shows the variables and how the research subjects responded as a group to the questionnaire.

Table 1. Mean Values and t-test Comparison of School Counselors (N=19) and Therapists (N=19) Responses to School-based Referral Factors

| | School Counselors | Therapists | t | p |
|---|---|---|---|---|
| QUESTIONNAIRE<br>All six factors combined | 25.34<br>[3.32] | 23.89<br>[4.09] | 2.95 | .003 |
| FACTOR #1<br>Therapist Accessibility | 5.50<br>[.40] | 5.07<br>[.57] | 2.63 | .012 |
| FACTOR # 2<br>Therapist Committment to the School | 4.94<br>[.53] | 4.61<br>[.69] | 1.63 | .112 |
| FACTOR #3<br>Therapist Philosophy and Beliefs | 5.40<br>[.36] | 5.41<br>[.61] | -0.13 | .898 |
| FACTOR #4<br>Therapist Reputation | 4.59<br>[.77] | 3.77<br>[.75] | 3.33 | .002 |
| FACTOR #5<br>Therapist Style | 5.02<br>[.72] | 5.06<br>[.54] | -0.21 | .839 |
| FACTOR #6<br>Therapist Credentials | 4.98<br>[.72] | 4.74<br>[.68] | 1.07 | .293 |

Notes:
- Standard Deviations are listed in parentheses below mean values.
- Critical Value for $t$(df=36, $p$<.05) is 1.96 for a two tailed test.

## Discussion

As hypothesized, school counselors and therapists do not agree on the factors that are used for making referrals when school-based problems are beyond the charter of the school counselor. While school counselors and therapists have common goals and objectives for children (Berkman & Rosenblum, 1982), both are over burdened with work and have limited resources (McDaniel, 1981; Cole, 1986). With a high student to counselor ratio and the broad duties of school counselors, there is a high need to be clear about responsibilities and priorities (Cole, 1986; Herr, 1986). One possible explanation for the differences is that school counselors and therapists have a different perspective on how to allocate their time. In this study, student to counselor ratios in schools ran as high as 700 to 1, thereby limiting time to get involved in a collaborative relationship with therapists or to get to know several therapists in an indepth business relationship. Therapists are also time limited as well. Their livelihood depends on efficient utilization of their time, and clients are generally very cost conscious. Most therapists do not charge clients for telephone calls to school counselors, for collaborating with school counselors, or for attending school meetings.

Interviews with school counselors and therapists did not agree with the questionnaire results that showed school counselors were generally in agreement with therapists on the importance of Therapist Commitment to the School. Therapist commitment to the school is very time consuming as discussed above. If the time constraint is the real issue, then it is possible that both school counselors and therapists agree on the importance.... but are not able to give this factor the priority they feel it deserves.

In addition to the findings of agreement on Therapist Credentials, clients also use other factors like trustworthiness, skill, competency, warmth, comfort, satisfaction and appreciation to evaluate therapists ( Bergan & Tombari, 1976; Dustin & Ehly, 1984; Epperson & Heesacker, 1985; Heesacker & Heepner, 1983;

Heppner & Heesacker, 1982; Kaul & Schmidt, 1971; Scheid, 1976).

Bossard & Gutkin (1983) points out that the client is sometimes the school and the dysfunctional child. In reviewing the data on the factors of Therapist Accessibility and Therapist Reputation, it appears that therapists in general are not good marketers of their services. Accessibility (eg., location, hours, fees) can be a significant barrier to clients. Heatherington & Allen (1984) and Clopton & Haydel (1982) agree that therapist's hours, location, and fee structure are elements that help determine how accessible the therapist is to clients. Reputation (eg., experience, getting referrals from school counselors, getting listed in the school community resources guide) are fundamental advertising principles. In the future, therapists may want to consider taking a systems approach to their business planning as well as using a systems approach in working with client problems.

General Impressions from Interviews

While therapists agreed that working with the schools is important, few in this study seemed to be doing so. In interviewing school counselors, the theme of non-involvement surfaced numerous times. They consistently reported feeling left out of the therapy process once a referral was made. And they reported getting little feedback or none at all from therapists during therapy or after therapy was completed. In some cases school counselors were reluctant to make referrals because of lack of knowledge about a particular therapist. School counselors reported wanting to know who they were referring to and what their credentials were, not in degrees but in types of cases, therapy approaches used by the therapist, and especially therapist style. The literature is well documented with the counseling qualifications of school counselors; they have the foundation to be an informed consumer of and a provider of high quality referrals.

Interviews with therapists about their interactions with school personnel left an impression of frustration in dealing with a large bureaucracy. Most

therapists did not have any idea how a therapist gets on a referral list. Others said it was who you know, not what you can do. The consensus was that the school referral process was fragmented and that schools did not have a clear policy on making referrals. The community resources book used by the school system was virtually unknown to most therapists. In regard to working with the schools, therapists stated that they found the communication process difficult because of conflicting schedules. School counselors have schedules to maintain in the schools and therapists are mostly in therapy sessions with clients during those hours. With a 10 minute break between clients, there is little opportunity for a therapist to call the schools to talk with a school counselor on a school classroom schedule.

The general theme of the interviews with school counselors was that they want to be more involved with the therapy process and they want to understand more about what therapists do, so they can make better referrals. School counselors want more information about the therapists to whom they are referring clients. Therapists, on the other hand, do not understand the school process. Few therapists in this study were "systems" trained and most did not see the school's continued involvement in the therapy process as legitimate. In addition, they saw school meetings and telephone calls as a costly use of their time. In interviews with therapists, several considered it important to work with the schools and listed a substantial number of school referrals per year. In all cases the predominate factors cited by therapists for their success in getting continued school referrals included accessibility, commitment to the school, and reputation. Therapists who appear to be successful in getting school referrals are those who work at building and maintaining a relationship with the schools. From a business perspective , they have developed a marketing strategy for their therapy practice that includes the school as a valuable market segment. A total systems approach in communicating with and working with the school cannot be overemphasized because the school counselor essentially becomes the

consumer and judge of service provided by therapists in solving school-based problems (Fairfield, 1985).

Implications of the Study

The school referral process is viewed as a mysterious process by many therapists who could be providing a valuable service to the schools and to dysfunctional children. An opportunity exists to find a means to bring more therapists into the school referral process. At the same time, the school could implement an accountability system using feedback from school counselors to measure the effectiveness of individual therapists for certain types of therapy referrals. As a result, school counselors would be in the position to make referrals with more knowledge and confidence. School counselors have expressed the desire to learn more about the therapy process and school counselors want to be more involved in therapy on a continuing basis. In-service training for school counselors in the therapy process and involvement in measuring therapy outcome and client satisfaction would broaden the school counselor's role. As a result of this broadened responsibility, dysfunctional children would receive better care from the school system in the form of appropriate referrals.

Therapists in the community need to recognize that location, hours, fees, and business policies restrict their availability to the schools and to clients. In addition, therapists could benefit by additional systems training and by recognizing the legitimacy of school involvement in the therapy process. Finally, therapists as a group, need to become better businesspersons and better marketers of their services.

Limitations

The information on how school counselors view the referral factors gathered in this study is statistically limited to the geographic research area of this study because of the research design. While the therapist selection was conducted through the use of a simple random sample, it was still

geographically restricted to a large metropolitan area in Northern Virginia. In addition the information used to establish the factors in this study came from a specific group of school counselors and therapists, and while this information is generally supported by the literature, generalizations to other school counselors and therapists should be made with caution.

# REFERENCES

Amateau, E. S. & Fabrick, F. (1984). Moving a family into therapy: Critical referral issues for the school counselor. The School Counselor, 15 (3), 285-294.

Amateau, E. S. & Fabrick, F. (1981). Family systems counseling: A positive alternative to traditional counseling. Elementary School Guidance and Counseling, 29 (3), 223-236.

Bergan, J. & Tombari, M. (1976). Consultant skill and efficiency and the implementation and outcomes of consultation. Journal of School Psychology, 14, 3-14.

Berkman, I. P. & Rosenblum, L. (1982). Serving high school students in need: A look at restrengthening the linkage between the school and community referral sources. Adolescence, 16 (66), 465-470.

Bossard, M. D. & Gutkin, T. B. (1983). The relationship of consultant skill and school organizational characteristics with teacher use of school based consultation services. School Psychology Review, 12, (1), 50-56.

Brown, B. (1980). A study of the school needs of children of one-parent families. Phi Delta Kappan, 61, 537-540.

Clopton, J. R. & Haydel, J. (1982), Psychotherapy referral patterns as influenced by sex of the referring therapist and the sex and age of the client. Journal of Consulting and Clinical Psychology, 50 (1), 156-157.

Cole, C. (1986). Obstacles to excellence in counseling. The School Counselor, 34, (2) 85-86.

Cole, C. (1987). From the editors desk. The School Counselor, 34 (4), 244.

Cricket Software (1985). StatWorks: Statistics with Graphics for the Macintosh. Philadelphia: Supplier.

DiMattia, P. (1984). Teachers and classrooms. In N. R. Bernstein & J. N. J. Sussex (Eds.) Handbook of Psychiatric Consultation with Children and Youth, 169-183. New York: Spectrum Publications.

Dustin, D. & Ehly, S. (1984). Skills for effective consultation. The School Counselor, 32 (1), 23-29.

Epperson, D. L. & Pecnik, J. A. (1985). Counselor rating form - short version: Further validation and comparison to the long form. Journal of Counseling Psychology, 32, 143-146.

Fairchild, T. N. (1985). Obtaining consumer feedback as a means of evaluating school psychology intern performance. Psychology in the Schools, 22, 419-428.

Fine, M. J. (1982). Issues in adolescent counseling. School Psychology Review, 11, (4), 391-398.

French, D. A. & Waas, G. A. (1985). Teachers' ability to identify peer-rejected children: A comparison of sociometrics and teacher reating. Journal of School Psychology, 23, 347-353.

Goldenberg, I. & Goldenberg, H. (1981). Overview: Family systems and the school counselor. The School Counselor, 28, (3), 165-177.

Heatherington, L. & Allen, G. J. (1984). Sex and relational communication patterns in counseling. Journal of Counseling Psychology, 31, (31), 287-294.

Heesacker, M. & Heppner, P.P. (1983). Using real-client perceptions to examine psychometric properties of the counselor rating form. Journal of Counseling Psychology, 30, 180-187.

Heppner, P. P. & Heesacker, M. (1982). Interpersonal influence process in real-life counseling: Investigating client perceptions, counselor experience level, and counselor power over time. Journal of Counseling Psychology, 29 (3), 215-223.

Herr, E. L. (1986). The relevant counselor. The School Counselor, 34 (1), 7-13.

Hoge, R. D. & McKay, V. (1986). Criterion-related validity data for the behavior checklist-teacher's report form. Journal of School Psychology, 24, 387-393.

Hutchinson, R., Barrick, A. L. & Groves, M. (1986). Functions of secondary school counselors in the public schools: Ideal and actual. The School Counselor, 34 (2), 87-91.

Hutton, J. B. (1985). What reason are give by teachers who refer problem behavior students? Psychology in the Schools, 22, 79-82.

Kaul, T. J. & Schmidt, L. D. (1971). Dimensions of interviewer trustworthiness. Journal of Counseling Psychology, 18, 542-548.

LaCrosse, M. B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the counselor rating form. Journal of Counseling Psychology, 27, 320-327.

Little, L. F. & Thompson, R. (1983). Truancy: How parents and teachers contribute. The School Counselor, 30 (4), 285-291.

McDaniel, S. (1981). Treating school problems in family therapy. Elementary School Guidance and Counseling, 15, 214-222.

Millard, T. A. (1981). The counselor as referral agent: Matching client problems with community agency resources. Journal of the International Association of Pupil Personnal Workers, 25 (1), 32-39.

Nicoll, W. G. (1984). School counselors as family counselors: A rationale and training model. The School Counselor, 31 (3), 279-284.

Perlman, H. H. (1979). Relationship: The Heart of Helping People. Chicago: The University of Chicago Press.

Robbins, S. B., May, T. M. & Corazzini, J. G. (1985). Perceptions of client needs and counseling center staff roles and functions. Journal of Counseling Psychology, 32, 641-644.

Scheid, A. B. (1976). Client's perception of the counselor: The influence of counselor introduction and behavior. Journal of Counseling Psychology, 23 (6), 503-508.

Tinsley, H. E., Workman, K. R. & Kass, R. A, (1980). Factor analysis of the domain of client expectancies about counseling. Journal of Counseling Psychology, 27 (6), 561-570.

Weinrach, S. G. (1984). Toward improved referral making: Mutuality between the counselor and the psychologist. The School Counselor, 32 (2), 89-96.

Wilcoxon, S. A. & Comas, R. E. (1987). Contemporary trends in family counseling: What do they mean for the school counselor, The School Counselor, 34 (3),219-225.

Worden, M. (1981). Classroom behavior as a function of the family system. The School Counselor, 28 (3), 178-188.

Young, N. (1979). Secondary school counselors and family systems. The School Counselor, 26 (3), 247-253.

# APPENDIX A

## Review of Current Literature

## APPENDIX A

### Review of Related Literature

School-based referrals are a direct outcome of some event observed in the school system. What follows is an indepth look at how family functioning impacts children's behavior and how school counselors play a pivotal role in the assessment, referral, and therapeutic process when children's behavior emerges as problematic in the classroom.

#### Characteristics of Healthy Families

Fisher & Sprenkle (1978) in a survey of therapist's perceptions of healthy families found that, "the aspects of healthy family functioning that are most valued center on the family's ability to create an environment where family members feel valued, supported and safe. They can express themselves openly and non-judgementally..." The influence of parents and living in a healthy family system are the most significant factors affecting childrens' behavior. It is the interaction patterns learned in the basic family unit that leads to the healthy adjustment and development of children (Crosby, 1976; Kramer, 1977). Green & Kolevzon (1984) adds that "..healthy children tend to emerge from healthy families..." and that youths who have not learned as children in the family how to develop meaningful relationships within the family and have not learned the basic life skills necessary to hold a menial job are unprepared to cope with the world around them. Green's review of the characteristics cited by three well known authors in the field of family therapy (Bowen, Minuchin, Satir) paint a profile of a healthy family. These characteristics, which follow, include both individual and group variables.

1- clear, direct, and specific communications

2- flexible and situationally appropriate family rules

3- individual maturity

4- clear boundaries for self differentiation

5- good problem solving skills

6- coping skills to handle dysfunctional situations

7- roles, expectations, & interactions are clearly defined

While there is some overlap in these characteristics, together they tend to show a family's affective structure, the family's way of thinking, and the family's behavior patterns (Green & Kolevzon, 1984). In a similar fashion, Epstein, Baldwin & Bishop (1983) describes family functioning in terms of structure and organization and in terms of interaction patterns of family members. To quantify the level of family functioning, Epstein developed the Family Assessment Device (FAD) based on the McMaster Model of Family Functioning. The FAD is a seven scale instrument measuring the family function level in Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control and General Functioning.

Families Under Stress

Olson, Sprenkle, & Russell (1979), in an attempt to shed more light upon the specific area of family stress, developed the Circumplex Model to describe a family's level of functioning. In support of this landmark work, Olson & Portner (1983) point out that each family member may see the functional elements differently and they may not want the same things (ie, during the adolescent years parents may want more communication with their teenager while the teenager is wanting more autonomy). In the Circumplex Model, the elements used to describe the first dimension of functioning, Family Cohesion (the degree to which family members are separated from or attached to each other) are:

1- emotional bonding of family members

2- boundaries between family subsystems

3- coalitions between family members

4- time space for each individual

5- friends, individual and joint

6- decision making

7- interests and recreation

The second dimension of the Circumplex Model is family adaptability (the ability to change in response to situational stress) with the elements:

1- power structure

2- role relationships

3- relationship rules

According to McCubbin & Patterson (1983), all families experience stress and stress is a normal process as families and individuals experience life. These life experiences include predictable development stages of children and adults and predictable changes over time in family members and with family relationships . The family life cycle concept describes the stages, emotional processes, and development tasks of normal family stages (Carter & McGoldrick, 1980; 17). Starting with the unattached young adult, Carter & McGoldrick contrast the different family stages as the individuals marry, as children enter and exit, and as the family in later life. The demands on family members at each transition stage are major sources of stress. In addition to these normal stages and transitions, some families experience abnormal catastrophic stresses (chronic illness, drug abuse, unemployment, separation and divorce, remarriage and adjustment to stepchildren, etc.).

The literature is well documented regarding how stress affects families in different ways. Some families function very well under difficult situations while other families seem to crumble under minor stress. Hills ABCX Model is a conceptual foundation to examine family variables in coping with stress (McCubbin & Patterson, 1983). Hill's model includes the stressful event, the

existing resources, and the family's perception of the stress, as the elements of the resulting crisis and the demand for change. The McCubbin, Boss, Wilson, & Lester study (cited in McCubbin & Patterson, 1983, p. 11) expanded on Hills original ABCX Crisis Model by adding post-crisis variables. The major addition with the Double ABCX Model is the concept of stress pile up and family coping over time. The stress pile up is the activating event and it can be a major crisis or a series of minor unresolved stresses.

Family development stages and transitions occur over long periods of time so families end up coping with more than one potential stressor at a time. The resulting stress pile-up creates an increased demand for change (McCubbin & Patterson, 1983). Single parent families are a good example of how a family can experience stress pile-up. Stressors can include separation and divorce, child custody battles, financial hardships, reentry into the work force for women, finding adequate child care, and disruptive visitation arrangements.

Children are not exempt from the stressful results of separation and divorce. Children from single parent families experience more problematic behaviors in the school setting (Brown, 1980). Using 1980 census data and current divorce projections, Brown estimated that 12 million children born in 1980 will experience some time in a single parent household, and many of these children will end up in remarried families. Since school counselors come in contact with virtually all of these children, Palmo, Lowry, Weldon & Scioscia (1984) see a growing need for school counselors to be more involved with families, even extending the counselor's role into being involved with the family therapy process in a true systems context.

## Systems Theory

Systems theory looks at behavior in a broader context of the environment and the interactions between the client and significant others (Goldenberg & Goldenberg, 1981). An important part of the systems model is how the

symptoms affect people close to or around the symptom bearer. Rather than seeing the client as an individual, systems theory sees the client as the entire family (Amateau & Fabrick, 1981; Goldenberg & Goldenberg, 1981; Worden, 1981) and is interested in not only how the family members interact but interaction quality with other pertinent systems in their larger context. Goldenberg & Goldenberg (1981) include hierarchy and power in the system and state "Behavior must be evaluated in system terms (transactions, relationships) in order to be fully understood." For example, children often become symptomatic in school. In the systems theory model, the family system is seen as having a powerful effect on the child's school performance, therefore the school counselor must include the family in the early stages of evaluation and treatment planning (Goldenberg & Goldenberg, 1981; Fine, 1982). For example, when using a systems approach to the problem behavior of school truancy, it is important to evaluate the interactions of the significant others in the child's environment. Significant others include family members, school personnel, and peers (Little & Thompson, 1983; McDaniel, 1981). When youths cannot meet their interactional needs in the family subsystems, they often seek to meet their needs outside the family (Kramer, 1977).

Schools: A Major Subsystem

The school environment is a major influence in the child's total system. In addition to being an academic experience, the school is also a social laboratory and a rehearsal for real life (DiMattia, 1984). In support of Palmo (1984) mentioned earlier, DiMattia goes on to suggest that schools should have a broader role than just academic teaching; they should accept responsibility for the physical and emotional development of their charges. Conti (1971) even recommends that the school counselor set up the first therapy session with the referral therapist.

From a systems perspective it is not unlikely to find that schools and mental health agencies share common goals and objectives for children (Berkman & Rosenblum, 1982). However, McDaniel (1981) sees the schools and mental health agencies as disengaged systems. As an example of this disengagement, McDaniel points out that few school counselors have contact with therapists. The resulting fragmentation of services with no clear focal point further adds to confusion during periods of stress and becomes a deterrent to families seeking help (Millard, 1981). In response to this fragmentation, school counselors and the mental health community have an opportunity to help shape a new environment for the child who experiences problems by becoming more involved in the family/therapy system (DiMattia, 1984; Lewis & Lewis, 1977; Young, 1979). McDaniel (1981) is pessimistic about increased involvement and points out the major obstacle to more involvement. Both schools and mental health agencies are already overburdened with work and both have limited resources.

Dysfunctional Behavior in the Classroom

The classroom behaviors of children reacting to stress take many forms, from disruptive behavior to decline in academic performance to truancy (Amateau & Fabrick, 1981,1984; Little & Thompson, 1983). School performance is no longer measured in academic achievement alone. School teachers and counselors are on the front line and they have been shown to be good evaluators of dysfunctional performance. Dysfunctional behavior in the classroom is an observable variable. Using various checklists that describe behavior, teachers and counselors can quantitatively measure social adjustment using tests like The Walker Problem Behavior Identification Checklist (Bowman & Myrick, 1987; Hoge & McKay, 1986). This checklist has five subscales; 1) Acting Out, 2) Withdrawal, 3) Distractibility, 4) Disturbed Peer Relations, and 5) Immaturity. In addition to quantitative measures, teachers see so many students that they

are in a good position to develop qualitative social and academic baseline performance standards (DiMattia, 1984).

Conceptual Interpretation of Classroom Behavior

School involvement begins with observation of some behavior that is considered dysfunctional in the school setting. The conceptual interpretation of the observed student behavior determines how counselors proceed (Worden, 1981). If the child is viewed as sick, psychotherapy and even hospitalization may be the preferred treatment. If the child is viewed as bad, the school may work with teachers and parents to set up consistant discipline or a behavior modification program. According to Fine (1982), symptom interpretation and the outcome wanted defines the choice of action. Referrals for psychotherapy interventions with behavioral dysfunction are usually made by the school counselor in a parent/school meeting where the school counselor, using his/her conceptual interpretation of the observed behavior typically gives the name of several providers who offer the therapy modality that fits the counselor assessment. If the child is viewed as sick, the choice will be individual therapy to treat an innate flaw in the child. If the child is viewed as reacting to a stressful environment, the treatment may include working with the parents (to teach better parenting skills), or family therapy (to work with the family system), or an ecological approach (working with the family system, the school system and other systems that have influence on the child). There are numerous therapy models to choose from, and the counselors treatment strategy follows conceptualization of the problem (Worden, 1981; Young, 1979).

Multidimensional Role of the School Counselor

Nicole (1984) reflects the changing views of many educators and counselors and suggests that the role of the school counselor is multidimensional. The counselor's role, initially starting as a testing and guidance role, is evolving

toward more interpersonal counseling and working with emotional adjustment difficulties. School counselors are now expected to intervene in significant areas such as chemical dependency, grief and bereavement, adolescent suicide, child sexual abuse, anger management, and support of children in single parent and remarried parent households. Exploring the problem with school teachers, the counselor, the principal, and the parents has several advantages. In addition to bringing out some good points to balance the problem side, the initial meeting sets the stage for mutual support between the school and family. With high student to counselor ratios and the broad duties of school counselors, there is a high need to be clear about responsibilities and priorities (Cole, 1986, 1987; Herr, 1986). While interpersonal and emotional counseling are viewed by some as the most important role of the school counselor, they also point out there is not sufficient time in the counselor's daily schedule to cover all the bases.

Teachers and counselors, through their school positions, have a natural access to families. In an everyday educational setting, the counselor can initiate assessment and treatment with the child who exhibits problematic behavior (Nicole, 1984). The counselor also has a critical role in moving the family into therapy when traditional school based counseling does not work (Amatea & Fabrick, 1984). The counselor can also assume a public relations role (Cole, 1987) for the school in working with the families of dysfunctional children. In a time of family stress the counselor represents the school and its actions, and communicates to the family the degree to which the school wants to be involved. Do they want to help, attack the parents, or just get rid of the problem child?

Therapist Dimensions and Effectiveness

Therapists in private practice and community mental health agencies become a temporary part of the child/family/school system when called on by the schools to help solve a problem. Therapists are evaluated by school

counselors and judged on a number of variables such as trustworthiness, attractiveness, and expertness (Heppner & Heesacker, 1982; Kaul & Schmidt, 1971); skill and competency (Bergan & Tombari, 1976; Dustin & Ehly, 1984; Epperson & Pecnik, 1985; Heesacker & Heppner, 1983) and other scoreable factors like warmth, , climate, comfort, satisfaction, appeal; academic prowess is not enough (Scheid 1976). Since client expectations have an impact on client satisfaction in the early stages of therapy (LaCross, 1980; Tinsley, Workman & Kass, 1980), the school counselor, by means of referrals made, plays a key role with the child/family in setting the stage for effective treatment.

Interdependence of Counselor and Therapist

While school counselors and therapists have common goals and objectives as members of the helping profession, the professional relationship between the two is built more on similar philosophies and communication than therapy outcome (Berkman & Rosenblum, 1982; Perlman, 1979). In building an interdependent relationship, therapists should be aware that school counselors see themselves as a part of the therapy process and that school counselors look favorably on therapists who consult with them and keep them informed of progress. In support of more school involvement, Bossard & Gutkin (1983) state that in making a referral, the client is sometimes considered the school and the dysfunctional child.

The early involvement of the School when there is a school-based problem is crucial. Aponte (1979) suggests that the counselor become the link between the school and family and the therapist because the counselor has daily access to the teachers, the child, and the family. Aponte further suggests that this joining of school, family and therapist is so important in eliciting the commitment of the school and family in a joint problem solving effort that the therapist should not be too anxious to start therapy but should instead be willing to wait until all the participants are available. Schools are often reluctant to engage in this type

meeting because their experience is that therapists want to change the school system. While there may be some truth to this, the therapist's primary approach is to change how the problem is viewed and to change interaction patterns. These changes, between the child and the significant others in his/her life, are essential to solving the problem naturally (brute force just doesn't work) within the context of the family subsystem, the school subsystem and the social subsystem of the child. In doing this, the therapist often supports the school system while strengthening the parent subsystem (Aponte, 1979).

In-School Treatment

School treatment of dysfunctional behavior is traditionally time limited due to the shortage of counseling resources. The high student to counselor ratio and the specialized training needed for intervening with more severe problems make in-school treatment impractical (Cole, 1987; Palmo, Lowry, Weldon & Scioscia, 1984; Young, 1979). Another factor considered is the shortage of evening hours to accommodate working parents. The school counselor often makes a traditional short term child-centered intervention. If the problems does not go away, then the child is referred (Amateau & Fabrick, 1984). Because of the shortage of counseling resources, Millard (1981) sees the school process as getting the facts, deciding with the parents to make a referral to a community therapist or to provide therapy in the school setting. Worden (1981) supports Millards "getting the facts" stage and describes a systemic role of data collection that includes the childs perception of the problem, the teachers perception and a family interview.

Referral Concepts

The decision to refer is often a joint process between the counselor and the parents (Worden, 1981). Making a referral should start with consideration of the client's best interests. Variables like therapist skill, time availability,

rapport, and client readiness for referral are important considerations (Hutton, 1985; Weinrach, 1984). In making the decision to refer, the counselor is faced with certain issues. Amateau (1984) categorizes the issues into three areas; deciding when a family needs help, motivating the family to seek treatment, and collaborating with the therapist. Dimattia (1984), takes a different approach and defines the issues in terms of family rights, lack of knowledge of treatment methods and therapist skills, and inadequate responses to needs at the societal and governmental level.

In making a referral to a therapist, the counselor often considers the client-therapist match. This match includes factors like gender, experience and qualifications, personality, location, hours, fee, etc. (Clopton & Haydel, 1982; Heatherington & Allen, 1984). Miele (1974) describes the interpersonal relations between counselor and therapist as the vehicle that provides information and the etiquette of the referral process. Mathews & Fawcett (1979) include in the referral process the need for training on how to make referrals and cites that referrals are most sucessful when to local therapists with easy access by clients.

Post Referral Collaboration

Making a referral does not end the school's role in solving dysfunctional school behavior. The literature is well documented with the desire for school counselors to be a part of the solution. The counselor can be a key participant in the therapy process by initiating school meetings and providing a communications link to the therapist on client progress in the school setting (McDaniel, 1981). A more active role exists for the schools that want to be involved. The teacher and counselor have the opportunity to become a full partner in the therapy process through initial collaboration and regular feedback (Dimattia, 1984). The feedback from the client to the counselor and the feedback from the therapist to the counselor becomes an important consideration for future referrals. The systems approach to communication and

the therapy process cannot be overemphasized because the counselor essentially becomes the consumer and judge of service provided by therapists in solving school-based problems (Fairfield, 1985).

# APPENDIX B

## Additional Results

## APPENDIX B

## Additional Results

In addition to the data from the research questionnaire, demographic data were collected on all respondents in the study. Data such as gender, education level, education field, years in the profession, and the number of school referrals given (school counselors) or number of referrals received (therapists) were collected to paint a profile of the respondents as a group.

Table 2 shows the gender of respondents. All school counselors were female. Of the therapists, 7 (36.8%) were male and 12 (63.2%) were female.

Table 3 highlights the difference in education level beteen therapists and school counselors, with therapists as a group attaining a significantly higher level of education. School counselors were predominately masters level (94.7%) while therapists were 52.6% masters level and 47.4% doctoral level.

Table 4 shows the education field for the highest degree attained by respondents. The education fields were social work, counseling & guidance, education, psychology, and other. The most often held degree held by school counselors was a masters in counseling and guidance (47.4%). The majority of therapists had a degree in psychology (57.9%). In reviewing the education level of therapists with psychology degrees, nine had Ph.D.s and two had a masters degrees.

Table 5 compares school counselors and therapists in the area of "years in profession, number of school referrals received or given, and an estimate on the length of treatment for the case example of Billy."

School counselors had a median experience level of 2 years (this position was a recently created position in the school system). Therapists were more experienced as a group with a median experience level of 12 years.

The number of school referrals reported varied widely (a range of 5-75 for both groups) with school counselors reporting a median of 15 referrals given per year and therapists reporting a mean of 20 referrals for school-based problems received per year from several sources including schools.

The length of treatment was selected as an indicator of how serious the problem of "Billy" was perceived. School counselors and therapists both had a median of 12 sessions to resolve the described problem, however the range varied widely.

Figure 4 shows a histogram of school counselor scores and therapist scores for the questionnaire. In addition, the Box & Whiskers shows the median score for both groups of respondents.

Tables 6 & 7 list each research scale with the questions making up the scales. The raw scores for school counselors and therapists are tabulated along with a mean and standard deviation for each question.

Table 2. Gender of Sample Respondents

| | School Counselors | Therapists | |
|---|---|---|---|
| Male | 0 | 7 | 7 |
| Female | 19 | 12 | 31 |
| | 19 | 19 | 38 |

Table 3. Education Level of Sample Respondents

| | School Counselors | Therapists | |
|---|---|---|---|
| Masters | 18 | 10 | 28 |
| Doctorate | 1 | 9 | 10 |
| | 19 | 19 | 38 |

Table 4. Education Field of Sample Respondents in Highest Degree Earned

| | School Counselors | Therapists | |
|---|---|---|---|
| Social Work | 1 | 5 | 6 |
| Couns & Guide | 9 | 1 | 10 |
| Education | 4 | 0 | 4 |
| Psychology | 0 | 11 | 11 |
| Other | 5 | 2 | 7 |
| | 19 | 19 | 38 |

Table 5. Median of Responses of Sample Respondents for Years in Profession, Number of School Referrals, and Estimated Treatment Period of Billy

| | School Counselors | Therapists |
|---|---|---|
| Years in Profession | 2 | 12 |
| School Referrals Given per Year | 15 | 0 |
| School Referrals Received per Year | 0 | 20 |
| Estimated Treatment Period (weeks) | 12 | 12 |

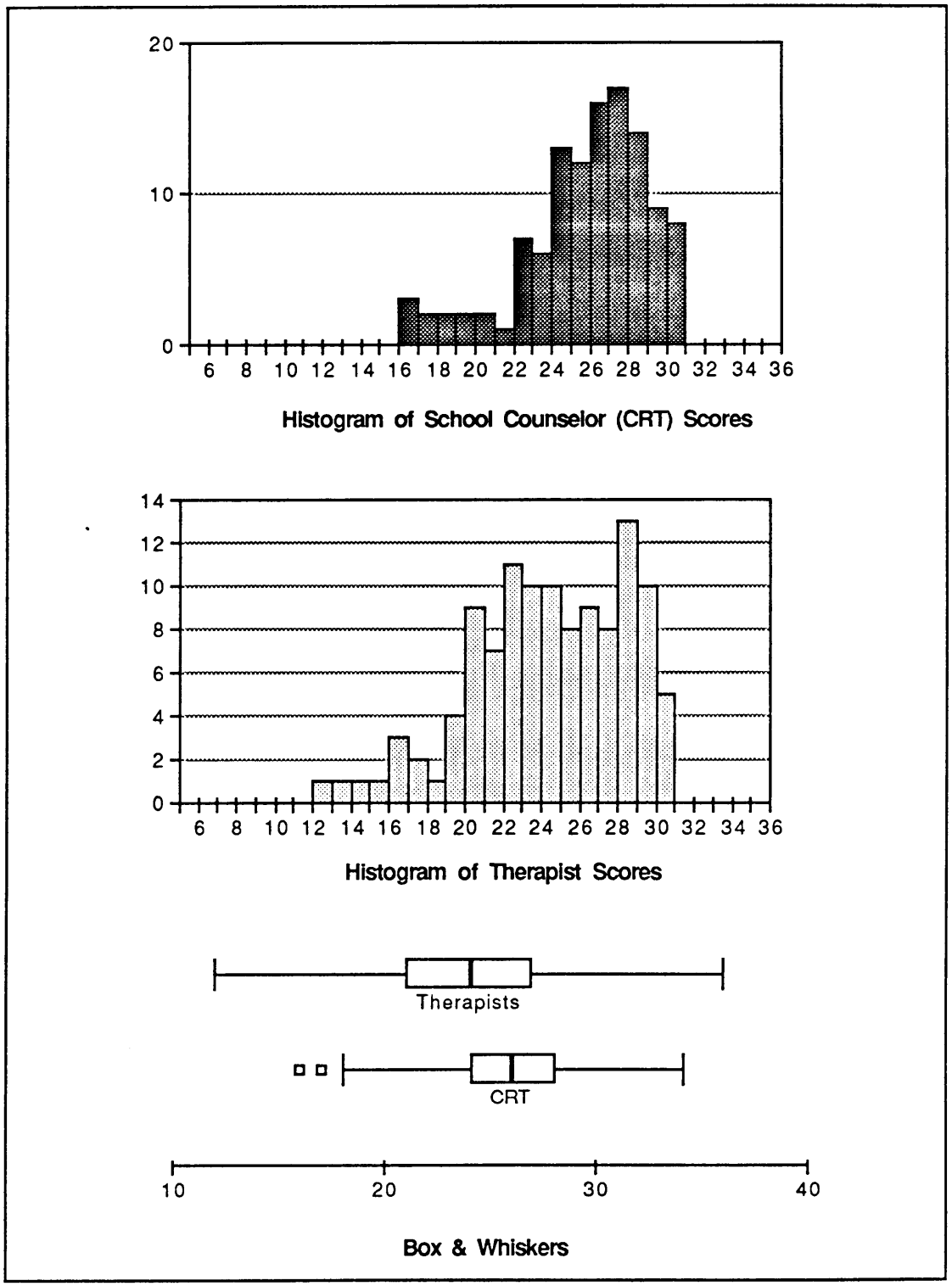


Figure 4. Graphical Comparison of Combined Scale Scores

**Table 6. Scale Composition with Scores for School Counselors**

| | | CODE NUMBER of RESPONDENTS | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | mean | SD |
| | Question | | | | | | | | | | | | | | | | | | | | | |
| SCALE 1 | 1 | 4 | 4 | 6 | 6 | 6 | 6 | 4 | 4 | 3 | 6 | 6 | 6 | 5 | 5 | 5 | 4 | 4 | 5 | 5 | 4.95 | 0.97 |
| Therapist's | 6 | 5 | 6 | 6 | 6 | 6 | 4 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 5.74 | 0.56 |
| Accessibility | 11 | 5 | 6 | 6 | 6 | 6 | 5 | 6 | 5 | 5 | 6 | 5 | 5 | 5 | 4 | 6 | 6 | 6 | 6 | 6 | 5.53 | 0.61 |
| | 16 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 4 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 5.74 | 0.56 |
| | 21 | 4 | 5 | 4 | 6 | 6 | 6 | 6 | 4 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 5.53 | 0.77 |
| | SUM | 23 | 27 | 28 | 30 | 30 | 27 | 28 | 24 | 24 | 30 | 28 | 29 | 28 | 26 | 29 | 28 | 28 | 28 | 27 | 27.47 | 2.01 |
| | avg. | 4.6 | 5.4 | 5.6 | 6 | 6 | 5.4 | 5.6 | 4.8 | 4.8 | 6 | 5.6 | 5.8 | 5.6 | 5.2 | 5.8 | 5.6 | 5.6 | 5.6 | 5.4 | 5.49 | 0.40 |
| SCALE 2 | 2 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 3 | 6 | 3 | 6 | 6 | 6 | 5.63 | 0.96 |
| Therapist's | 7 | 5 | 6 | 4 | 6 | 4 | 6 | 5 | 6 | 6 | 6 | 6 | 5 | 5 | 4 | 5 | 4 | 4 | 6 | 6 | 5.21 | 0.85 |
| Committment | 12 | 5 | 4 | 6 | 4 | 4 | 4 | 3 | 5 | 4 | 4 | 6 | 5 | 6 | 3 | 4 | 4 | 3 | 5 | 6 | 4.47 | 1.02 |
| to the School | 17 | 4 | 6 | 4 | 5 | 6 | 4 | 5 | 5 | 4 | 6 | 6 | 5 | 5 | 4 | 1 | 5 | 6 | 6 | 6 | 4.89 | 1.24 |
| | 22 | 4 | 4 | 6 | 4 | 4 | 4 | 5 | 4 | 3 | 6 | 4 | 5 | 5 | 4 | 6 | 6 | 3 | 6 | 2 | 4.47 | 1.17 |
| | SUM | 24 | 26 | 26 | 25 | 23 | 24 | 24 | 26 | 23 | 28 | 28 | 26 | 27 | 18 | 22 | 22 | 22 | 29 | 26 | 24.68 | 2.67 |
| | avg. | 4.8 | 5.2 | 5.2 | 5 | 4.6 | 4.8 | 4.8 | 5.2 | 4.6 | 5.6 | 5.6 | 5.2 | 5.4 | 3.6 | 4.4 | 4.4 | 4.4 | 5.8 | 5.2 | 4.94 | 0.53 |
| SCALE 3 | 3 | 4 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 6 | 5 | 5.68 | 0.58 |
| Therapist's | 8 | 4 | 4 | 4 | 5 | 5 | 3 | 5 | 5 | 5 | 5 | 6 | 4 | 4 | 3 | 1 | 3 | 4 | 5 | 5 | 4.21 | 1.13 |
| Philosophy | 13 | 5 | 6 | 4 | 6 | 5 | 6 | 6 | 6 | 4 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 5.63 | 0.68 |
| & Belief | 18 | 5 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 6 | 5 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 5.74 | 0.45 |
| System | 23 | 5 | 6 | 6 | 6 | 6 | 5 | 6 | 4 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 5.68 | 0.58 |
| | SUM | 23 | 28 | 26 | 29 | 27 | 26 | 28 | 27 | 25 | 29 | 30 | 26 | 28 | 26 | 24 | 26 | 27 | 29 | 28 | 26.95 | 1.81 |
| | avg. | 4.6 | 5.6 | 5.2 | 5.8 | 5.4 | 5.2 | 5.6 | 5.4 | 5 | 5.8 | 6 | 5.2 | 5.6 | 5.2 | 4.8 | 5.2 | 5.4 | 5.8 | 5.6 | 5.39 | 0.36 |
| SCALE 4 | 4 | 1 | 6 | 6 | 4 | 3 | 1 | 5 | 4 | 4 | 6 | 4 | 3 | 6 | 5 | 6 | 4 | 6 | 5 | 4 | 4.37 | 1.57 |
| Therapist's | 9 | 5 | 6 | 5 | 6 | 6 | 5 | 5 | 5 | 6 | 6 | 6 | 4 | 4 | 6 | 2 | 6 | 6 | 4 | 5 | 5.16 | 1.07 |
| Reputation | 14 | 3 | 3 | 4 | 1 | 3 | 1 | 4 | 5 | 6 | 4 | 4 | 1 | 5 | 3 | 6 | 4 | 4 | 6 | 6 | 3.84 | 1.64 |
| | 19 | 3 | 6 | 6 | 4 | 5 | 4 | 5 | 4 | 5 | 6 | 5 | 5 | 6 | 6 | 1 | 6 | 5 | 6 | 6 | 4.95 | 1.31 |
| | 24 | 4 | 6 | 6 | 6 | 6 | 6 | 5 | 4 | 3 | 5 | 5 | 4 | 5 | 4 | 1 | 4 | 6 | 6 | 2 | 4.63 | 1.46 |
| | SUM | 16 | 27 | 27 | 21 | 23 | 17 | 24 | 22 | 24 | 27 | 24 | 17 | 26 | 24 | 16 | 24 | 27 | 27 | 23 | 22.95 | 3.87 |
| | avg. | 3.2 | 5.4 | 5.4 | 4.2 | 4.6 | 3.4 | 4.8 | 4.4 | 4.8 | 5.4 | 4.8 | 3.4 | 5.2 | 4.8 | 3.2 | 4.8 | 5.4 | 5.4 | 4.6 | 4.59 | 0.77 |
| SCALE 5 | 5 | 4 | 6 | 4 | 6 | 4 | 4 | 5 | 5 | 6 | 6 | 4 | 5 | 6 | 4 | 4 | 6 | 6 | 6 | 4 | 5.00 | 0.94 |
| Therapist's | 10 | 5 | 6 | 6 | 6 | 6 | 6 | 4 | 6 | 6 | 6 | 6 | 4 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 5.63 | 0.68 |
| Style | 15 | 4 | 5 | 4 | 6 | 6 | 4 | 5 | 6 | 5 | 6 | 6 | 4 | 6 | 3 | 6 | 5 | 6 | 6 | 6 | 5.21 | 0.98 |
| | 20 | 3 | 6 | 1 | 5 | 4 | 2 | 5 | 5 | 3 | 4 | 3 | 4 | 5 | 3 | 6 | 5 | 6 | 4 | 5 | 4.16 | 1.38 |
| | 25 | 4 | 6 | 4 | 6 | 4 | 4 | 6 | 5 | 5 | 6 | 6 | 5 | 6 | 4 | 3 | 5 | 6 | 6 | 6 | 5.11 | 0.99 |
| | SUM | 20 | 29 | 19 | 29 | 24 | 20 | 25 | 27 | 25 | 28 | 25 | 22 | 29 | 19 | 25 | 27 | 30 | 27 | 27 | 25.11 | 3.57 |
| | avg. | 4 | 5.8 | 3.8 | 5.8 | 4.8 | 4 | 5 | 5.4 | 5 | 5.6 | 5 | 4.4 | 5.8 | 3.8 | 5 | 5.4 | 6 | 5.4 | 5.4 | 5.02 | 0.71 |
| SCALE 6 | 26 | 4 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 4 | 6 | 5 | 4 | 6 | 6 | 6 | 6 | 4 | 5.47 | 0.84 |
| Therapist's | 27 | 3 | 6 | 6 | 6 | 5 | 6 | 6 | 5 | 6 | 6 | 5 | 5 | 5 | 5 | 6 | 5 | 6 | 5 | 6 | 5.42 | 0.77 |
| Credentials | 28 | 4 | 2 | 6 | 6 | 4 | 6 | 6 | 5 | 4 | 6 | 2 | 5 | 5 | 5 | 6 | 6 | 6 | 5 | 6 | 5.00 | 1.29 |
| | 29 | 3 | 6 | 3 | 4 | 3 | 6 | 4 | 5 | 1 | 6 | 1 | 5 | 5 | 6 | 6 | 5 | 2 | 5 | 6 | 4.32 | 1.70 |
| | 30 | 4 | 4 | 5 | 3 | 4 | 6 | 4 | 6 | 5 | 6 | 4 | 4 | 6 | 5 | 6 | 4 | 5 | 5 | 3 | 4.68 | 1.00 |
| | SUM | 18 | 24 | 26 | 25 | 22 | 30 | 25 | 27 | 22 | 30 | 16 | 25 | 26 | 25 | 30 | 26 | 25 | 26 | 25 | 24.89 | 3.59 |
| | avg. | 3.6 | 4.8 | 5.2 | 5 | 4.4 | 6 | 5 | 5.4 | 4.4 | 6 | 3.2 | 5 | 5.2 | 5 | 6 | 5.2 | 5 | 5.2 | 5 | 4.98 | 0.72 |

**Table 7. Scale Composition with Scores for Therapist Sample**

| | | CODE NUMBER of RESPONDENTS | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | mean | SD |
| | Question | | | | | | | | | | | | | | | | | | | | | |
| SCALE 1 | 1 | 3 | 4 | 4 | 5 | 6 | 5 | 6 | 6 | 4 | 5 | 4 | 4 | 2 | 4 | 6 | 3 | 6 | 5 | 5 | 4.58 | 1.17 |
| Therapist's | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 4 | 4 | 6 | 6 | 5 | 4 | 4 | 5 | 5.37 | 0.83 |
| Accessibility | 11 | 6 | 5 | 6 | 6 | 6 | 3 | 5 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 5 | 5 | 6 | 5.58 | 0.77 |
| | 16 | 4 | 4 | 4 | 5 | 4 | 1 | 2 | 6 | 6 | 5 | 6 | 4 | 5 | 5 | 5 | 6 | 2 | 5 | 6 | 4.47 | 1.47 |
| | 21 | 5 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 4 | 6 | 6 | 5 | 3 | 6 | 6 | 4 | 5 | 5 | 6 | 5.37 | 0.90 |
| | SUM | 24 | 24 | 25 | 28 | 28 | 21 | 25 | 30 | 26 | 28 | 27 | 22 | 20 | 27 | 29 | 24 | 22 | 24 | 28 | 25.37 | 2.85 |
| | avg. | 4.8 | 4.8 | 5 | 5.6 | 5.6 | 4.2 | 5 | 6 | 5.2 | 5.6 | 5.4 | 4.4 | 4 | 5.4 | 5.8 | 4.8 | 4.4 | 4.8 | 5.6 | 5.07 | 0.57 |
| SCALE 2 | 2 | 4 | 6 | 6 | 6 | 5 | 6 | 5 | 1 | 6 | 5 | 6 | 6 | 6 | 4 | 6 | 5 | 5 | 6 | 6 | 5.26 | 1.24 |
| Therapist's | 7 | 6 | 5 | 5 | 6 | 5 | 6 | 5 | 5 | 6 | 6 | 6 | 4 | 5 | 5 | 6 | 5 | 3 | 5 | 6 | 5.26 | 0.81 |
| Committment | 12 | 1 | 2 | 3 | 4 | 6 | 5 | 6 | 5 | 3 | 4 | 5 | 4 | 2 | 5 | 5 | 2 | 4 | 4 | 5 | 3.95 | 1.43 |
| to the School | 17 | 2 | 4 | 5 | 6 | 4 | 6 | 2 | 1 | 6 | 3 | 6 | 4 | 3 | 4 | 5 | 5 | 5 | 5 | 5 | 4.26 | 1.48 |
| | 22 | 6 | 3 | 4 | 4 | 5 | 4 | 5 | 4 | 6 | 6 | 6 | 4 | 4 | 4 | 3 | 3 | 3 | 2 | 6 | 4.32 | 1.25 |
| | SUM | 19 | 20 | 23 | 26 | 25 | 27 | 23 | 16 | 27 | 24 | 29 | 22 | 20 | 22 | 25 | 20 | 20 | 22 | 28 | 23.05 | 3.46 |
| | avg. | 3.8 | 4 | 4.6 | 5.2 | 5 | 5.4 | 4.6 | 3.2 | 5.4 | 4.8 | 5.8 | 4.4 | 4 | 4.4 | 5 | 4 | 4 | 4.4 | 5.6 | 4.61 | 0.69 |
| SCALE 3 | 3 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 4 | 6 | 5 | 6 | 4 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 5.68 | 0.67 |
| Therapist's | 8 | 6 | 3 | 4 | 6 | 5 | 4 | 6 | 2 | 5 | 3 | 6 | 3 | 2 | 6 | 5 | 4 | 3 | 6 | 3 | 4.32 | 1.45 |
| Philosophy | 13 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 4 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 5 | 4 | 5.68 | 0.67 |
| & Belief | 18 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 3 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 4 | 4 | 6 | 6 | 5.58 | 0.90 |
| System | 23 | 4 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 6 | 6 | 5.79 | 0.54 |
| | SUM | 28 | 27 | 27 | 30 | 29 | 28 | 30 | 18 | 29 | 26 | 30 | 25 | 26 | 30 | 29 | 26 | 23 | 29 | 24 | 27.05 | 3.05 |
| | avg. | 5.6 | 5.4 | 5.4 | 6 | 5.8 | 5.6 | 6 | 3.6 | 5.8 | 5.2 | 6 | 5 | 5.2 | 6 | 5.8 | 5.2 | 4.6 | 5.8 | 4.8 | 5.41 | 0.61 |
| SCALE 4 | 4 | 6 | 5 | 6 | 5 | 6 | 1 | 6 | 4 | 6 | 6 | 6 | 5 | 5 | 6 | 4 | 5 | 4 | 6 | 5 | 5.11 | 1.24 |
| Therapist's | 9 | 5 | 3 | 6 | 4 | 5 | 6 | 5 | 4 | 4 | 5 | 4 | 4 | 2 | 4 | 6 | 5 | 3 | 6 | 4 | 4.47 | 1.12 |
| Reputation | 14 | 4 | 2 | 2 | 1 | 4 | 2 | 1 | 4 | 4 | 2 | 4 | 3 | 1 | 4 | 2 | 3 | 2 | 1 | 4 | 2.63 | 1.21 |
| | 19 | 5 | 3 | 5 | 1 | 4 | 4 | 6 | 5 | 4 | 6 | 4 | 3 | 6 | 4 | 4 | 4 | 2 | 2 | 5 | 4.05 | 1.39 |
| | 24 | 2 | 3 | 2 | 2 | 1 | 1 | 1 | 6 | 6 | 4 | 4 | 2 | 1 | 4 | 1 | 3 | 1 | 1 | 4 | 2.58 | 1.68 |
| | SUM | 22 | 16 | 21 | 13 | 20 | 14 | 19 | 23 | 24 | 23 | 22 | 17 | 15 | 22 | 17 | 20 | 12 | 16 | 22 | 18.84 | 3.73 |
| | avg. | 4.4 | 3.2 | 4.2 | 2.6 | 4 | 2.8 | 3.8 | 4.6 | 4.8 | 4.6 | 4.4 | 3.4 | 3 | 4.4 | 3.4 | 4 | 2.4 | 3.2 | 4.4 | 3.77 | 0.75 |
| SCALE 5 | 5 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 6 | 6 | 5 | 6 | 5 | 5 | 5 | 4 | 6 | 5 | 4 | 5 | 5.37 | 0.68 |
| Therapist's | 10 | 2 | 6 | 4 | 4 | 6 | 3 | 5 | 6 | 4 | 6 | 5 | 6 | 4 | 2 | 6 | 6 | 5 | 4 | 5 | 4.68 | 1.34 |
| Style | 15 | 5 | 5 | 5 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 5 | 5 | 4 | 6 | 4 | 4 | 4 | 6 | 5.26 | 0.81 |
| | 20 | 4 | 3 | 5 | 6 | 3 | 6 | 6 | 5 | 4 | 6 | 6 | 5 | 5 | 4 | 6 | 2 | 4 | 4 | 5 | 4.68 | 1.20 |
| | 25 | 5 | 6 | 6 | 6 | 4 | 6 | 5 | 6 | 6 | 5 | 6 | 5 | 4 | 5 | 6 | 6 | 5 | 5 | 4 | 5.32 | 0.75 |
| | SUM | 22 | 25 | 26 | 28 | 24 | 26 | 28 | 29 | 26 | 28 | 29 | 26 | 23 | 20 | 28 | 24 | 23 | 21 | 25 | 25.32 | 2.69 |
| | avg. | 4.4 | 5 | 5.2 | 5.6 | 4.8 | 5.2 | 5.6 | 5.8 | 5.2 | 5.6 | 5.8 | 5.2 | 4.6 | 4 | 5.6 | 4.8 | 4.6 | 4.2 | 5 | 5.06 | 0.54 |
| SCALE 6 | 26 | 6 | 3 | 6 | 6 | 5 | 6 | 5 | 5 | 4 | 5 | 4 | 6 | 5 | 5 | 5 | 5 | 4 | 4 | 4 | 4.89 | 0.88 |
| Therapist's | 27 | 6 | 6 | 5 | 6 | 5 | 6 | 5 | 6 | 6 | 6 | 6 | 5 | 5 | 6 | 6 | 5 | 5 | 6 | 4 | 5.53 | 0.61 |
| Credentials | 28 | 6 | 6 | 6 | 6 | 6 | 1 | 6 | 4 | 6 | 6 | 6 | 4 | 4 | 6 | 6 | 5 | 5 | 6 | 6 | 5.32 | 1.29 |
| | 29 | 5 | 3 | 6 | 1 | 6 | 1 | 4 | 3 | 4 | 6 | 5 | 3 | 1 | 5 | 1 | 2 | 4 | 2 | 1 | 3.32 | 1.86 |
| | 30 | 6 | 3 | 5 | 6 | 6 | 6 | 4 | 5 | 1 | 6 | 6 | 3 | 4 | 5 | 5 | 5 | 5 | 1 | 6 | 4.63 | 1.61 |
| | SUM | 29 | 21 | 28 | 25 | 28 | 20 | 24 | 23 | 21 | 29 | 27 | 21 | 19 | 27 | 23 | 22 | 23 | 19 | 21 | 23.68 | 3.40 |
| | avg. | 5.8 | 4.2 | 5.6 | 5 | 5.6 | 4 | 4.8 | 4.6 | 4.2 | 5.8 | 5.4 | 4.2 | 3.8 | 5.4 | 4.6 | 4.4 | 4.6 | 3.8 | 4.2 | 4.74 | 0.68 |

# APPENDIX C

Instrument

# RESEARCH QUESTIONNAIRE

## DEVELOPING A SCHOOL BASED REFERRAL SYSTEM: COMPARISON OF FACTORS CITED BY SCHOOL COUNSELORS (CRT) AND THERAPISTS

**School Counselors**
**(In-school Counselors)**

**Therapists**
**(Outside the School System)**

**RESEARCH QUESTION: Is there a difference between School Counselors and Therapists in the factors cited for making referrals to specific therapy providers?**

| QUESTIONNAIRE: School Based Referral Systems | 1= Unimportant<br>2= Moderately Unimportant<br>3= Somewhat Unimportant<br>4= Somewhat Important<br>5= Moderately Important<br>6= Important |
|---|---|
| 1. Therapist's office is located within 25 minutes driving distance from the school and/or clients home. | 1 2 3 4 5 6 |
| 2. The therapist calls the school for specific information about the case. | 1 2 3 4 5 6 |
| 3. The therapist works with the family to help solve school related problems. | 1 2 3 4 5 6 |
| 4. When giving a referral to an organization, giving the name of a specific therapist is..... | 1 2 3 4 5 6 |
| 5. The therapist is friendly. | 1 2 3 4 5 6 |
| 6. The therapist has hours that will fit the work schedule of the client's parents. | 1 2 3 4 5 6 |
| 7. The therapist provides feedback to the CRT on a regular or as needed basis. | 1 2 3 4 5 6 |
| 8. The therapist has a short-term problem solving approach to resolve behavior type problems. | 1 2 3 4 5 6 |
| 9. The therapist specializes in children's behavior problems | 1 2 3 4 5 6 |
| 10. The client's personality will mesh with the personality style of the therapist | 1 2 3 4 5 6 |
| 11. Clients can get an appointment without waiting more than two weeks. | 1 2 3 4 5 6 |
| 12. The therapist will attend school meetings concerning the treatment and progress of the client. | 1 2 3 4 5 6 |
| 13. The therapist sees school problems as symptomatic of a larger systems problem involving the family and the social setting of the client. | 1 2 3 4 5 6 |

| QUESTIONNAIRE: School Based Referral Systems | 1= Unimportant<br>2= Moderately Unimportant<br>3= Somewhat Unimportant<br>4= Somewhat Important<br>5= Moderately Important<br>6= Important |
|---|---|
| 14. The CRT has personal experience with the therapist in solving school related problems. | 1 2 3 4 5 6 |
| 15. The therapist shows respect for the CRTs training and experience in conversations about the client. | 1 2 3 4 5 6 |
| 16. The therapist has a sliding scale fee that reduces the cost of therapy for lower income families. | 1 2 3 4 5 6 |
| 17. The therapist provides information about treatment methods so CRTs understand the therapy process. | 1 2 3 4 5 6 |
| 18. The therapist respects the family structure and value system and does not try to impose the therapist's values on the clients. | 1 2 3 4 5 6 |
| 19. The therapist is recommended by other CRTs and school counseling personnel. | 1 2 3 4 5 6 |
| 20. The therapist expresses concern and empathy for school personnel affected by the client's problem. | 1 2 3 4 5 6 |
| 21. The therapist will provide information for the client's insurance company. | 1 2 3 4 5 6 |
| 22. The therapist provides brochures and other written information about their qualifications and availability. | 1 2 3 4 5 6 |
| 23. The therapist is flexible and shifts their approach when one approach is not working. | 1 2 3 4 5 6 |
| 24. The therapist is listed in the Fairfax County Community Services Guide with a description of services provided. | 1 2 3 4 5 6 |
| 25. The therapist provides hope for the clients and school personnel. | 1 2 3 4 5 6 |

| QUESTIONNAIRE: School Based Referral Systems | 1= Unimportant<br>2= Moderately Unimportant<br>3= Somewhat Unimportant<br>4= Somewhat Important<br>5= Moderately Important<br>6= Important |
|---|---|
| **26. What therapist education level is needed to work with Billy's situation?**<br>_____<br>_____ | 1 2 3 4 5 6 |
| **27. What field or speciality area should the therapist have experience in?**<br>_____<br>_____ | 1 2 3 4 5 6 |
| **28. Do you think therapists should be licensed in Virginia? If yes, what license?**<br>_____<br>_____ | 1 2 3 4 5 6 |
| **29. Should the therapist be a clinical member of a recognized organization? If so, what ones?**<br>_____<br>_____ | 1 2 3 4 5 6 |
| **30. How many years experience in the therapy field are required to work with Billy. What factors influence this number?**<br>_____<br>_____ | 1 2 3 4 5 6 |

# DEMOGRAPHICS of the Research Study—-
## School Counselors

1. Name: Home phone:
2. School: School phone:
3. Education:
4. Number of Years as a CRT:
5. Prior Work Experience:
6. Professional Affiliations:
7. Number of School-Related Therapy Referrals Given per Year:
8. For the " Case Example of Billy"
   A. What is your preferred therapy orientation?
   B. How many sessions would you expect?
9. For your average case load, what percentage do you see of:
   A. Solveable in the school setting with the child alone
   B. Solveable in the school setting with the parents & child
   C. Referred out for individual therapy
   D. Referred out for family therapy

# DEMOGRAPHICS of the Research Study– Therapists

1. Name: Home phone:

2. Organization: Work phone:

3. Education:

4. Number of Years as aTherapist:

5. Prior Work Experience:

6. Professional Affiliations:

7. Number of School-Related Therapy Referrals Received per Month:

8. For the " Case Example of Billy"

   A. What is your preferred therapy orientation?

   B. How many sessions would you expect?

9. For your average case load, what percentage do you see of:

   A. Adults

   B. Children

   C. Families

   D. School problems (include those not school referred)

10. Do you prefer to work with

   A. Adults

   B. Children

   c. Families

REFERENCES

Aponte, H. (1979). The family-school interview: An eco-structural approach. Family Process, 15, 303-312.

Amateau, E. S. & Fabrick, F. (1984). Moving a family into therapy: Critical referral issues for the school counselor. The School Counselor, 15 (3), 285-294.

Amateau, E. S. & Fabrick, F. (1981). Family systems counseling: A positive alternative to traditional counseling. Elementary School Guidance and Counseling, 29 (3), 223-236.

Bergan, J. & Tombari, M. (1976). Consultant skill and efficiency and the implementation and outcomes of consultation. Journal of School Psychology, 14, 3-14.

Berkman, I. P. & Rosenblum, L. (1982). Serving high school students in need: A look at restrengthening the linkage between the school and community referral sources. Adolescence, 16 (66), 465-470.

Bowman, R. P. & Myrick, R. D. (1987). Effects of an elementary school peer facilitator program on children with problem behaviors. The School Counselor, 34 (5), 369-378.

Bossard, M. D. & Gutkin, T. B. (1983). The relationship of consultant skill and school organizational characteristics with teacher use of school based consultation services. School Psychology Review, 12, (1), 50-56.

Brown, B. (1980). A study of the school needs of children of one-parent families. Phi Delta Kappan, 61, 537-540.

Carter, E. A. & McGoldrick, M. (1980). Special issues in families and in family therapy, In E. A. Carter & M. McGoldrick (Eds.), The Family Life Cycle: A Framework for Family Therapy (pp 221-340). New York: Gardner Press.

Clopton, J. R. & Haydel, J. (1982). Psychotherapy referral patterns as influenced by sex of the referring therapist and sex and age of the client. Journal of Counsulting and Clinical psychology, 50 (1), 156-157.

Cole, C. (1986). Obstacles to excellence in counseling. The School Counselor, 34, (2) 85-86.

Cole, C. (1987). From the editors desk. The School Counselor, 34 (4), 244.

Conti, A. (1971). A follow-up study of families referred to outside agencies. Psychology in the Schools, 8, 338-340.

Crosby, J. E. (1976). Illusions and Disillusion: The self in Love and Marriage. Belmont: Wadsworth.

DiMattia, P. (1984). Teachers and classrooms. In N. R. Bernstein & J. N. J. Sussex (Eds.) Handbook of Psychiatric Consultation with Children and Youth, 169-183. New York: Spectrum Publications.

Dustin, D. & Ehly, S. (1984). Skills for effective consultation. The School Counselor, 32 (1), 23-29.

Epperson, D. L. & Pecnik, J. A. (1985). Counselor rating form - short version: Further validation and comparison to the long form. Journal of Counseling Psychology, 32, 143-146.

Epstein, N. B., Baldwin, L. M. & Bishop, D. S. (1983). The McMaster family assessment divice. Journal of Marital and Family Therapy, 9, 171-182.

Fairchild, T. N. (1985). Obtaining consumer feedback as a means of evaluating school psychology intern performance. Psychology in the Schools, 22, 419-428.

Fine, M. J. (1982). Issues in adolescent counseling. School Psychology Review, 11, (4), 391-398.

Fisher, B. L., Giblin, P. R. & Hoopes, M. H. (1982). Healthy family functioning: What therapists say and what families want. Journal of Marital and Family Therapy, 8, 273-284.

Fisher, B. L. & Sprenkle, D. H. (1978). Therapists' perception of healthy family functioning. International Journal of Family Counseling, 6, 9-17.

Goldenberg, I. & Goldenberg, H. (1981). Overview: Family systems and the school counselor. The School Counselor, 28, (3), 165-177.

Green, R. G. & Kolevzon, M. S. (1984). Characteristics of healthy families. Elementary School Guidance & Counseling, 19, 9-18.

Heatherington, L. & Allen, G. J. (1984). Sex and relational communication patterns in counseling. Journal of Counseling Psychology, 31, (31), 287-294.

Heesacker, M. & Heppner, P.P. (1983). Using real-client perceptions to examine psychometric properties of the counselor rating form. Journal of Counseling Psychology, 30, 180-187.

Heppner, P. P. & Heesacker, M. (1982). Interpersonal influence process in real-life counseling: Investigating client perceptions, counselor experience level, and counselor power over time. Journal of Counseling Psychology, 29 (3), 215-223.

Herr, E. L. (1986). The relevant counselor. The School Counselor, 34 (1), 7-13.

Hoge, R. D. & McKay, V. (1986). Criterion-related validity data for the behavior checklist-teacher's report form. Journal of School Psychology, 24, 387-393.

Hutton, J. B. (1985). What reason are give by teachers who refer problem behavior students? Psychology in the Schools, 22, 79-82.

Kaul, T. J. & Schmidt, L. D. (1971). Dimensions of interviewer trustworthiness. Journal of Counseling Psychology, 18, 542-548.

Kramer, J. (1977). Family counseling as a key to successful alternative school programs for alienated youth. The School Counselor, 24 (3), 194-196.

LaCrosse, M. B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the counselor rating form. Journal of Counseling Psychology, 27, 320-327.

Lewis, M. D. & Lewis, J. A. (1977). The counselors impact on community environments. Personnel and Guidance Journal, 55, 356-358.

Little, L. F. & Thompson, R. (1983). Truancy: How parents and teachers contribute. The School Counselor, 30 (4), 285-291.

Little, L. F. (1980). The impact of Gestalt group therapy on parents' perceptions of children identified as problematic. (Doctoral Dissertation, University of Kentucky. Dissertation Abstracts International, DEN81-16912, 42/02A, p616.

Mathews, R. M. & Fawcett, S. B. (1979). Community Information Systems: Analysis of an agency referral program. Journal of Community Psychology, 7 (4), 281-289.

McCubbin, H. I. & Patterson, J. M. (1983). Introduction In H. I. McCubbin & J. M. Patterson (Ed.), Stress and the Family Volume 1: Coping with Normative Transitions (pp xxi-xxxi). New York: Brunner/Mazel.

McDaniel, S. (1981). Treating school problems in family therapy. Elementary School Guidance and Counseling, 15, 214-222.

Meile, R. L. (1974). Referral Network: Brokers and Providers. American Journal of Mental Deficiency, 78 (4), 404-408.

Millard, T. A. (1981). The counselor as referral agent: Matching client problems with community agency resources. Journal of the International Association of Pupil Personnal Workers, 25 (1), 32-39.

Nicoll, W. G. (1984). School counselors as family counselors: A rationale and training model. The School Counselor, 31 (3), 279-284.

Olson, D. H., & Portner, J. (1983). Family Adaptability and Cohesion Evaluation Scales. In E. E. Filsinger (Ed.), Marriage &; Family Assessment: A Sourcebook for Family Therapy (pp 299-315). Beverly Hills: Sage.

Olson, D. H., Sprenkle, D., & Russell, C. (1979). Circumplex model of marital & family systems l. Family Process, 18, 3-28.

Palmo, A. J., Lowry, L. A., Weldon, D. P., Scioscia, T. M., (1984). Schools and Family: Future perspectivess for school counselors. The School Counselor, 31 (3), 272-278.

Perlman, H. H. (1979). Relationship: The Heart of Helping People. Chicago: The University of Chicago Press.

Scheid, A. B. (1976). Client's perception of the counselor: The influence of counselor introduction and behavior. Journal of Counseling Psychology, 23 (6), 503-508.

Tinsley, H. E., Workman, K. R. & Kass, R. A, (1980). Factor analysis of the domain of client expectancies about counseling. Journal of Counseling Psychology, 27 (6), 561-570.

Weinrach, S. G. (1984). Toward improved referral making: Mutuality between the counselor and the psychologist. The School Counselor, 32 (2), 89-96.

Worden, M. (1981). Classroom behavior as a function of the family system. The School Counselor, 28 (3), 178-188.

Young, N. (1979). Secondary school counselors and family systems. The School Counselor, 26 (3), 247-253.

The three page vita has been removed from the scanned document. Page 1 of 3

The three page vita has been removed from the scanned document. Page 2 of 3

The three page vita has been removed from the scanned document. Page 3 of 3