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Expanding Our Reach: Marriage and Family Therapists in the Public School System

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Abstract

As states change their legislation to include Marriage and Family Therapists (MFTs) as approved mental health providers in schools, it is important to understand the experiences of MFTs in this context to improve training and increase our effectiveness. MFTs with experience working in public schools (N = 21) discuss the advantages and rewards of working in schools, challenges they have experienced, how they have dealt with those challenges, and training they recommend for MFTs seeking to work in schools. Qualitative results have implications for practitioners, training, and supervision. The possibility of a specialization in School-Based Family Therapy is discussed.

Keywords: School-Based Family Therapy, public schools, training

Marriage and Family Therapists in the Public School System

In recent years, dialogues have increased between divisions of the American Association for Marriage and Family Therapy and state governments around the topic of altering legislation to allow for the formal hiring of MFTs by United States public school systems (AAMFT, 2003; AAMFT, 2007). According to the *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (1999), the untreated mental health needs of children and their families have become a national health crisis. Schools, more and more, are being seen as a natural entry point for addressing the mental health needs of children and adolescents (Foster, Rollfeson, Doksum, Noonan, & Robinson, 2005). Despite mental health services existing in most U.S. schools, the demand for services outweighs the available resources (Foster et al., 2005). As systemically trained mental health professionals, MFTs seem ideal collaborators in advancing the effort. Unfortunately, the Elementary and Secondary Education Act (ESEA) does not list MFTs as qualified school mental health professionals, thus MFTs are not able to be employed as qualified mental health service providers in most states (AAMFT, 2003). Although MFTs cannot be employed as qualified providers, the needs of schools are great and MFTs are being hired through specially created positions and under non-MFT titles (Mary Hale-Haniff, personal communication, September, 15, 2008).

The purpose of this study was to explore the experiences of MFTs working with or within public school systems in order to further our ability to provide effective services in schools as states change their legislation to include MFTs as approved public school mental health providers. Implications for a specialization in School-Based Family Therapy are discussed.

The Need for Mental Health Services in Schools

The problem of untreated child mental health has become a U.S. legislative priority within the past decade. Kataoka, Zhang, and Wells (2002) found that an estimated 7.5 million youngsters with serious emotional disturbances are not receiving the help they need – especially those without insurance. Schools are in a unique position to offer screening and mental health services to families and children who would otherwise not have access (Foster et al., 2005). Untreated mental health disorders in children and adolescents can lead to school failure, unemployment, drug abuse, and suicide (Kataoka, Zhang, & Wells, 2002). Further, students who drop out of school are more likely to have poorer physical health and to suffer from depression throughout their life (Belfield & Levin, 2007; Liem, Dillon, & Gore, 2001).

In a review of research on school interventions targeting mental health and academic outcomes, Hoagwood, Olin, Kerker, Kratochwill, Crowe, and Saka (2007) found support for the efficacy of treating child and adolescent mental health and academic issues through school-based mental health programs. Unfortunately, Foster et al. (2005), in a study of 1,595 U.S. school districts drawn from the U.S. Department of Education's public school data file, found that despite some form of mental health services existing in most schools, student need for mental health services is outpacing available resources, with financial constraints of families and inadequate school mental health resources the most frequent barriers to service. Although several districts in this study tried to supplement their on-site mental health staff with community referrals to meet the growing need, one-third of districts reported that the availability of outside providers to deliver services had decreased in recent years (Foster et al., 2005).

The Need for Family Therapy in Schools

With financial and staff resources being outpaced, allocating resources to the most pressing needs would provide the most efficient use of funds. The report by Foster et al. (2005)

found that the most commonly cited mental health issues for both male and female students across elementary, middle, and high school levels were social, interpersonal, and family issues, yet only 58% of schools reported providing “Family Support Services,” which may or may not include family therapy.

The importance of involving families in interventions to reduce problematic behaviors in children and adolescents has been well documented in the literature. For example, in a review of the literature on family treatments for childhood behavioral and emotional disorders, Northey, Wells, Silverman, and Bailey (2003) found that family-based interventions were superior to individual interventions for the treatments of youth with externalizing disorders when parents are also experiencing emotional problems. Hogue and Dauber (2006) also found that greater use of family-focused therapy predicted reductions in children’s internalizing and externalizing symptoms and family conflict. Studies have also established the importance of family involvement for children’s academic success. The Southwest Educational Development Laboratory, in its annual synthesis, reviewed findings that students with involved parents, regardless of income or background, were more likely to earn higher grades and test scores, pass their classes, attend school regularly, have better social skills, improved behavior, graduate, and go on to postsecondary education (Henderson & Mapp, 2002). More recently, Englund, Egeland, and Collins (2008) found that parenting behavior distinguished between children who maintained a positive academic trajectory and those who were likely to dropout. Specifically, both parental involvement in children’s academics during middle school and the quality of the parent-child relationship during adolescence predicted drop-out for children who had otherwise been doing well behaviorally and academically (Englund et al., 2008).

The Involvement of MFTs in U.S. Schools

According to the American Association of Marriage and Family Therapy (AAMFT, 2008), MFTs are the only mental health professionals who are required to receive training in diagnosing and treating mental health disorders within a family systems context. Although MFTs are one of the five core mental health disciplines recognized by the Health Resources and Services Administration (Public Health Code, 2012), MFTs are not among the list of professionals identified in the Elementary and Secondary Education Act of 1965 as approved mental health providers in U.S. schools (AAMFT, 2008).

Although MFTs could not be directly employed by schools in the U.S. prior to 2008, family therapists have been working in schools by obtaining dual licensure in marriage and family therapy and school counseling, psychology, or social work; establishing working relationships with local schools as outside contractors; or being placed in a school during a masters internship. Several of these MFTs with dual expertise have applied marriage and family therapy models to school environments. For example, Metcalf (2008) and Kim Berg (2004), among others, have applied solution-focused principles to the framework in which school personnel view and interact with students, and Winslade and Monk (2007) have used Narrative concepts to create techniques for school counselors helping students explore who they are and who they want to be. In several parts of the country, MFTs have formed strong relationships with local schools. Sherman, Shumsky, and Rountree (1994) described effective programs based out of Queens College in New York where a marriage and family therapy program partnered with multiple schools as a resource for referrals and therapy. Laundy and associates worked with local schools in Connecticut to include MFTs in multidisciplinary teams (Laundy, Ciak, & Wawrzyniak, 2008), and Rambo and Boyd (2009) have joined with schools in southern Florida to implement bullying prevention programs using marriage and family therapy masters interns.

Although little research has been done on the impact of MFTs in school settings, preliminary data is encouraging. Rambo and Boyd (2009) found that, on average, 85% of students seen by MFTs in southern Florida public schools improved academically, 91% improved their attendance, and 92% completed class and homework more regularly. Additionally, a clinical intervention by MFTs targeting dropout prevention with female adolescents through an afterschool program resulted in positive academic and therapeutic change (Blumer & Werner-Wilson, 2010). Further, Laundy, Nelson, and Abucewitz (2011) found that the vast majority of school staff in the Connecticut schools in which MFTs were present believed that MFTs provided a unique service to their school systems and that the work MFTs do with families will improve school outcomes.

In recognition of the need for family involvement and the mental health needs of students, states are changing their legislation to allow MFTs to be hired into school mental health programs (AAMFT, 2003). For example, Connecticut, the first state to certify MFTs to work in schools in 2008, requires coursework in child development, learning theories, school-based systems theory, federal and state law pertinent to education, strategies for communicating and collaborating with families, the rights of families and students, the responsibilities of teachers, policies and procedures in schools, and health factors impacting student outcomes (State of Connecticut Regulation of State Board of Education, 2010). The Connecticut certification also requires a 300 hour practicum in a school setting (State of Connecticut Regulation of State Board of Education, 2010). Texas (An act relating to the public health, 2011), Maine (An act to allow marriage and family therapists, 2011), and New Mexico (Amendment to the New Mexico register, 2010) have recently passed legislation that includes MFTs in the list of mental health

personnel for primary and secondary education. No additional training is needed for MFTs to work in schools in these states.

As states change their legislation to include MFTs as approved mental health providers in schools, it is important to understand the experiences of MFTs in this context to improve training and increase our effectiveness. Through thematic analysis, we sought to explore the experiences MFTs working with or within public school systems, specifically examining: what roles MFTs fill in public schools as well as the advantages they perceive, the challenges they have faced; and what training, knowledge, and skills they believe are important for MFTs preparing for positions within U.S. public schools.

Method

Participants

Because of the challenges in finding MFTs with experience in schools, a snowball sampling method was used. Marriage and family therapy masters programs known to place interns in schools were asked to forward an email explaining the study and asking for participation to current and past students, and state marriage and family therapy organizations were asked to post in their e-newsletters the primary investigator's contact information with a description of the study. MFTs interested in participating contacted the primary investigator and were sent an email link to the anonymous online survey and asked to further the recruitment email to other MFTs they knew working with or in public schools.

Participants were 21 MFTs (18 female and 3 male) who had experience working in schools throughout the United States. Fourteen of the participants were Caucasian, one was mixed ethnicity, and six did not indicate their ethnicity. Nine participants had spent about one year in schools (the majority during a masters internship), seven participants had between one

and five years of experience, two participants had between five and 10 years of experience, and three participants had over 10 years of experience working in schools (two of them also had additional experience supervising masters marriage and family therapy interns in school settings). Although all of our participants considered themselves MFTs (either through attending a marriage and family therapy graduate program, and/or being licensed in marriage and family therapy), some of our participants held degrees and/or licenses in additional mental health fields: social work, school counseling, mental health counseling, art therapy, and clinical psychology.

Participants reported providing therapy in school districts in 10 states throughout the United States (several participants had provided services in multiple districts and some in multiple states): Texas (*n* = 6), Florida (*n* = 4), Illinois (*n* = 3), Oregon (*n* = 3), Connecticut (*n* = 2), California (*n* = 1), Colorado (*n* = 1), Massachusetts (*n* = 1), North Carolina (*n* = 1), and Pennsylvania (*n* = 1). They worked in urban, rural, wealthy, poor, and racially diverse school districts in these states. Seven participants had experience in school districts with 10,000 students or less, 11 participants provided services in districts with 10,000-50,000 students, and seven participants provided services to school districts with over 50,000 students. The percentage of students who received free or reduced lunch ranged from less than 20% (in 10 districts), to over 50% of students (in five districts), and in 43% of these school districts, less that 50% of students were White.

Participants reported working with families with children in a wide range of grades (see Figure 1) and providing a variety of services. All of the MFTs in our study reported providing individual therapy to students, 86% of participants provided family therapy, 76% consulted with teachers and administrators, 72% participated in family consultations (attending meetings with school personnel on behalf of the family), 72% conducted therapy with the parents of students,

and 72% ran student therapy groups. To a lesser extent, participants also conducted classroom observations (48% of participants), specialized therapy with special needs students (43%), classroom interventions (38%), couples therapy (33%), sibling group therapy (33%), school guidance counseling (24%), and other services (14%).

[Figure 1 about here]

Instrumentation

Data were collected through the use of an online survey. Participants were asked open ended questions for demographic information including sex, age, ethnicity, training/licenses obtained, length of time in the field of marriage and family therapy, and length of time working in or with the public school system. Participants were also asked to indicate the grades they worked with, the positions they held in schools, and the services they provided (participants were asked to indicate all that applied from a list of possible activities). Participants were then asked to respond in an open-ended format to several questions regarding their experiences as an MFT within a school system. The questions used for this study, specifically, regarded what participants perceived as the therapeutic advantages to working in a school system, what they found rewarding about the experience, the general challenges they experienced working in a public school setting, common ethical challenges they experienced, how they had navigated these multiple challenges, and what guidance or suggestions for additional training they had for MFTs looking to work in schools.

Data Analysis

Participants' answers to the open-ended questions were analyzed using thematic analysis (see Braun & Clarke, 2006). Qualitative analysis is particularly suited to work seeking to capture the "essence" of an experience through the voices of the participants (Creswell, 1998). We used

the literature, our experiences, and conversations with MFTs who had experiences in schools to create our research questions and guide our initial coding. The first author is a Caucasian female who is a licensed MFT (LMFT) and has conducted therapy in an urban school district and supervised MFT students in a rural school setting. The second author is a Caucasian male who is a licensed Social Worker (LMSW) with experience working as a volunteer in an urban school district.

We used a thematic analysis methodology to interpret the qualitative description of the experience of MFTs in schools (Braun & Clarke, 2006). Similar to the analysis methods of grounded-theory (Strauss & Corbin, 1998) our thematic analysis involved open, axial, and selective coding (Braun & Clarke, 2006). During open coding, the first phase of analysis, the authors read the transcripts line by line, and concepts were created. Because our goal was to understand the experiences of our participants, we used meaning units as the unit of analysis. Graneheim and Lundman (2006) define meaning units as "words, sentences, or paragraphs containing aspects related to each other through their content and context" (p. 106). Qualitative analysis accommodates both inductive and deductive reasoning, and using concepts from previous studies or experience can be particularly useful at the inception of data analysis (Berg, 2001). During axial coding, the concepts generated in open coding were related to each other and revised through a constant comparative method (Strauss & Corbin, 1998). The researchers sorted, compared, and contrasted the codes into categories until the analysis generated no new categories and did not further elaborate on existing categories (Strauss & Corbin, 1998). We then moved into selective coding involving a careful examination of the open and axial coding. Throughout this process, we had open conversations about how our biases may be impacting our interpretations. Once the final coding scheme was developed (see Table 1), we coded cases

independently then met to compare codes and discuss discrepancies and come to consensus. This continued until all cases were coded.

Results

In reviewing therapists' descriptions of their experiences in schools, the authors discerned three main classes in the responses: benefits of working in schools, challenges of working in schools, and strategies and training for overcoming challenges. Each of these classes had multiple themes and coding categories within it (see Table 1 for an overview).

[Table 1 about here]

When all or nearly all responses within a theme mentioned a coding category, we refer to that code as the primary issue within the theme. If nine or more responses mentioned a coding category, we refer to that code as a main issue, and if fewer than nine participants mention a code, we do not address the magnitude of the response.

Benefits

The first class addressed was that of benefits, which is defined as aspects of working in schools that participants found positive for either clients or for the participants themselves. The analysis identified two themes within this class: therapeutic advantages and rewarding experiences.

Therapeutic advantages. Participants were asked to describe the advantages of working in or with school systems based on their experiences. Four coding categories emerged under the theme of therapeutic advantages: collaboration, accessibility, first-hand assessment and intervention, and consistency in care.

The ability to easily collaborate with other professionals committed to the success of the family and child was seen by therapists as the primary advantage to working in schools. One

therapist explained, “I find it an incredible advantage to have a relationship with and direct immediate access to the child’s teachers, administrators, school support personnel, classmates, up to date (to the minute!) school records and direct knowledge of the resources available within the school system and [how to] effectively access them….I can consult with all the teachers of a student to modify assignments based on therapeutic need…I can use my specific knowledge of a teacher’s personality to understand and direct the student to improved coping skills in a certain class…. [and] I can garner support and involvement from parents for their child’s education.”

Accessibility to populations who would not otherwise receive treatment was mentioned as another main advantage to working in public schools. For example, one therapist said, “The biggest advantage is that you can help children whose parents might never otherwise have obtained therapy for them. You are able to help those with low socio-economic [status].” Another therapist mentioned, “Children and families can access services confidentially and with fewer labels through the school system.”

Another advantage to being an MFT in the school system mentioned by participants is the ability to intervene “in the same environment in which the ‘problematic’ behavior occurs” thereby allowing for “useful skill learning” when issues are “fresh and immediate.” One therapist mentioned that “you get to observe [children] in their own environment instead of their or their family’s depiction of their life.”

Finally, greater consistency of care was mentioned as an advantage of working in the public schools due to “few no shows,” the therapist being “available regularly to the student,” and that the “therapeutic relationship can continue for a long-period of time and can be ‘passed off’ to the next therapist in that student’s life.”

Rewarding experiences. Therapists were also asked to discuss the most rewarding aspects of conducting therapy in the schools. Responses fell into three coding categories: therapeutically working with the students and families, being part of the school community, and again, collaboration.

Therapists found working therapeutically with the students and their families to be the primary rewarding experience. For example, one therapist said the most rewarding aspect was "being able to see the student grow in the school and also being able to see them grow and make changes at home." Another therapist said the most rewarding aspects were, "being able to support students and sometimes intervene and help change maladaptive coping/thinking patterns before they have a chance to continue to form more strongly, having a starting place in letting this generation know that counseling can help and hopefully they will be more open to it, [and] also the groups are a great way for students to not feel so isolated and get to have that 'me too' feeling, even if they are quite challenging to run at times!" Another therapist's most rewarding experiences included "empowering children and families to function more fully, remediating generations of poorly understood, but inherited, learning problems…"

Therapists also experienced being part of the school community as rewarding. One therapist said, "Being part of the school community is so much fun! I love going to assemblies during the day and visiting classrooms and becoming part of the fabric." Another therapist mentioned, "I love how dynamic the school is; the fast pace with which you meet with students."

The collaboration offered as being part of the school system could also be rewarding "when teachers get it-when they can change some of their approaches…and when they involve the parents at home in their world." Other therapists found it rewarding to get support from school personnel for the services they provide, working together to provide students with

services they would otherwise not receive, and "building multidisciplinary teams in one setting; the synergy of a well-integrated school multidisciplinary team is powerful, cheaper in the long run, and more effective for children and families."

Challenges

The next class we address is that of challenges experienced by the participants, defined as any aspects of participants' experience as an MFT practicing in a school setting that participants found as obstacles to effectiveness. The analysis identified four themes within this class: the structure of the school system, collaboration, therapy with children and families, and professional ethics.

Structure of the school system. One challenge that participants identified was the structure of the school system. Four codes emerged under this category: wanting to provide more help than was possible to provide, being an outsider, differing priorities and focus, and working within the system.

Participants found it challenging to not always be able to provide as much help as they wanted. One therapist commented that "there are time restraints, often limiting the therapy time to 15 or 30 minute increments, sometimes less." Another MFT said, "The biggest problem is the prohibition on diagnosing and in referring students to community resources."

Another challenge experienced by participants was being viewed as an outsider by school personnel. One therapist mentioned, "Schools are very political…some schools are not responsive to outside support and they are very unwilling to bring in people... Other schools are willing and want additional supports."

Therapists also found that their therapeutic priorities sometimes did not align with those of the school they were in. For example, one therapist explained, "I had to work around school

activities, so even if we had a set weekly time, there were often school sanctioned events that were occurring simultaneously and these took precedence over group therapy." Another therapist said that schools are "individually focused" rather than sharing the systemic viewpoint of MFTs. Additionally, sometimes just working within the system itself provided obstacles, such as it "takes much longer to accomplish a simple clerical issue such as repairing a computer or photocopying a document."

Collaboration. MFTs reported a range of collaborative experiences with school staff, administrators, and teachers. Although many positive experiences were had with school staff, administrators, and teachers, challenges included gaining trust and buy-in, having differing views of the problem and solution, handling teachers' personal issues, and balancing the competing needs of students for therapy and academic instruction.

Gaining trust and buy-in for the effectiveness of therapy was reported to be a main issue in collaboration. Some school personnel had skeptical views of the effectiveness of therapy. For example, one therapist said, "…I have seen instances where administrators did not believe in the positive effects of counseling and these administrators would put roadblocks in the way. Some administrators come from the school of 'just pull yourself up by your bootstraps and get over it'." Another mentioned that a teacher's view of therapy "could affect how therapy was talked about in the classroom and therefore influence students either negatively or positively."

Additionally, therapists found it challenging to change teachers' or administrators' views of the students. One therapist explained that "it was hard at times to let upper administration know that there were some students that I thought were getting tagged as a 'bad' kid because of their history and getting them to let go of their biased opinion." Another therapist added, "Most teachers were okay to collaborate with but a lot of them did not understand where

the teenager was coming from and wrote them off as a bad kid going nowhere." Another therapist said, "The largest challenge is when teachers have difficulty seeing the whole picture of a child and family's functioning, and prefer to think only in linear ways about the child's academic performance."

Therapists needed to attend to the issues of teachers as well. For example, one therapist explained, "Many teachers have their own issues with which they have never dealt and they bring those into the classroom. Since the hierarchy in a classroom is similar to a single-parent family, many family dynamics from the teachers' and students' family of origin get acted out in the classroom." Another therapist said, "In many instances, teacher and student had a negative relationship and my role felt similar to mediation." One therapist observed, "Many teachers find their profession frustrating and appreciate the opportunity to vent to a good listener. There are times when teachers fall into a win/lose situation or power struggle with a student."

Similarly, therapists reported that at times collaboration was challenging when students struggled with both mental health and academic issues. One participant commented, "It is challenging when therapy interferes with class time for a class they are struggling in." Sometimes the multiple needs of students resulted in teachers feeling too "overwhelmed" to collaborate or simply wanting a "quick fix."

Therapy with children and families. Although not without advantages, conducting therapy with children and families in a school context also has some unique challenges. Therapists' responses about these challenges fell into three coding categories: the logistics of doing therapy, engaging families, and keeping a systemic view in an individually-focused environment.

A main issue identified by participants in conducting therapy in a school setting was dealing with logistical challenges such as not having enough time per session or in a day to see everyone who wants to be seen; students being absent, suspended, or taking an exam during a scheduled appointment; finding private space; or feeling safe during home visits. For example, one therapist commented, “There appears to be a great need for family therapy, which is difficult to have take place, as the time slots are shorter...” Another therapist mentioned, “It became increasingly difficult to obtain a private room in which to meet, due to schools needing all the space they can get for classes…”

MFTs also reported challenges engaging families in therapy. For example, one therapist said, “I get frustrated because sometimes I cannot get the families to meet with me because they know I am meeting with their children regardless.” Another therapist pointed out that “some families had a negative personal experience in their own schooling- simply walking into a school building is intimidating for them.”

Therapists also found it challenging to have a systemic view in an individually-focused environment. For example, one therapist explained, “Therapy around school issues typically consisted of consultation and identification of strengths of the children. The school was not often interested in the well-being of the family… [and] many schools tended to call the therapy team before calling the families. This triangulation created a message passing dynamic that needed to be addressed.”

Professional ethics. Participants mentioned several ethical challenges that were particularly dominant in their experience of working therapeutically in a school. Three coding categories emerged: issues around confidentiality, boundaries, and school policies.

The primary ethical issue MFTs discussed was keeping confidentiality between students and with staff in this system. For example, one therapist said of ethical challenges, “Primarily confidentiality …there’s not much of it in the public schools. The teachers and administrators feel it is their right to know anything and everything that goes on in that group. Making the employees feel appreciated yet maintaining confidentiality is especially difficult.” Another therapist pointed out the importance of, “ensuring the client’s understanding and commitment to confidentiality in the groups, as they all have relationships with other peers outside the group. I have also had some office staff share info with others about the students that I was working with.”

MFTs also reported that boundaries can be challenging to manage in a school environment “when families of office staff want counseling…,” or when “students are in need of certain items [you could buy for them].” School policies were also reported as a source of ethical challenge, such as when there are “conflicts between our professional code of conduct, HIPPA, and school board policies and procedures,” or when “the school may have a special agenda to increase attendance as their primary goal. Sometimes this is not in the client’s best interest.”

Strategies and Training for Overcoming Challenges

The final class that emerged from the responses was strategies for overcoming challenges, and additional training that respondents suggested for future MFTs working in schools. The analysis identified three themes within this class: general survival guidelines, additional training, and specific advice on handling ethical challenges.

General survival guidelines. Therapists found several skills helpful when managing challenges related to the structure of the school system, collaborating with school personnel, and conducting therapy with children and families. Therapists’ recommendations for overcoming

these challenges fell into four coding categories: using engagement strategies, working to communicate effectively, developing professional skills, and having a mentor.

The main approach therapists employed to overcome challenges was to use a wide variety of engagement strategies with school personnel and families. Therapists mentioned several techniques for establishing positive relationships with school personnel such as spending "a lot of time working with the administrative staff, getting their buy-in," "taking a one-down position," and spending time in the classrooms. For example, one therapist said, "I establish strong rapport with office staff as soon as possible. I come prepared with identification, badges, and permission forms, [and] show up regularly for appointments so my face becomes familiar with staff." Therapists also discussed strategies for engaging students and families such as regularly checking in and connecting with parents and students. For example, a therapist said, "I think it's really important to get buy-in from students. Help them see your time as valuable to them and help create something that they will want to work hard for."

Communication was also seen as an important skill. For example, therapists found it important to establish "clear expectations of roles", "ask teachers for their help and input," and "communicate weekly with counselors." One therapist said, "Communication was the key. As long as there was open communication, it helped soften some of these difficulties."

Therapists named several professional skills that have helped them navigate challenges, such as maintaining a confidential therapeutic focus and professional image, creating a unique niche for themselves, applying therapeutic skills when working with "resistant teachers," and using "common sense, patience, persistence, dedication, sincerity, flexibility, and creativity." Having a mentor who knows the system was also mentioned to "help [you] navigate …and also stand up for you."

Additional training. Participants also provided suggestions for additional training for future MFTs in schools. Their recommendations fell into four coding categories: coursework, learning the school system, learning about issues facing the population, and learning about laws and ethics associated with working in schools.

A main suggestion therapists had for preparing to work in a school district was to take additional coursework in a variety of areas. Suggested topics included parent education, parent-child coordination, play therapy, drug counseling, childhood disorders, assessment with children, applying a systems perspective to systems other than the family, being effective in a school setting, special education policies/procedures and classifications, and evidence-based practice requirements in education.

Participants also recommended getting to know the school system that you will be working with. For example, therapists mentioned that it is important to find out "how to navigate through [the school system] and the loopholes…to benefit your students that you see," what institutional policies there are, "how far to push the envelope without getting yourself in trouble," and to discuss the "reality of turf wars and strategies to increase a strength-based perspective in collaboration with colleagues."

Participants also stressed the importance of knowing the population with which you are working. This can be accomplished through such things as "attending educational trainings with administrators and teachers…", "understanding the liability issues in education", and learning the "support systems available to clients."

Therapists also thought it was important to know the laws and ethics pertaining to mental health. For example, one therapist recommended, "know the ethics behind confidentiality and how much you can disclose to a teacher."

Handling ethical challenges. When asked how therapists managed the ethical challenges of working in a school district and what they would recommend, three coding categories emerged: protect client information, consult or get supervision, and clarify expectations regarding confidentiality and treatment.

The main strategies mentioned by participants in handling ethical challenges were those that protected confidentiality. These included being cautious or vague in what they shared, using release of information forms, keeping school meetings focused on school performance rather than family functioning, using a specific note taking format that protects confidentiality, or asking teachers or administrators what they would like to see rather than answering questions about what is happening in therapy.

Therapists also consulted a variety of sources, such as journal articles, peers, seniors in the field, their supervisor, or their mentor. For example, one therapist said, "get supervision to maintain a broader perspective of the system."

Clarifying expectations around confidentiality and treatment was also recommended. For example, one therapist suggested, "Before starting to work with someone, clarify your role and the limits to the information you will share. Have the school personnel, students, and parents be aware of these practices." Additionally, another therapist recommended "setting up expectations at the beginning of groups, and how to deal with confidentiality breaches."

Discussion

The idea that it would be beneficial for MFTs to apply our systemic training to the systems in which families interact and adapt our training to prepare MFTs for being effective in these larger systems is not new (e.g. Boyd-Franklin & Bry, 2000; Fox, Hodgson, & Lamson, 2012; Terry, 2002), but has still largely not been integrated into the majority of our masters

programs. The public school system presents an excellent opportunity to develop and implement such an effort. Over the next ten years, enrollment in public elementary and secondary schools is expected to increase to over 50 million students (National Center for Educational Statistics, 2012). Research findings emphasize the importance of family involvement for student mental health and school success, with relational and family issues being the most commonly reported mental health issues across grades levels (Foster et al., 2005). Despite mental health services existing in most U.S. schools, the demand for services outweighs the available resources (Foster et al., 2005).

When therapists are able to overcome the barriers and challenges to providing services to families in a school setting, working within school systems provides strong advantages: consistency in care, collaboration with school staff and other mental health professionals to increase positive outcomes, and the ability to assess and intervene in a larger system in which children and their families regularly interact. Given these important advantages it is not surprising that therapists who have worked in schools find this work rewarding on multiple levels and emphasize the importance of having MFTs in schools. Importantly, schools are in a unique position to offer screening and mental health services to families and children who would otherwise not have access (Foster et al., 2005). Our participants enthusiastically supported this sentiment. For example, one therapist said, “[The] public school system is the best way to reach out to families.” Another participant voiced, “We better integrate health care with education. Healthy children learn better, and receiving behavioral health services in schools prevents larger problems later; primary prevention at its best.”

As the Medical Family Therapy model evolved through the 1970’s and 1980’s to be officially defined in the 1990’s (Doherty, McDaniel, & Hepworth, 1994), so too has School-

Based Family Therapy been evolving over time. Over the years, MFTs have partnered with schools to improve child and family outcomes through multiple avenues (as contractors, dual-licensed school mental health employees, and interns). Simultaneously, the educational system has coming to recognize the importance of family functioning for school achievement and child development (e.g. Henderson & Mapp, 2002; Hogue & Dauber, 2006; Englund, Egeland,& Collins, 2008). With their systemic training, MFTs are uniquely suited to collaborate in the effort to increase student mental health and school success. As states amend legislation to include MFTs as approved mental health providers for schools, it will be necessary for MFTs to be prepared to work with families through a larger system as part of a multidisciplinary team. Although much of what is covered in a Commission on Accreditation for Marriage and Family Therapy Education accredited marriage and family therapy program is applicable to practice in a school setting, additional knowledge and training is necessary for us to be able to effectively speak the language of school-based mental health professionals and navigate school systems.

Many of the challenges faced by our participants related to differences between their systemic, therapeutic, and ethical values and those of the school systems in which they worked. In order to effectively communicate, they sought additional information on school structure and roles; took further coursework related to the populations and issues they were seeing; cultivated relationships with multiple levels of the school system; clarified their role as part of multidisciplinary school-based mental health team; became advocates for family therapy; adapted their view of when, where, and for how long therapy could occur; and set boundaries to protect against ethical pitfalls. These strategies demonstrate an effort by these individuals to integrate marriage and family therapy into the structure, policies, and culture of school systems

while maintaining ethical boundaries and maximum therapeutic effectiveness, and they provide an initial blueprint for training programs to consider.

As MFTs, we see individuals and families in the context of their social environment. The more we effectively collaborate with the community systems in which families are interacting, the more we are able to have larger-scale positive community impact (Doherty & Beaton, 2000). To this end, we propose that it would be beneficial for marriage and family therapy masters programs to include more education and skill development targeted at collaborating with community systems to bring about larger change (i.e. collaborating with the medical and school systems with which families are connected, as well as further levels of intervention [see Doherty & Beaton, 2000]). Just as we consider the many expressions of culture when working with our clients, it is likely that how we integrate ourselves into community systems and connect with families through these systems will vary based on the culture of those systems and the surrounding community. Further, we suggest increasing partnerships with local community systems to increase training opportunities for students, integrating a broader systems perspective into our degree programs, networking and collaborating with mental health professionals already embedded in larger community systems (e.g. social workers, school psychologists, school counselors), or advocating for policy change at the state level.

As states move to adopt legislation allowing MFTs to be hired into school-based mental health positions, our field will need to adapt in order to meet the needs of clinicians preparing to work in schools. Along these lines, we suggest the establishment of School-Based Family Therapy as a specialization similar to Medical Family Therapy. We expect the need for school-based family therapists to grow and therefore increase the need to integrate this knowledge into the foundational education of MFTs. Similar to the ideas put forth by Terry (2002), we see

coursework that brings together marriage and family therapy students with students from school-based mental health training programs as an important component to bridging the cultures between fields and fostering collaboration. Further, we find it essential to provide practicum opportunities for students in the schools. Since every school system has a different culture, we find it essential to talk to school administrators, teachers, and school mental health personnel to create a joint collaboration that meets the needs of all parties involved.

We additionally recognize the need for specialized training in navigating the general structure of school systems for MFTs. Specifically, our participants indicated several areas that they found to be particularly important for increasing MFT effectiveness in a school setting. MFTs with experience in schools pointed out the importance of knowing how to articulate what an MFT is, the services we can provide, and how we can contribute to multidisciplinary teams to maximize overlapping and unique expertise. Our participants also suggested learning strategies for gaining buy-in from school staff and students; understanding the role of key school personnel, key acronyms and terms, and state and federal laws that govern school structure and services; how to set up clear communication channels with school personnel and families; methods for adhering to ethical guidelines and therapeutic practices while respecting school culture, structure, and rules; learning how to bridge the gap between the frameworks of other mental health professionals and school staff and the systems perspective of marriage and family therapy; and engaging families to increase communication between schools and families. Participants further suggested that MFTs preparing to work in a school setting seek out further training or coursework in play therapy, drug counseling, parent education, childhood disorders and development, and assessment with children. This is not meant to be a comprehensive list of skills and knowledge nor a complete picture of the future of School-Based Family Therapy, but

rather seeds for furthering the discussion of important components of training MFTs for School-Based Family Therapy.

The need for systemically trained mental health providers in schools is great, and as states change legislation to support the hiring of MFTs in public schools, it is important to understand the experiences MFTs have had in this context to improve training and, thereby, the effectiveness of MFTs in this complex system. As voiced by our participants, the better our knowledge of school systems, our ability to collaboratively communicate our systemic views with school staff and mental health teams, and our capacity to work at multiple levels of the system, the better prepared we will be to enact change for the benefit of families and the larger systems in which they are embedded.

Limitations

This study had several limitations. First, since this population was not easily identifiable or accessible, an online snowball sampling method was used. The online format may not have garnered the same information as a face-to-face interview would have, and it is possible that those participants who chose to participate are therapists who feel particularly passionate about MFTs working in schools. Other therapists who chose not to participate may have had poor experiences or did not find the experience valuable. Additionally, most of the participants had experience working as staff in schools rather than as outside contractors, so challenges may be different working form this role. One participant indicated that some of the advantages, such as collaboration, were more challenging due to her intermittent presence.

Further Research

Hearing from MFTs about their experiences working in schools provides information on what training could better prepare them to work in schools and what issues may need to be

addressed in supervision. We feel that it is also important to understand the experiences of teachers, administrators, parents, and students of having MFTs in schools in order to gain an understanding of what is working and what is not from their perspectives. Importantly, we suggest that research is needed on the impact of MFTs in schools on not only mental health and family functioning outcomes, but school outcomes as well (e.g. attendance, test scores, grades, referrals). Providing evidence of the effectiveness of MFTs in schools is a step towards garnering support for the presence of MFTs in schools through changes in policy, as well as providing feedback for clinicians and supervisors on how to improve services for children, families, and the schools and communities they are a part of.

Conclusion

Given the importance of family functioning to student mental health and academic success, the accessibility of schools to most populations, and the great need for family mental health services in schools, it is important for MFTs to be prepared to work in this environment. This study was the first to examine the experiences of MFTs in public schools. Participants discussed both the unique challenges and great rewards they experienced while working in public schools across the country. As more states approve MFTs as school mental health providers, it is important we learn how to be as effective as possible within this larger system.

References

AAMFT. (2003). *Getting MFTs into the schools: The good, the bad, and the ugly.* Retrieved from http://www.aamft.org/members/advocacy/nclb%20fact%20sheet%208-08.pdf.

AAMFT. (2007). MFTs in the schools. *Family Therapy Magazine, 6,* 6.

AAMFT. (2008). *Family therapists in the schools.* Retrieved from http://www.aamft.org/members/advocacy/april%202001%20(esea).pdf.

An act relating to the public health threat presented by youth suicide and the qualification of certain persons serving as marriage and family therapists in school districts, Texas Ed. Code §21.003(b) (2011)

An act to allow marriage and family therapists to provide related services in public schools, M.R.S.A. §7007 (2011).

Amendment to The New Mexico Register, Volume XVIII, Number 20, 6.63.3, effective January 29, 2010. Retrieved from http://www.nmcpr.state.nm.us/nmregister/xxi/xxi02/6.63.3amend.pdf.

Belfield, C. R., & Levin, H. M. (2007). Policy brief 1: The economic losses from high school dropouts in California. UC Santa Barbara, Gevirtz Graduate School of Education, California Dropout Research Project.

Berg, B.L. (2001). *Qualitative Research Methods for the Social Sciences.* Boston: Allyn and Bacon.

Berg, I. K., & Shilts, L. (2004). *Classroom solutions: WOWW approach.* Milwaukee, WI: BFTC Press.

Blumer, M. L. C., & Werner-Wilson, R. J. (2010). Leaving no girl behind: Clinical intervention

effects on adolescent female academic “high-risk” behaviors. *Journal of Feminist Family Therapy, 22*, 22- 42. doi: 10.1080/08952830903453620

Boyd-Franklin, N., & Bry, B. H. (2000). *Reaching out in family therapy: Home-based, school, and community interventions*. New York, NY: The Guilford Press.

Braun, V. & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. doi: 10.1191/1478088706qp063oa

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage Publications.

Doherty, W. J., & Beaton, J. M. (2000). Family therapists, community, and civic renewal. *Family Process, 39*, 149-161. doi: 10.1111/j.1545-5300.2000.39201.x

Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *Journal of Family Therapy, 16*, 31-46.

Englund, M. M., Egeland, B., & Collins, A. (2008). Exceptions to high school dropout predictions in a low-income sample: Do adults make a difference? *Journal of Social Issues, 64*, 77-93. doi: 10.1111/j.1540-4560.2008.00549.x

Foster, S., Rollefson, M., Doksum, T., Noonan, D., & Robinson, G. (2005). *School mental health services in the United States, 2002-2003*. DHHS Pub. No. 9SMA0 05-4068. Rockville, MD: Center for Mental health Services, Substance Abuse and Mental Health Services Administration.

Fox, M. A., Hodgson, J. L., & Lamson, A. L. (2012). Integration: opportunities and challenges for family therapists in primary care. *Contemporary Family Therapy, 34*, 228-243.

Graneheim U.H., & Lundman B. (2004). Qualitative content analysis in nursing research concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*

24, 105–112. doi: 10.1016/j.nedt.2003.10.001

Henderson, A., & Mapp, K. L. (2002). *A new wave of evidence: The impact of school, family, and community connections on student achievement*. Austin, TX: Southwest Educational Development Laboratory.

Hoagwood, K. E., Olin, S. S., Kerker, B. D., Kratochwill, T. R., Crowe, M., & Saka, N. (2007). Empirically based school interventions targeted at academic and mental health functioning. *Journal of Emotional and Behavioral Disorders, 15*, 66-92. Retrieved from http://ebx.sagepub.com/content/by/year

Hogue, A., & Dauber, S. (2006). Treatment techniques and outcomes in multidimensional family therapy for adolescent behavior problems, *Journal of Family Psychology, 20*, 535-543. doi: 10.1037/0893-3200.20.4.535

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002, September). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548-1555. doi: 10.1176/appi.ajp.159.9.1548

Laundy, K. C., Clark, M. A., & Wawrzyniak, M. (2008, November). *Ethical and legal issues in team treatment of Asperger's syndrome.* Paper presented at the annual conference of the American Association of Marriage and Family Therapy, Memphis, TN.

Laundy, K. C., Nelson, W., & Abucewicz, D. (2011, August). Building collaborative mental health teams in schools through MFT school certification: Initial findings. *Contemporary Family Therapy*. Advance online publication. doi: 10.1007/s10591-011-9158-2

Liem, J. H., Dillon, C. O., & Gore, S. (2001). *Mental health consequences associated with dropping out of high school.* Paper presented at the 109th Annual Conference of the American Psychological Association, San Francisco, CA.

Metcalf, L. (2008). *Counseling toward solutions: A practical solution-focused program for working with students, teacher, and parents* (2nd ed.). San Francisco, CA: Jossey-Bass.

National Center for Educational Statistics, Institute of Education Sciences. (2012). *The condition of education.* Retrieved from http://nces.ed.gov/programs/coe/index.asp

Northey, W. F. Jr., Wells, K. C., Silverman, W. K., & Bailey, C. E. (2003) Childhood behavioral and emotional disorders. *Journal of Marital and Family Therapy, 29,* 523-545. doi: 10.1111/j.1752-0606.2003.tb01693.x

Public Health Code, 42 C.F.R. §5, Appendix C, Part I (2012 through October 12).

Rambo, A., & Boyd, B. (2009, October). *MFTs in school settings: Getting in and doing well.* Paper presented at the annual conference of the American Association of Marriage and Family Therapy, Sacramento, CA.

Sherman, R., Shumsky, A., & Rountree, Y. B. (1994). *Enlarging the therapeutic circle: The therapists' guide to collaborative therapy with families and schools.* New York: Brunner/Mazel Publishers.

State of Connecticut Regulation of State Board of Education. (2010). Regulations concerning state educator certificates, permits, and authorizations. Retrieved from http:// www.sde.ct.gov/ sde/lib/sde/pdf/cert/regulations/Regulations_Adopted_on_12-1-2010.pdf

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory* (2nd ed.). London: Sage Publications.

Terry, L. L. (2002). Family counseling in the schools: A graduate course. *The Family Journal, 10,* 419-428. doi: 10.1177/106648002236762.

U.S. Department of Health and Human Services. (1999). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services. Retrieved from http:// www.surgeongeneral. gov/ topics/cmh/childreport.html

Winslade, J. M., & Monk, G. D. (2007). *Narrative counseling in schools: Powerful and brief* (2nd ed.). Thousand Oaks, CA: Corwin Press.

Table 1.

Coding scheme for MFTs in Schools

Class: Benefits
- Theme: Therapeutic Advantages
  - Code: Accessibility
  - Code: Collaboration
  - Code: First-hand assessment and intervention
  - Code: Consistency in care
- Theme: Rewarding Experiences
  - Code: Therapeutically working with students & families
  - Code: Being part of the school community
  - Code: Collaborating

Class: Challenges
- Theme: Structure of the School System
  - Code: Wanting to provide more help
  - Code: Being an outsider
  - Code: Different priorities & focus
  - Code: Working within the system
- Theme: Collaboration
  - Code: Positive experiences
  - Code: Gaining trust & buy-in
  - Code: Changing views of probs. & kids
  - Code: Teacher personal issues
  - Code: Competing demands
- Theme: Therapy with Children & Families
  - Code: Logistics
  - Code: Engaging families
  - Code: A systemic view in an individually-focused environment
- Theme: Professional Ethics
  - Code: Confidentiality
  - Code: Boundaries
  - Code: School policies

Class: Strategies and Training for Overcoming Challenges
- Theme: General Survival Guidelines
  - Code: Engagement strategies
  - Code: Effectively communicate
  - Code: Professional skills
  - Code: Have a mentor
- Theme: Additional Training
  - Code: Coursework
  - Code: Learn the school system
  - Code: Learn about issues facing the population
  - Code: Know laws, ethics, etc.
- Theme: Handling Ethical Challenges

Code: Consultation/supervision
Code: Clarify expectations of confidentiality & treatment
Code: Protect client information

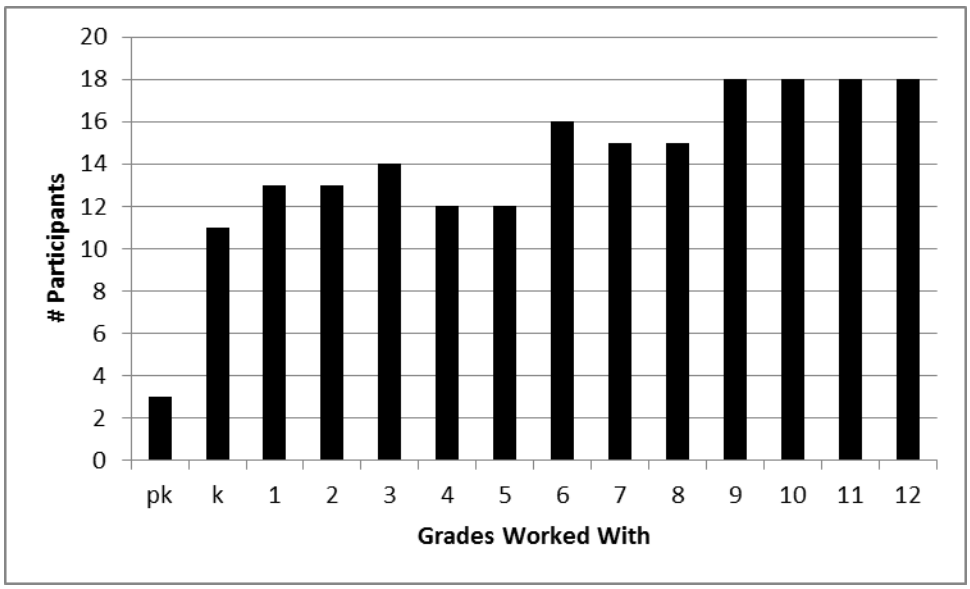

Figure 1. Number of particpants with experience working with students and their families at each grade level preschool through twelfth grade.