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THE USE OF FAMILY THERAPY WITH SPECIAL NEEDS CHILDREN AND THEIR FAMILIES

A Dissertation Presented

By

JOSEPH P. COSTANZO

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1983

School of Education

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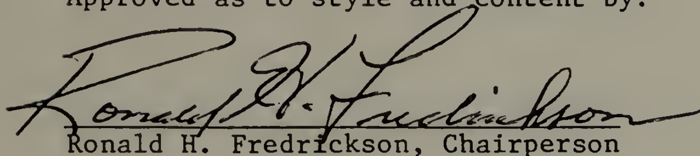

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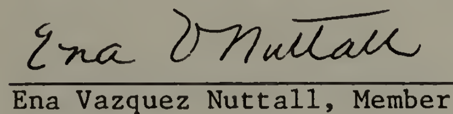

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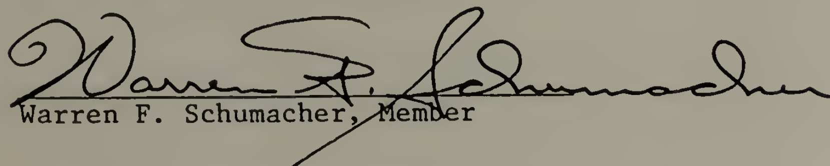

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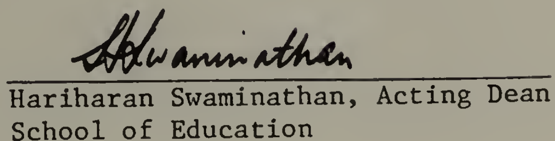

Hariharan Swaminathan, Acting Dean
School of Education

To my wife Nancy

ACKNOWLEDGEMENTS

The writing of this dissertation has consumed an enormous amount of time and energy. The process itself has been educational in many unexpected ways. Quite simply, I have learned a great deal about myself.

I want to express special thanks to my wife Nancy. Her constant love and support have been a source of strength for me. Her intelligence, common sense and joy of life provided the ingredients for the successful completion of this dissertation. Nancy has always been my best friend, colleague and teacher.

I would also like to extend recognition to my parents. Their high value on education provided me with a firm foundation for future endeavors. I have benefitted from their gifts many times over.

I would like to thank Dr. Ronald H. Fredrickson, Chairman of my Dissertation Committee. His caring manner and high professional standards will leave a lasting impression. Dr. Ena Vazquez Nuttall provided a great deal of assistance throughout the graduate program especially in the beginning stages. Dr. Warren Schumacher also had a clear understanding of my research and provided invaluable, concrete suggestions.

I am also grateful to Dr. Joyce Sager for her outstanding assistance. She is an individual of admirable personal and professional qualities. The cooperation extended me by my Special Service office

staff is greatly appreciated. In particular, Miss Yvette LaBonte provided the necessary organization and follow through to assist me with my professional responsibilities at work.

ABSTRACT

The Use of Family Therapy with Special Needs Children
and their Families

(May 1983)

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The purpose of this study was to determine whether there was a relationship between participation in family therapy by special needs children and their families as determined by changes in special education program categorization and per pupil expenditures.

Research was conducted in three public school systems in Massachusetts. The three public school systems represent two suburban communities and several rural communities for a total of ten individual town. Ten percent (1,189 students) were classified as special need students. Thirty-two of these students actually participated in family therapy at least once with an adult member of the family.

An archival research approach was used to identify those students who participated in family therapy during the 1978-1979 school year (pre-observation period). It was hypothesized that at the time of the post-observation period (1979-1980 school year) the experimental group (students participating in family therapy) would have a sig-

nificantly lower program classification than the control group (subjects not participating in family therapy). It was also hypothesized that a lowering of program classification would result in a corresponding lowering of per pupil expenditures.

The assumption that family therapy would lead to a lower mean prototype for the experimental group than for the control group was not supported by the data. There was no significant difference between the mean prototype for the experimental group and the control group after the subjects had participated in family therapy for those subjects in the experimental group [t(62)= .44; p. .05]. The *E* group experienced an increase of $51,566 and the *C* group experienced a decrease of $10,247 at the time of the second observation.

It was concluded that further research is necessary to determine if a relationship exists between participation in family therapy and a reduction in special education services. Implications for school psychologists and administrators, classification of special needs students, family therapy treatment goals, effectiveness of family therapy and per pupil expenditures were presented and discussed. Suggestions for future research were made.

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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study is to determine whether the variable component of family therapy written into the individual educational plan of a special needs student will alter the program categorization of that student. Family therapy may be an option which would assist public schools in maintaining special needs students in their local school environment, while at the same time providing a less costly alternative to expensive out-of-district day and residential placement.

Description of the Study

Chapter I will present a statement of the problem, which is an investigation of the use of family therapy by public schools for special needs students. Our field investigation is geographically based in western Massachusetts; because of this we focus specifically on "The Special Education Act of 1972 in Massachusetts," the first mandate causing special education to receive public attention in the state of Massachusetts. The later passage of a national policy in 1975, "The Education for All Handicapped Children Act, Public Law 94-142," however, has caused the issue of special education

to have national ramifications. Because of this, it is imperative that this investigation define what a special education population is as specifically defined by "The Special Education Act of 1972 in Massachusetts" and "The Education for All Handicapped Children Act, Public Law 94-142." This study will also present strong economic ramifications specific to Massachusetts since the passage of Proposition 2 ½. Because of severe economic constraints to the school systems under consideration, an awareness of the economic advantages adds a further dimension to this study of the effects of the use of family therapy with special needs students.

Finally, Chapter I will present several definitions of family therapy within the framework of special needs students and their families. Chapter II will further expand the use of family therapy with a review of the literature which identifies those studies in which family therapy has been used for special needs children and their families.

In Chapter III the method and design of this study is presented with the hypotheses of the research; the primary hypothesis being that it is anticipated that the experimental group of students will experience a lowering of special educational program category (prototype) when family therapy is a component of their individual educational plan. An archival research approach will provide the data for our investigation.

In Chapter IV we will present and analyze the findings and

conclusions of this investigation. This investigation will contribute to what is presently a paucity of available research which addresses the issue of whether or not public schools use family therapy for their special needs students. It should also provide substantial evidence supporting the training and use of school counselors and school psychologists as family therapists, thereby enhancing and improving the education of the special needs students (and his family) while at the same time being cost effective.

"The Special Education Act of 1972 in Massachusetts" and "The Education for All Handicapped Children Act, Public Law 94-142"

The current status of both state and federal public laws require public school systems to provide free and appropriate special education services which are based on identified student need. As a result of these mandates, special education has received considerable attention during the past decade. This is partially attributed to the passage and implementation of such public laws as "The Special Education Act of 1972 in Massachusetts" (or, as it has become known, Chapter 766), which mandates that each school district in the State of Massachusetts be given until September 1974 to implement all sections of the laws (Owen, 1975, p. 2). This was followed in 1975 by the enactment of the most comprehensive pieces of federal legislation ever passed for the benefit of special needs school-aged populations. "The Education for All Handicapped Children Act, Public Law 94-142" set

forth, as national policy, the proposition that education must be extended to handicapped people as a fundamental right (Lilly, 1979, p. 6). Public Law 94-142 was enacted as a permanent, lifetime law with no expiration date.

Definition of special needs population in accordance with Chapter 766 and Public Law 94-142. The terms special needs, exceptional, handicapped and disabled are often used interchangeably in the literature. However, for the purpose of this research these terms will be used in accordance with the definition established under Chapter 766 in Massachusetts. The Chapter 766 regulations (1978) define a child in need of special education as:

> . . . a child, who because of temporary or more permanent adjustment difficulties or attributes arising from intellectual, sensory, emotional, or physical factors, cerebral dysfunctions, perceptual factors or other specific learning impairments, or any combination thereof, is unable to progress effectively in a regular program and requires special education. Children of ages three and four shall qualify as children in need of special education in one or more areas listed above (p. 1).

For purposes of comparison, Federal Public Law 94-142, which has been implemented nationally, defines a special needs child as:

> Those evaluated as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or as having specific learning disabilities, who because of those impairments need special education and related services (Kaufman, 1978, p. 1).

Chapter 766 requires school systems to provide special education

services to children ages three to twenty-one if they are determined to have a special need as a result of a team evaluation, and if they do not have a high school diploma. At the present time, a team evaluation may include some or all of the following assessments:

> Regulation 321.1: An assessment of the child's educational status by an Administrative representative of the school department.
>
> Regulation 321.2: An assessment by a teacher who recently had or currently has the child in a classroom or other teaching situation.
>
> Regulation 321.3: A comprehensive health assessment by a physician.
>
> Regulation 321.4: An assessment by a psychologist which includes an individual psychological examination culminating in specific recommendations.
>
> Regulation 321.5: An assessment by a nurse, social worker or a guidance or adjustment counselor of pertinent family history and home situation factors.
>
> Regulation 321.6: Any additional assessments needed, e.g., early childhood specialist when the child is 3 or 4 years of age.

The evaluation team recommends, and the special education administrator determines if an educational program is required to meet the child's educational needs. If a special education is deemed appropriate, an individual education plan (IEP) is developed and submitted to the child's parents or guardians for their approval.

It is estimated that approximately 10 to 15 percent of school-aged populations have handicapping conditions that require a special education program.

A commonly agreed upon list of special needs categories was established in the early 1970's (with some variation from state-to-state and author-to-author). Lilly (1979, pp. 17-18) proposes the following:

Table 1

LIST OF SPECIAL NEEDS CATEGORIES

1. Mental Retardation
    a. Educable
    b. Trainable
    c. Custodial
2. Emotional Disturbance
    a. Behavioral disorders
    b. Severe emotional disorders
3. Learning disabilities
4. Visual impairment
5. Hearing Impaired
    a. Deaf
    b. Heard-of hearing
6. Speech impairment
7. Orthopedic handicaps and special health conditions
8. Giftedness

It is important to note that "gifted children and youth in the school population are not specifically provided for under the Education for All Handicapped Act, since giftedness is not commonly viewed as a handicapping condition" (Swanson and Willis, 1979, pp. 17-18). Chapter 766 in Massachusetts does not view giftedness as a handicap-

ping condition either.

<u>"Mainstreaming" and program categorization (prototypes) for special needs students</u>. A major goal of Chapter 766 and Public Law 94-142 is to provide educational opportunities for special needs children in the least restrictive educational program. In some respects, public schools' general educational programs are divided into two parts: regular education and special education. Therefore, the issue of mainstreaming centers around how to provide the greatest amount of regular education and the least amount of special education and still meet the handicapped child's educational needs.

The terms "mainstreaming" and "least restrictive program" may be confusing, but are actually terms used interchangeably in special education jargon. According to Chapter 766 regulation 111.0 "mainstream" is defined as:

> "Least restrictive prototype"--the program that, to the maximum extent appropriate, allows a child to be educated with children who are not in need of special education. For purposes of the program prototypes that are listed in 502.1 through 502.6 of these regulations, one prototype is less restrictive than another if it appears before the other (Regulations 766, 1978, p. 2).

Those special needs children (who are the focus of this paper) are commonly mainstreamed into the public school settings and are categorized by the following:

> Prototype 502.1: Regular education with modifications (no direct special eduacation).
> Prototype 502.2: Regular education program with no more than 25% time in special education.

Prototype 502.3: Regular education with no more that 60% in special education.
Prototype 502.4: Substantially separate program (little or no regular education).

Other special needs students are placed in more restrictive programs as a result of the severity of their need, lack of an appropriate educational program within a public school or a decision by an Appeals Officer or Court. Commonly used restrictive programs are:

Prototype 502.5: Day school program (private day school).
Prototype 502.6: Residential school program (24 hour, seven day a week placement). (Chapter 766 Regulations)

It is important to point out, that, generally less restrictive programs are much less costly than more restrictive programs. Prototypes 502.5 and 502.6 can be tremendously expensive.

Table 2 reflects the average cost of special education programs by prototype in Massachusetts. An analysis of these data demonstrates a consistent increase in per pupil expenditures as the prototype becomes more restrictive. Likewise, special education program expenditures in all prototypes have become more expensive with each school year. This increase in program costs is complicated by the proposed decrease in federal funds as well as fiscal restrictions placed upon public schools due to such realities as Propisition 2 ½ in Massachusetts.

Table 2

MASSACHUSETTS DEPARTMENT OF EDUCATION
BUREAU OF DATA COLLECTION AND REPORTING
SPECIAL EDUCATION PROGRAMS

Average per pupil expenditures by prototype in Massachusetts*

School Year	502.1	502.2	502.3	502.4	502.5	502.6
1977-78	$1,999	$2,098	$3,091	$3,971	$5,466	$7,123
1978-79	2,269	2,342	3,288	4,183	6,072	8,409
1979-80	2,401	2,547	3,518	4,740	6,837	10.540
1980-81	Figures not available at this time					

*Massachusetts Department of Education, Bureau of Data Collection,1981.

Special education and tax restrictions. Despite the fact that Chapter 766 and Public Law 94-142 require disabled children to get a free and appropriate education in the least restrictive environment possible, recent cutbacks in revenues to public schools have created a difficult set of circumstances. For example, the passage of the so-called referendum bill, Proposition 2 ½ in Massachusetts has imposed taxation restrictions on cities and towns and has eliminated fiscal autonomy for local school committees. Proposition 2 ½ has made it increasingly more difficult for public schools to meet the requirements of these special education laws. This problem is further complicated by the proposed cutbacks in federal funds to public school education.

The Education of The Handicapped News Service (1981) headlined an article, "New Reagan Budget Would Slash Special Education," and stated the following:

> The fiscal 1982 budget for the education of the handicapped children would be cut substantially in Congress accepts President Reagan's most recent round of budget cuts (p. 1).

This attempt to reduce federal expenditures for the education of handicapped children and youth supports a statement by Frampton and Rowell (1938):

> The history of the cure and training of the handicapped must of necessity follow social and educational trends rather than create them. The wounded do not form the advance guard of the army (p. 4).

Despite possible local, state and federal cutbacks in funding, local school systems will still be required to comply with mandated special education laws. In many respects, public schools are entrapped by state and federal public law mandating, costly educational services and possible reductions in available monies to pay for programs for the handicapped student. On the one hand, schools are required to meed the identified special needs of their students; on the other, schools have budgetary restrictions that limit available monies. This dilemma faced by public schools makes it inevitable to investigate cost-effective program options for the special education

population.

Public schools currently have well-trained counselors and psychologists as members of their professional staffs. It is possible that these professionals can be given additional training in family therapy which could be used as a means of keeping the special needs child in the public school. This may be a cost-effective alternative to private day and residential placements.

For example, according to Chapter 766 (1981) regulation 502.6 Residential School Program:

> Each school committee shall arrange for the provision of a program within this prototype to each child in need of special education for whom an IEP specifies such a program based on a finding by the Administrator of Special Education, upon recommendation by the TEAM that a residential school program is necessary to meet the educational goals and objectives of the IEP . . . (p. 55).

Also, the need for such alternatives is further supported by the fact that it is unlikely that school-aged populations will disappear, or that local and state education agencies will no longer be responsible for the education of these children. However, the major purpose of this study is to determine whether or not public schools are using family therapy as a component to a student's individual educational plan. School systems may already be using family therapy as one means of keeping students in a less restrictive special educational program, and hence a less expensive educational program.

In order to understand the issue presented more thoroughly, one needs to understand how family therapy is defined as well as its

relationship to special needs populations and their respective families.

Definition of Family Therapy

Family therapy is a psychotherapeutic approach for which there is a wide variation in theoretical positions and clinical techniques. The Encyclopedia of Human Behavior (1970) defines family therapy as "a form of group psychotherapy in which the family is the therapeutic unit; its object is to alter the home influences that contribute to the disorder of one or more members (p. 447). Coleman (1964) defines family therapy as the "treatment of the family or key family members as a group rather than treatment of the patient apart from his family setting" (p. 661).

This statement is supported by a report from the Group for the Advancement of Psychiatry (1970):

> Family therapy is not a treatment method in the usual sense, there is no generally agreed upon set of procedures followed by practitioners who consider themselves family therapists. What these practitioners hold in common is the premise that psychopathology in an individual may be an expression of family pathology and the conviction that seeing a family together may offer advantages over seeing its members individually. . . .
>
> Some family therapists will interview only the whole family; others will see pairs of individuals as well as the whole group, still others typically see only an individual but with the goal of changing his family context so that he can change (GAP Report, 1970, p. 572).

Selvini-Palazzoli, Boscolo, Cecchin and Prata (1974) point out that there is, however, no single definition of family systems or of

family therapy that all family therapists would endorse (p. 428).

Selvini-Palazzoli et. al. (1974), further state:

> . . . there does not exist to date a comprehensive theory of family therapy, it seems nevertheless possible to state a common denomination: the trend away from the disturbed individual seen as an artificially isolated monad toward the study and the treatment of dyads, triads, the entire nuclear family, and finally, of the complex network of relationships in which every family is embedded. However, beyond this one point of agreement, workers in our fields are known to hold radically divergent views about questions of epistemology and practice . . . (p. 429).

This wide variation in theoretical positions has attracted a number of critics who claim that "family therapy is a hodgepodge of part-theories and part-techniques, that it is more an art form than a clinical science" (Zuk, 1976, p. 299).

The point, however, is not to judge the merits of a specific family therapy model, or even the general field of family therapy. It is important to keep in mind the diversity of theoretical models and techniques as indicated by Selvini-Palazzoli (1974) and the GAP Report (1970).

In general, family therapists do hold the following in common:

> (1) The focus on the family as a functioning unit; (2) The belief that within the family, the behavior of any single member affects, and is affected by, the behaviors of all the other members; and (3) The contention that many behaviors which appear deviant or dysfunctional if an individual is viewed alone, have functional value for maintaining the family system and for adapting the individual within his family context (Levinger, 1979, p. 7).

The use of family therapy has received tremendous growth in both

interest and application by mental health practitioners. This growth is exemplified in a statement made by Richard Simon (1981):

> The seeds planted 25 years ago have flowered. The rebels have taken over the palace. Family therapy is firmly entrenched within the mental health establishment. Years ago, family therapy was something you did on the sly. Today there are many settings where doing individual therapy is the embarrassing secret you might wish to keep from your more gung-ho family therapist colleagues (p. 1).

Although family therapy has become the psychotherapy of choice for many mental health professionals, is it the treatment of choice for special educators responsible for deciding what type of services are most appropriate for special needs students? Chapter II of this study will provide research which substantiates that family therapy does have a positive effect on students who fall within the range of one or more special needs categories, and to their families. In Chapter IV specific instances in the lowering of prototypes of those students who have had family therapy written in as a component of their individual educational plans will be researched.

Stress and the Family of a Handicapped Child

Featherstone (1980) in A Difference in the Family includes two chapters which explore some of the ways a disability can alter the family unit. In her chapter of marital stress, Featherstone (1980) states that a child's handicap attacks the fabric of a marriage in four ways. It excites powerful emotions in both parents. It acts

as a dispiriting symbol of a shared failure. It reshapes the organization of the family. It creates fertile ground for conflict (p. 91).

In her chapter on siblings, Featherstone states that brothers and sisters of handicapped children feel the tug of what almost amounts to two different cultures. They stand with one foot in the world of normal classmates, and the other in their exceptional family. They live among ordinary children; they long for simple fellowship with others their own age. Yet playmates sometimes treat a handicapped child cruelly. Forced to mediate, to explain, and sometimes to choose between conflicting loyalties, brothers and sisters can end up angry at the normal world, the disabled child and themselves. Richard, a college student whose younger brother suffers from severe hearing loss and deformities of both arms, describes a recent crisis:

> This past summer I worked at a playground. One day a bunch of kids and I were playing. Everybody stands in a circle and throws a ball to one another. And all of a sudden these kids started dropping away from the circle. I was playing with them, so I did not really pay much attention to why some kids were dropping out. It was just slowly getting more and more quiet and I turned around: my brother was standing there of course, this is summertime, he has short sleeves on and these kids, even now I am tempted to say these little creeps, it really upsets me--they made a circle around my brother, just made a circle around him and started looking at him and I just did not know what to do . . . (p. 142).

The handicapping condition of one family member may affect all members of the family to include the need for special needs programming for not only the special needs child, but for the other children in the family.

Educators, especially special educators, must be made aware of the stress produced in a family by a handicapped child. Families of special needs children are often faced with extraordinary demands on their time, finances (especially for medical costs) and physical energy. This is often complicated by internal feelings of fear, anger, guilt, self-doubt, and loneliness which stresses marriage and other family relations. This is particularly true as the special needs child grows older and the handicapping condition may set the child off from other children and other members of the family may encounter anger, hostility, and even cruelty. Neaf (1975) provides some insight into this problem for the handicapped child's siblings by reporting the following conversation:

> One day after school Chris confronted me. There was a white line around his mouth. He suddenly looked very small and vulnerable for eight years old.
> "Mom," he asked, "What is a vegetable?"
> I knew immediately what was coming. In spite of my intentions always to give honest answers, I heard myself stalling, "Vegetable? Oh, you know, peas, carrots . . . ."
> "No. Not that kind! You know what I mean! The kids on the bus said my brother is a vegetable."
> "It's just a word." Suzanne, then ten years old, broke in. "It's a word some of the kids use when they want to hurt you or be mean and nasty. Like dumdum, rattlebrain and . . . ." she swallowed, "retarded."
> "Do the kids say things like that?" I wished I hadn't asked. Their faces told the whole story (p. 153).

This issue is of particular importance to educators. Although the more noticeable handicapped child may receive the attention, other children in the family may develop educational problems par-

tially as a result of their sibling's handicap. It may be possible that the use of family therapy may minimize potential problems for other members of the family, and thereby avoid future special education needs for siblings of the handicapped child.

In the late 1950's and early 1960's a major study was conducted by Farber (1959) on the impact a severely retarded child had on the stability of the family:

> Farber studied 240 families with severely retarded children (IQ of 50 or below) who were sixteen years of age or under. One-hundred and seventy-five of the 240 had a retarded child at home. Sixty-five had placed their child in an institution. A two and one-half hour interview of the parents was conducted in the home. In addition, parents were asked to complete a series of scales and questionnaires, and the family's integration was measured by still another instrument. Thus, the subjects were scrutinized rather intensively, which makes Farber's research one of the most important in this area (Seligman, 1979, pp. 66-67).

Farber (1959) concluded:

> . . . the parent can expect that a retarded boy, especially after the age of nine, will have a disruptive effect on marital relations; he can anticipate personality problems for the sister, who is given many responsibilities for the child; the parents must be aware of the degree to which the family has its own resources and supportive interaction in facing crisis situations; and he can expect the degree of helplessness of the retarded to affect the personality of his normal children adversely (p. 80).

Farber's 1959 findings have not been contradicted, but they may now be outdated.

One of the most important aspects of his conclusions is the adverse effect the special needs child may have on the other children

in the family. Educators need to be aware of the fact that the original special needs child may not be the only child requiring special services but also the other children in the family. This issue is of particular importance. Although a great deal of attention may be focused on the handicapped child by the home and school, the potential for other children in the family developing educationally related problems is very real. It may be possible that the appropriate use of family therapy may minimize the potential stress to family relations and thereby prevent the development of educational problems among siblings. Hence, the disruptive impact may exceed the boundaries of the home and extend into the school affecting the siblings adversely.

McIntire and Payne (1971) conducted a study that examined the relationship between school achievement, intelligence quotient and adequacy of family functioning with 23 third and fourth graders. They conclude:

> The findings provide considerable support for considering family dynamics as an important and integral part of the "total child"; since the previously described results indicate a significant relationship between elementary school achievement and family functioning. . . . Specifically, it is the internal, interpersonal dynamics which relate significantly to the achievement, not extra familial areas or those which focus primarily on areas such as physical or health conditions in the home (p. 57).

These studies lend support to the fact that the traditional school efforts to ameliorate educational problems by focusing exclusively on the "pupil in school" may have ignored a critical aspect of the problem, the family. Since research has been conducted

that concludes: certain handicapped children may have a disruptive, negative impact on adequacy of family functioning (Farber, 1959); well adjusted children show higher levels of achievement than do poorly adjusted students; and a child's home experiences influence school performance (McIntire and Payne, 1971). As a result, public school educators are faced with a double-edged problem. Educators must provide special education programming and services for the initially identified handicapped child but may, at some future time, have to provide similar services to other children in the family.

Conclusion

Despite the diversity of family therapy theories, family therapy is receiving tremendous popularity as a psychotherapeutic treatment. Likewise, special education has made a tremendous impact on the public schools in terms of per pupil expenditures, and use of staff and facilities. However, there is little data that indicates how often family therapy is used by public schools for their handicapped students.

The school-aged special needs child, in most cases, spends the majority of the day in either the school or home environment. The family and the school should be brought together in a coalition for the betterment of the child. The current special education laws bring together the school and the parents to discuss the child's educational program, yet the outcome of these meetings rarely involves

the family beyond the meeting except for occasional quarterly reports or telephone calls.

It is the purpose of this present study then, to examine the use of family therapy by the public schools for these special needs children, and by so doing, amplify for examination, aspects of this issue for future investigation and analysis.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

It was noted in Chapter I (p. 6) that the list of special needs categories includes a wide range of handicapping conditions, specifically: mental retardation, emotional disturbance, learning disabilities, visual impairment, orthopedic handicaps and special health conditions. It is the obligation of the school system to provide special education services to children ages three to twenty-one if they are determined to have a special need as a result of a team evaluation, and if they do not have a high school diploma.

In Chapter II a review of the literature which relates to the use of family therapy with school-aged special needs children and their families will support the following findings:

1. The use of family therapy as a psychotherapeutic treatment is a variable which provides help to a special needs child and his family.

2. The field of family therapy as a clinical, empirical treatment lacks a consistent research design methodology.

Criterion Used to Determine Literature for Review

The following criteria were established for purposes of this review:

1. The study must indicate that family therapy is the primary psychotherapeutic treatment.

2. The family must have a child or youth (ages three through twenty-one as specified in Massachusetts Chapter 766) who manifests an identifiable special need. The special need must manifest conditions which could potentially result in an educational special need designation if a special education Team evaluation were conducted under the provisions of Chapter 766 (See p. 4 of this dissertation).

3. Only those types of special needs conditions commonly found in a public school setting would be reviewed. For example, children with certain physical handicaps would be reviewed, but not children who are severely emotionally disturbed and require the most restrictive program, institutionalization.

The criteria used to determine literature for review in itself exemplifies the multifaceted challenge that the special needs child presents to the public school setting; his special needs may be physical, emotional and/or social. The literature reviewed studies many of these aspects as they comply with the criteria discussed above. Because of the multifaceted nature of the studies, some overlapping of results occurs.

The review of the literature, therefore, will begin with the first uses of family therapy, almost a century before special education laws were enacted, in which there existed a dichotomy between the social and psychological treatment--the social belonging to the

realm of the special needs child and his family, and the psychological, pertaining to the child and his physician.

Family Therapy and Social Work

The history of social work reveals that the first professional social workers not only worked with individuals but with married couples and families. From the very beginning, social workers dealt with entire families. One of the earliest supporters of working with entire families was Mary Richmond who became one of the main organizers of the national organization of social workers. In her book, Social Diagnosis (Richmond, 1917) quoted the Swiss neuropathologist, Dubois, as referring to "the necessity of not confining one's therapeutic efforts to the patient alone, but extending it to those who live with them. This is the way to obtain lasting results" (Gurman and Kniskern, 1981, pl 6).

From the birth of social work as a profession in 1877, social workers began dealing with the entire family through group interviews, visitations to the home, and counseling. From the onset, "work with families" was the catchword to describe their general treatment approach.

As we have move through the twentieth century both psychologists and social workers have remained cognizant and supportive of the need of family therapy as a positive psychotherapeutic variable, because of the handicapping effect on parent-child relations of a special needs child.

This issue was discussed in an article by Anderson (1981) entitled "The Handicapped Child's Effect on Parent-Child Relations: A Useful Model for School Psychologists." Anderson (1981) states:

> While the parents' role in the development, maintenance, and/or management of the range of childhood problems and handicaps has received widespread attention, the handicapped child's contribution to the development and maintenance of parent behavior and parent-child relationships has not been clearly articulated, and, certainly, less often considered in assessment and intervention (p. 82).

Anderson (1981) continues to elaborate on the issue of parent-handicapped child relations by stating:

> Whether a child's problems were rooted originally in organic difficulties or in disorders or skill deficits of parents, when they come to the attention of professionals, they must be viewed in the context of mutually developed and maintained patterns of parent-child interaction. Thus the child and his parents are both initiators as well as recipients in those patterns. They both provide antecedent and consequence events which serve to influence the form and frequency of one another's behaviors. In this manner of thinking, the view that the parent is the teacher/socializer and the child is a passive learner is inappropriate (p. 82).

Moroney (1978) provides additional general support for the use of family therapy from a more conceptual point of view. Moroney (1978) states:

> Social services are usually defined as those designed to help individuals and groups meet basic needs, to enhance social functioning, to develop potential and to promote general well-being. A useful starting point is to recognize that families are a social service organization in that they, as well as the organized health and welfare system, carry out these functions.

> Furthermore, it is clear that families provide more social care to dependent members than do health and welfare agencies.
> Families who care for the handicapped are not faced with acute crises. They are normal families under pressure from long-term management problems. They require support, they want someone to take the time to listen and to provide them with useful information. Finally, they need relief and practical help (p. 211).

Despite an expressed commitment to working with families by social workers, psychological treatment of special needs children remained focused almost exclusively on the individual child. Bowen points out that:

> A psychiatric principle may have accounted for the family movement remaining underground for some years. There were rules to safeguard the personal privacy of the patient/therapist relationship and to prevent contamination of transference by contact with the patient's relatives. Some hospitals had a therapist to deal with the carefully protected intrapsychic process, another psychiatrist to handle the reality matters and administrative procedures, and a social worker to talk to the relatives. In these years this principle was a cornerstone of good psychotherapy. Finally, it became acceptable to see families together in the context of research (Guerin, 1976, p. 3).

"The Special Education Act of 1972 in Massachusetts" and "The Education of All Handicapped Children Act, Public Law 94-142"--both enacted in the 1970's have removed the "underground" nature of much psychotherapy. Special needs children's education is now public responsibility; as such it has become "acceptable to see families together in the context of research" (Guerin, 1976, p. 3).

The next section of this chapter reviews several special needs categories that have been serviced with family therapy. In most cases no model of family therapy is apparent, rather only a positive

statement as to the fact that family therapy was the variable present in these studies which provided positive results.

Family Therapy and Mental Retardation

The American Association of Mental Deficiency has defined mental retardation as subaverage general intellectual functioning with impairment in adaptive behavior (Coleman, 1964, p. 519). This definition is further explained in the stipulation that a child should not be classified as mentally retarded unless he is deficient in both intellectual functioning, as indicated by IQ level, and in adaptive behavior, as measured by such instruments as the Vineland Social Maturity Scale or the American Association on Mental Deficiency (AAMD) Adaptive Behavior Scales (Anastasi, 1976, p. 519).

The birth of a mentally retarded child, particularly a severely or profoundly retarded child, may have a significant impact on all members of the family. A major problem that may occur is that parents become overly involved with meeting the needs of the mentally retarded child so as to make the boundaries of the parental subsystem totally rigid (resistant to change and growth), to the exclusion of the other siblings. Conversely, other siblings may take on the role of caring for the mentally retarded child with the effect of breaking down the parental subsystem (Turner, 1980, p. 167).

Turner (1980) discusses major therapeutic goals when the mentally retarded child is seen as the source of crisis in the family. The

therapy can be seen as two-fold in nature: (1) to deal with immediate crisis interventions (the hurting, dysfunctional family), and (2) long-term counseling involved with goal-setting and family role development for flexibility in future problem periods. It must be remembered that the problem of mental retardation has no solutions, and as such, the subsequent disruptions in family development and organization should be expected in both instances (Turner, 1980, p. 170).

The case study does not provide a case study per se. It does provide information concerning family reactions and changes in family structure when a member of the family is mentally retarded. This information is useful to both educators and clinicians alike. In addition, the author provides suggested therapeutic intervention to be used in family therapy with this type of family.

Public school educators concerned with issues related to child development are aware that the home environment exerts a powerful influence on the development of young children (Anatasi, 1967). However, the influence of parental environment has been determined primarily with non-handicapped children. This study was conducted as a five year longitudinal study of the relationship between the home environment and school adjustment of 104 TMR children and their families. Nihira et. al. (1981) describe the characteristics of the subjects by stating:

> Their mean IQ was 42.4 (standard deviation 50 = 9.9) on the Wechsler Intelligence Scale for Children or the Stanford-Binet Intelligence Scale. In terms of IQ-level classification by AAMD

> standards (Crossman, 1977), 11 percent of the subjects were mildly retarded, 59 percent were moderately retarded, and 30 percent were severely retarded. All of them residents in their natural homes with their parents or relatives. The age range of these children at the time of the data collection was 9 to 16 years, with a mean age of 12.5 years. Seventy-eight percent were White, 16 percent were Hispanic, and the remaining 6 percent were Black or other minority.
>
> Approximately 80 percent of the parents were married with both mother and father figures present at home. The average age of the fathers was early 40's and of the mothers, late 30's. The average educational level of both mother and father was high school education. The occupational level of the head of household varied greatly with an average Duncan socio-economic index of 46, indicating the middle-class level of occupational status (p. 9).

The results of this appear to indicate that the home environment is related to the development of the handicapped child as well as the non-handicapped child. The study identified specific factors within the home that are of importance to the personal and social adjustment of TMR children in school. Results reveal that specific factors of home environment were significantly related to the adjustment of TMR children in school, including (a) harmony and quality of parenting, (b) educational and cognitive stimulation available at home, (c) emotional support for learning, and (d) cohesiveness of family members (Nahiva, et. al., 1981, p. 8). The researchers also found these specific factors to be more important than social climate, family values or orientation, and the traditional indices of family background, such as the mother's education, socio-economic status, or number of children (Nahiva, et. al., 1981, p. 14). Although family therapy was not used in this study, the data seem to lend support for the use of family therapy as a potential treatment to effect these

specific home environment factors that are significantly related to the TMR child's adjustment in school. This is especially important as a means of providing the least restrictive educational program possible.

A study comparing the development of mongoloid children reared at home with those reared in institutions found it to be obvious that the mongoloid child will be adversely affected by early institutionalization of the matched group, the children placed at birth were functioning in the severely retarded range--those who had been at home in the early years were mainly in moderately retarded range. Early home care thus was seen to be the difference between trainability and non-trainability (Centerwall and Centerwall, 1960, p. 683). The conclusion of Centerwall and Centerwall's (1960) research was more meaningful to the study of family therapy with special needs children when coupled with a study by Gianni and Goodman (1963).

Gianni and Goodman (1963) conducted a study in which counseling services were made available to families of infant mongoloids at the time of the initial crisis reaction shortly after the infant's special need was identified. Of the first 100 families studied, all of whom had applied for State institutionalization, the majority responded eagerly to the opportunity for looking beyond what had appeared to be an unalterable decision. Twenty-four of these families indicated that they planned to keep their children at home, at least during the crucial early developmental period. In most instances the shift ap-

pears to be clinically sound (Gianni and Goodman, 1963, p. 747). These studies contain merit to the present study because they demonstrate that counseling with the family can assist in keeping a child in a less restrictive program and, thereby, possibly averting the more serious development problems associated with the most restrictive environment, institutionalization.

Family Therapy and Emotional Disturbances

Juvenile Delinquency. Juvenile delinquency is more of a legal term than a psychological or educational one. However, from a psychological point of view, delinquency is under the classification of personality disorder or character disorder in which the behavior is characterized by "patterns of maladjustive behavior" [acting out] (Coleman, 1964, p. 352). Depending on the state, juvenile delinquents are usually eighteen years old or younger and considered delinquent if they have committed a misdeamenor or felonies. Beal and Duckro (1977) define juvenile status offenders (JSO) as the title used to describe a youth whose offenses are of such a nature that they would not be considered a criminal were they committed by an adult. They are not acts of violence against persons or property. The cases of the juvenile status offenders are typically violations of the adolescents socially prescribed role in the school or family system. Common examples are runaways, truancy, curfew violations and the ever popular incorrigibility (p. 76).

A conservative estimate suggests that the JSO's constitute 26% (184,000) of all children's cases coming before the court annually in the United States. Twenty-three percent of the males and seventy percent of the females who were committed to correctional institutions in 1975 were juvenile status offenders (Horn, 1975, p. 32). In some juvenile court systems, family therapy is seen as an alternative to placing "milder" (JSO) cases of deliquency with more hard core deliquents in correctional institutions.

In a study by Beal and Duckro (1977) family therapy is used as an alternative to legal action for juvenile status offenders (p. 77). The study was the result of a special intervention program called The Juvenile Status Offenders Unit (JSOU) in a large south-western city.

A sample of 44 JSO families were randomly selected from one month's operations. A control group composed of using a proportionate sample of 54 families selected from status offenders' clients in the same month, one year earlier, before the prehearing had begun operations (Beal and Duckro, 1977, p. 79). The number of cases closed because of termination, or referred without court action, was selected as a measure of program effectiveness.

The results indicate fully 83 percent of the families in the prehearing (JSOU) program were terminated or referred. Only 17 percent of the JSO cases were taken before court, this compared with 35 percent under the traditional probation officer-juvenile client

system. These results indicate that the juvenile status offenders prehearing program was indeed remarkably successful in achieving its purpose (Beal and Duckro, 1977, p. 79).

This was one of the better designed (and explained) studies in that the presenting problem method (subjects, procedures, independent variable) and results were clearly delineated. This may also be a useful study to read or replicate for those interested in family therapy effectiveness with "mild" juvenile delinquency or status offenders.

In a study by Garrigan and Bambeck (1975), short term family therapy was used with emotionally disturbed children. It was one of the few studies reviewed that sought improvements not only in the family but in the school. This study was conducted at the Centennial School at LeHigh University. The experimental and control families had boys attending classes for the emotionally disturbed at Centennial School. These were white middle class families. The Centennial students were considered the identified patients. These boys had a mean age of 12.4 years and a range of 11.3 to 15.1 years of age (Garrigan and Banbeck, 1975, p. 381). The identified clients had the following characteristics: emotional disturbances and no history of psychosis, mental retardation, uncontrolled hearing loss, or language disorder; both parents lived together and parents had no history of psychosis.

The treatment group of nine families received six consecutive

weeks of family therapy. The control group also had nine families with the identified clients of both groups matched for age and IQ, but the control gorup received no therapy.

In conclusion, the authors state that short term therapy seems to produce significant gains in family adjustment as judged by the identified client. Although there was no significant change in classroom adjustment as judged by the teacher, a majority of parents treated with their children believed the program was useful enough in that they would seek further therapy if offered (Garrigan and Bambeck, 1975, p. 383). This study provided an excellent experimental design, explained its methods and procedures clearly as well as the results and the conclusions.

In a study by Rosenthal, Mosteller, Wells and Rolland (1974) which focused on families characterized by multiple delinquency invariable learning problems of the children, and disruptive behavior (often violence or threat of very serious violence) on the part of both children and parents existed (p. 126). These families were seen through the Roxbury Court Clinic (Boston), and those families selected for treatment were considered to be problem families to the community.

The study revealed that there are certain characteristics in hard-to-treat lower socio-economic families that may account for the positive results in the family therapy. We now view these character-

istics as specific indicators for family treatment: (1) all were highly cohesive families; (2) all were families in whom pathological patterns were widely shared (as a result of their level of cohesiveness); (3) all were families with patterns disruptive to the self-esteem and functioning of individual members; (4) all shared the depressed qualities . . . (Rosenthal, et. al., 1974, p. 128).

There were five families which included 26 children seen over a period of a minimum of two years. The authors quote a portion of a study by Robbins (1966) in St.Louis that has indicated that it is the children such as those we have described who grow up to be the adult neurotics, psychotics, and criminals rather than the neurotic children on whom child guidance clinics have traditionally concentrated, who grow up to be relatively normal adults (p. 141).

Robbins' (1966) comments provided some excellent insights into the use of family therapy with hard to reach families with delinquent members. It also raised some thought-provoking notions such as should more mental health programs be geared toward the future criminals of the inner city than the mild neurotics of the suburbs. However, this study did not provide any conclusive evidence that family therapy is successful with these types of families.

Minuchin, Chamberlain and Granbard (1967) made a comment about delinquent children in an article entitled "A Project to Teach Learning Skills to Disturbed, Delinquent Children" that is appropriate to this research. Minuchin, et. al. (1967) state:

> It has been our experience that the psychological disturbance of children in such families (multi-problem lower-class families) almost always is accompanied by lack of achievement in school and academic subjects, despite individual intelligence tests showing that some children are of normal or superior intelligence (p. 558).

Edwards (1977) provides a brief case study of a 15 year old student who has a problem with a substance abuse in the form of alcohol. Judy was found making a scene at a subway station during school hours as a result of intoxication. Edwards (1971) states:

> Judy was adopted in 1962, at the age of eight months, and was very "special" to the Williams. The family functioned well until Judy was 13. At that time she began to be truant at school. Later she got into groups in which there was excessive drinking and the parents complained that Judy was a discipline problem at home. Her behavior became progressively worse until she was referred for therapy at the age of 15 (p. 23).

Although there is no mention of the number of sessions, the author claims that the early sessions resulted in a period of calm for the family in that Judy had left her delinquent friends and began going to school. However, the parents got depressed and were seen as a couple without Judy. Judy and her parents were seen both as a family and as individuals/couple throughout the entire series of sessions. As a result of the therapy sessions, a combination of family, couples and individual therapies, Edwards (1977) states:

> Mother felt "fulfilled" as a good mother. Father was more involved with emotional issues within the family and less involved into detective work with daughter, and Judy was functioning well at school and home. The family eventually reached a better level of equilibrium and organization than before the initial stress occured (p. 24).

The author discusses the theoretical aspects of the therapy but there is initially no mention of techniques used, number of sessions family members spent in the various therapeutic modalities, individual, couple, or family therapy.

School related problems: failure, truancy and dropouts. Freund and Cardwell (1977) discuss a case study of Paul who was referred by his guidance counselor after he failed to complete even one academic subject in three years. The presenting problems were as follows:

> At fourteen, Paul continued in the seventh grade. The Committee on the Handicapped reported he was often late to class, though rarely truant, and that he was often disruptive in class. The school staff emphasized that Paul had been mostly apathetic and unmotivated, but that their psychological testing indicated that he possessed average or about average abilities (p. 50).

The school's special education evaluation team labelled Paul emotionally handicapped, thus making this case study one of the few located in the literature in which a child's special needs are identified from an educational perspective and reported as such.

The family was seen for approximately ten weeks which resulted in a combined effort between the family and the school personnel to develop a highly structured program for Paul. Within two weeks of the new school program, both his teachers and parents reported improvements. The authors state that across all five academic subjects, Paul's teachers reported completed assignments, attention in class and a sharp rise in performance (p. 56).

This article is significant in that the therapist viewed the school failure as not residing within simply the individual student or family. Instead, the therapist saw the school as a possible contributor to the problem. Therefore, the focus of this family therapy case study exceeded the traditional realm of the family but intervened at the school level. Although the article provides some useful intervention strategies at both the school and family levels, one must be aware that there are too many variables unaccounted for to determine the effectiveness of this particular approach.

In a family therapy case study, McKinney (1970) discusses the initial resistance and subsequent engagement of a Miss T., age 28, and her three illegitimate daughters, ages 8. 10, and 13, who had been known to various health, welfare and juvenile agencies for years (p. 329). The youngest child was mildly retarded. All the children had poor school attendance as a result of truancy, shabby appearance and misconduct in school. In the opinion of the author, these problems, which are common among low-income inner city families, may be partially alleviated through the use of family therapy by social case workers.

This case study found family therapy helpful in improving the family's personal appearance, living conditions, and understanding of financial obligations and priorities. Miss T. also gained in confidence which eventually permitted her to visit the school alone to work through the problems the children were having in school. The case study does not mention any change in the school situation for

the children.

This case study is primarily concerned with how parents and children who have been emotionally deprived can learn to adapt and mature in treatment emphasizing communication and interdependence within the family (McKinney, 1970, p. 327).

Feldman (1981) presented a brief case of a 16 year old male who attempted suicide on two occasions. He was very bright, but had dropped out of school and was in trouble with the law for attempting to distribute amphetamines (p. 45). The author discusses the etiology (from a psychodynamic theoretical perspective), but never clearly concludes any specific details about the case except, getting the family to understand one another through family therapy was "long, difficult and only a minimally successful task."

In a case study by Musliner (1980), the therapist saw a six year old first grader who was referred by his guidance counselor for a problem with vomiting. The boy, since the beginning of kindergarten, had been vomiting each morning before school and continuously complained of stomach aches while in school. The therapist viewed the child's problem as a useful tactic in having control within his family. Musliner (1980) reports the following results: all told, over the ten weeks from the inception of the intervention to the end of the school year, Jerry (the identified patient) vomited only eight times outside of his DVT (designated vomiting time--a behavioral therapeutic intervention) and not at all during the last month. Jerry did not resume his vomiting when he entered the second grade and at present

(midway through the third grade) remains vomit-free (p. 108). This case study provides an interesting use of family therapy combined with a behavioral program. However, there are a multitude of factors which could have contributed to the change other than the actual therapy such as cooperation of the school personnel, e. g., Jerry's guidance counselor. The author believes that all other factors were contributory.

Ayhmer (1977) reports a case study in which a 12 year old boy is receiving bad grades in school. The boy's mother had been divorced for twelve years and had not remarried. The father, however, had. The boy and his mother were seen together for the first interview. This interview revealed that the boy still sees his father, though remarried, on the average of twice a week; therefore, the therapist had the father join the second session. Ayhmer (1977) states the following:

> Within the first minutes of this interview, it became very clear that this couple was still deeply entrenched in their struggles with each other as if the divorce and ten years intervening had not occurred. We therefore said to them that they still looked and acted like a family to us, regardless of documents showing otherwise, and that we would agree to see them all together to work on "their problems" as a family. After about six stormy and occasionally warm sessions, mother mused aloud in a softer voice, "You know, I'm beginning to think that I may be able to go through life not hating this man intensely." At this, father seemed surprised and their son visibly relaxed with a sigh of relief. His next report card showed striking improvement in academic performance. This couple, after ten years of bleeding edges and one remaining, finally got divorced (pp. 6-7).

The author uses this case study as a means to explain how unresolved

issues of anger, unfulfilled expectations, and rejection can be felt across the years and generations despite a legal divorce.

Tiller (1978) reports on a family therapy outcome case study involving an eight year old girl presenting a history of multiple tics with associated hoarse coughing and panting. The child refused to attend school becuase of a six day history of repetitive jerking movements of her arms and head, associated with a cough-like sound. As a result of her tics, she was hospitalized in a children's hospital. In the final week (seven therapy sessions), both parents said how well everyone was feeling, that Ruth was free of tics, and that they did not wish to pursue the matter further. At brief reviews five months later and nine months after the first presentation, Ruth remained asymptomatic (Tiller, 1978, p. 221).

Psychosomatic disorders. Psychosomatic or psychophysiologic disorders are physical symptoms resulting from continued emotional mobilization during sustained stress, which often involve actual tissue damage (Coleman, 1964, p. 669). Coleman (1964) further states that "one out of every two patients seeking medical aid is suffering from an illness related to an emotional stress" (p. 249). Although psychophysiologic disorders are "most frequent during periods of young and middle adulthood, they may occur from early childhood to old age" (Erfmann, 1962).

Psychosomatic symptomatology is divided into two categories: primary and secondary. The distinction between the two categories is well explained by Minuchin, Baker, Liebman, Milman, Todd, 1975):

> In primary psychosomatic symptomatology, a physiological disorder is already present. These include metabolic disorders like diabetes, allergic dialtesis such as that found in asthma, and so forth. The psychosomatic element lies in the emotional exacerbation of the already available symptom. In the secondary psychosomatic disorder, no such predisposing physical disorder can be demonstrated. The psychosomatic element is apparent in the transformation of emotional conflicts into somatic symptoms. These symptoms may crystalize into a severe and debilitating illness like anorexia nervosa (pp. 1032-1033).

Asthma: A primary psychosomatic disorder. In a case study by Minuchin and Fishman (1979), they discuss the case of a boy who had mild asthma symptoms for five and a half years, which became severe at nine years of age. The boy's daily functioning was disrupted due to the asthma [a disorder characterized by painful wheezing and gasping due to blocking of the bronchial passages by spasmodic contractions and excessive secretion of mucus] (Goldenson, 1970, p. 122). He had to visit the emergency room on a number of occasions. The authors indicate that within a month of therapy, the boy's asthma ameliorated. He no longer had to be rushed to the emergency room and his relationships with peers improved. Minuchin and Fishman (1979) further state:

> A 2½ year follow-up reveals that Billy (identified patient) occasionally had mild episodes of shortness of breath but no frank wheezing. The parents reported that the youngster was more independent and assertive. They complained for the first time that they had to punish him occasionally. He had more friendships and was doing well in school (p. 89).

The severity of asthma among school-aged children is emphasized by a report of the Asthma in The Schools Subcommittee of the American Lung Association of Massachusetts. This report states:

> Asthma is a very common condition occurring in 5-9% of children. It is the most common cause of children, under the age of 17 years-being absent from school. An estimated 25-50% of classroom absenteeism is caused by asthma (Twarog, 1981, p. 17).

Therefore, it is possible that many of these children are receiving instruction in their homes [Chapter 766 regulation 502.7(a)] unnecessarily as family therapy may alleviate the more severe asthmatic symptoms.

The following case study was presented in an article by Combrinck-Graham (1974):

> Nancy, an 11 year old girl, was admitted to the Children's Hospital of Philadelphia after she had refused to eat anything for a week. The younger of two sisters by four years, Nancy had been asthmatic since age one. Since age six, the asthma had been so severe that she had been more or less a chronic invalid (p. 828).

Nancy weighed 130 pounds six months prior to admission. She weighed 83 pounds at the time of admission. Combrinck-Graham (1974) reports the following summary of treatment:

> In 24 hospital days and 11 outpatient family sessions over a period of 10 months, this anorectic child, who had lost more than 50 pounds, gained 50 pounds and grew four inches. . . . Two months after therapy ended, Nancy was discharged from treatment by her allergist since she had no further symptoms (p. 830).

In a study by Minuchin, Baker, Rosman, Liebman, Milman, Todd (1975), family therapy was used to determine if a change in family behavior patterns would result in the disappearance of psychosomatic symptoms. One of the experiments involved 10 children with intract-

able asthma. Most of the asthmatic group were steroid-dependent.

One of the unique aspects of this study was the close working relationship between pediatricians and family therapists. This combined treatment approach has provided some encouraging results as seen in Table 3, page 44.

Anorexia nervosa and encopresis: secondary psychosomatic disorders. Anorexia nervosa is a disorder of self-starvation in children which can be fatal. Minuchin has researched this area extensively, and based on a structural family therapy model (a theoretical model that views the family as comprised of internally structured parts), concludes that the disorder is not localized within the individual; the "crazy" symptom of not eating exhibited by the patient was redefined as an interpersonal problem. Family members are seen as mutually regulating each other's behavior so that changes in any part of the family system affects the functioning of the other parts (Minuchin, Rosman, Liebman, and Baker, p. 2).

In the same study by Minuchin et. al., which later evolved into a full length book entitled Psychosomatic Families: Anorexia Nervosa in Context, 16 therapists worked with 53 anorexic patients and their families over a period of six years. The characteristics of the patients are described as follows:

> Patients came from a variety of middle and upper middle class backgrounds; all were white. Six of the patients (11% of the group) were male. Their cases and course of treatment were similar to those of the girls. Patients were diagnosed as

Table 3

SUMMARY OF TEN CASES OF INTRACTABLE ASTHMA

Patient No.	Referral Time: Sex-Age,yr	Age at Onset	Steroid Dependent	Clinical Severity, Grade*	Duration Family Therapy	Current Status Grade*	Follow-Up Post Therapy
1	F-8	3 yr	Yes	3	7 mo	1	2 yr 8 mo
2	F-12	3 yr	Yes	3	6 mo	1	2 yr 2 mo
3	F-12	15 mo	Yes	3	9 mo	1	1 yr 8 mo
4	M-16	11 yr	No	3	5 mo	1	3 yr 2 mo
5	M-14	18 mo	Yes	4	22 mo	2	2 yr 2 mo
6	M-8	6 yr	Yes	3	8 mo	1	1 yr 2 mo
7	M-11	3½ yr	Yes	3	6 mo	1	2 yr
8+	F-11	1 yr	Yes	3	11 mo	1	1 yr 11 mo
9	M-12	18 mo	Yes	4	Ongoing	2++	10 mo
10	F-6	6 yr	No	2	Ongoing	1++	9 mo

*Pinkerton (1970) Scale for Evaluation of Clinical Severity of Asthma; Grade 1, no school loss, mild attacks, occasional need for use of bronchodilator; grade 2, days off from school, mild to moderate attacks, need for regular use of bronchodilator; grade 3, weeks off school, more prolonged and severe attacks, steriod plus bronchodilator therapy; grade 4, more than 50% school loss, persistent symptoms, need for special schooling, regular steroid therapy.

+Asthma-free for past 17 months

++Treatment continuing for other problems

(Minuchin, et. al., 1975, p. 1036)

> anoretic on the basis of a weight loss of 20% or more body weight, not due to any organic cause as determined by the pediatricians. In our sample, the range of weight loss went from 20% to 50%, with a median of 30%. In their behavior and verbalizations the patients exhibited the pathognomic signs of anorexia nervosa: denial of hunger, delusional body image, and fear of fatness. Forty percent of the patients had been treated prior to referral to us, usually with some form of individual treatment; almost 20% had been previously hospitalized. The interval between onset and to us ranged from 1 month to 3 years; median time was 6 months; the median treatment was 6 months long. These figures do not include three cases who dropped treatment after two or three sessions [attrition of 6%] (p. 13).

Evaluation of therapeutic outcome was based on two general factors: degree of remission of the anorexia symptoms, and a clinical assessment of the patient's functioning in the home, school and socially. The evaluation was based on the patient's condition at the time of the therapy but also on information through a follow-up program. Patients, families and pediatricians were contacted at intervals ranging from three months to four years, with a median of one year. There was also a follow-up of 25% of the cases for a two-year period. The outcome was reported as follows:

> Of the 50 patients who continued treatment, 43 made complete recoveries from the anorexia, 4 were judged to be in only fair condition, and 3 were improved, and were transferred elsewhere for treatment with some success. Within the recovered group, 2 of the children relapsed, were treated again and have remained in recovered condition for 6 months or more. If we count only the absolute recoveries, we can say we have achieved 86% successful outcome. Since most published samples of this size report rates more closely approaching a 30-49% improvement rate on follow-up, we consider our findings to be substantial evidence of effective psychotherapy.
>
> Results of the clinical assessment have been similarly gratifying. Forty-four of the patients were rated as making a

> good adjustment, 3 as only fair, and 3 unimproved. Counting only the satisfactory adjustments, the outcome is 88% effective (Minuchin, et. al, p. 14-15).

This study demonstrated that a different therapist could utilize the same theoretical model and obtain results. This article also provides a basic overview of structural family therapy.

In a study by Palazzoli, Boscolo, Cecchin and Priata (1974), they reported on the successful resolution of behavioral problems (encopresis and anorexia, respectively) in two children through the use of brief therapy with the patients (p. 429).

The first case involved a nine year old child with a problem of encopresis. Goldenson (1970) defines encopresis as involuntary defecation not caused by organic defect or illness (p. 393). The child soiled his pants every day at school, entertained his friend with "incredible stories," and wrote school compositions filled with lies and fantasies.

The therapists worked through the parents to impact on the family system and treatment was terminated after seven sessions. The authors claim the treatment resulted in an end to the encopresis and that everything was going well in school. A telephone follow-up was conducted in three months time with the same positive results.

In the second case, a young married couple requested help for their two year old daughter who had been suffering from anorexia for the last six months. In the fifth and last session, the therapists prescribed a dramatic intervention . . . a rite (symbolic burial of

an infant brother who had recently died) involving all three family members and designed to convey to Marella (the identified patient), who was only at the beginning of the verbal phase of her development, a clear and unequivocal message that the younger brother had died . . . that same afternoon Marella was found playing in her room chewing with great appetite a large piece of bread which she had fetched from the kitchen (Palazzoli et. al., 1974, p. 438). The authors report that a follow-up was conducted six months later and Marella "continued to do well." This article is of particular interest for clinicians in that it clearly explains intervention techniques that may be replicated.

Selvini Palazzoli et. al. (no date), describe, in detail, the first session of family therapy with a patient seriously suffering from anorexia (p. 1). The authors present the identified problem as such:

> When the Sala family contacts our Centre telephone, Antonella has been anorexia for five months. Because of the frightful quick loss of weight--more than thirty pounds in two months--she had been sent four times to a hospital without ever improving. . . . The date of the first session, Antonella is in such a state of emaciation (weight is 70 pounds, 5 ft. 9 in. tall) that her life is endangered (p. 2).

There is no contact with the family before the second session (no indication of time between sessions) and the following is reported after the second session:

> The mother looked depressed, her face worn out, says that Antonella has begun eating again, though, according to the girl herself, she

> does it with effort and lack of appetite. Even at night she gets up to eat and drink something. . . . Antonella looks better physically, her face is not as thin as it was, her dress is smarter and her hairdressing is becoming (p. 16).

The authors provide a good explanation of the therapeutic strategies used in the first session which is in marked contrast to the majority of family therapy case studies reviewed. However, it would be difficult to determine if Antonella's improvement is of a permanent nature since the authors report the results of only one session and one follow-up study.

Family Therapy and Hearing Impairment

The Committee on Nomenclature of the Conference of Executives of American Schools for the Deaf proposed the following classifications and definitions:

> 1. The deaf: Those in whom the sense of hearing is non-functional for ordinary purposes of life. This general group is made up of two distinct classes based entirely on the time of the loss of hearing:
>   (A) The congenitally deaf: Those who were born deaf
>   (B) The adventitiously deaf: Those who were born with normal hearing but in whom the sense of hearing became non-functional later through illness or accident
> 2. The hard of hearing: Those in whom the sense of hearing, although defective, is functional with or without a hearing aid (Cruichshank, 1971, p. 420).

As in the case of families with other special needs children, the first time that a family determines that a child is auditory impaired often results in a disruption to the entire family. Although

deafness may occur at any time as a result of accidents or illness, deafness in an infant or young child is often denied or rationalized by the family especially the parents. Mindel and Vernon (1971) point out in their book entitled, They Grow in Silence: The Deaf Child and His Family, the following observation:

> That this recourse to denial and accompanying rationalization has been noted by numerous workers. When early childhood specialists, physicians or even friends and neighbors make the family aware of the hearing handicap, the initial reaction on the part of the parents is often one of sadness and grief which culminates in anger toward the deaf child. In turn, this anger translates into guilt and a vicious cycle of negative feelings within the family (p. 14).

Mindel and Vernon (1971) also point out the following:

> That rage and depression pervade the relationship within families containing a deaf child and this remains a chronic source of friction and distress (p. 16).

In a study by Robinson and Weathers (1974), family therapy was used with a family in which the parents were deaf and mute and their three children could hear. The presenting problem was a "life-threatening weight loss in a ten-year-old boy who had bizarre eating habits" (p. 235). According to the parents:

> Johnny (the identified patient) began losing weight and acting strangely, putting food in his mouth but not ingesting it and expressing much concern about body building. During the same period, he was underachieving in school and began getting unsatisfactory grades in conduct (Robinson and Weathers, 1974, p. 326).

Co-therapists worked with the family over a six month period for

a total of 11 sessions. Sign language and finger spelling were used to communicate with the parents. At the end of the eleven sessions, the therapists had achieved their goals as indicated by a follow-up study. The therapists contacted the boy's pediatrician and found he was no longer shy and expressing body fantasies. He weighed 63 pounds, a 24 pound gain from his lowest of 39 pounds (Robinson and Weathers, 1974, p. 330). He had also improved in his school work as reflected by his report card.

In a study conducted at the Family and Marriage Clinic, University of Rochester School of Medicine and Dentistry by Shapiro and Harris (1976), 24 deaf children and their families were referred for family therapy; however, only three families agreed to participate. In all cases, a trial of individual therapy was attempted unsuccessfully due to various problems such as lack of motivation. The family therapy was conducted over a period of several weeks, and for all three cases positive gains were reported by the therapists and supervisors. From these results, we gained the impression that family therapy proved the most feasible and beneficial when the deaf patient was a child or adolescent (Shapiro and Harris, 1976, p. 89).

The authors emphasized a point of caution about their findings. The study was not intended to be a systematic study of the various types of therapy for the deaf. Instead, it was a first-time adventure in the use of family therapy with families of the deaf.

The authors do provide a case study of a 17 year old deaf female

with the following presenting problems: insomnia, depressive mood, poor appetite, and uncontrollable crying spells and a suicidal threat. After individual therapy was attempted with no success, family therapy was initiated on a weekly basis. Participants in the family therapy sessions were:

> The identified patient, her parents, her two younger sisters (15 and 10), her aunt (her mother's sister-in-law), her maternal grandmother, and a cousin, also age 17 years (aunt's daughter). The patient sat next to the deaf therapist with an expression of distrust and anger. Father sat at a distance from the mother with the youngest daughter separating them. The mother sat close to the aunt and grandmother, and the three women frequently conferred with each other (Shapiro and Harris, 1976, p. 9).

The authors provide an excellent explanation of the dynamics working within this family. The case is made more interesting as the authors claim that it is "of particular interest because it is fairly typical of the problems presented by deaf patients and their families"(p. 94). The disruptions in communication, the pervasive guilt and rage, the denial of deafness, and the parental conflicts were all strongly in evidence in this family. . . . To have focused on the girl alone as the source of problems would have been limiting and misleading; she was clearly representative of a whole family system experiencing pain and confusion (Shapiro and Harris, 1976, p. 94).

This article brings up some critical issues: a lack of research in this area; lack of family therapists trained to work with the deaf;

tremendous resistance to engage in family therapy on the part of these families (more so than non-deaf member families).

Shapiro and Harris (1976) conclude that:

> The application of family therapy to problems of the deaf is still too recent and infrequent to yield definitive conclusions as to the applicability and effectiveness of this method of treatment (p. 94).

Nevertheless, our two years of trial-and-error attempts to treat deaf patients with their families resulted in sufficient gains to convince us that family therapy should be given serious consideration as an effective means of working with the deaf (p. 95).

Orthopedic Handicaps and Special Health Conditions

Statement of the problem. Chapter 766 makes this particular category unique and potentially very costly for public school administrators. According to Chapter 766 (1978) regulation 502.7 (a):

> Each school committee will prove a type A home or hospital program to each child, who, in the judgement of the child's physician, will have to remain at home or in the hospital on a day or night basis or any combination of both, for a period of not less than fourteen or more than sixty days during any school year, in order to not endanger the health or safety of such child or that of others. . . . (p. 58).

Thus, the decision is made only by a physician (psychiatrists included) and does not involve the educational administrator whose school committee must pay for the child's educational program in either the home or the hospital. However, Chapter 766 regulation 502.7 (a)

further states:

> . . . the school committee shall provide such physician with information presenting the programs which the school system could make available as alternatives to the home or hospital program (p. 58).

The key phrase in this regulation is "alternatives to the home or hospital program." The use of family therapy may be a possible alternative to home or hospital placement if it can be demonstrated that it is successful with certain special health conditions.

The potential for costly, individualized special education programs is implied in an article by Sampson (1975), entitled, "The Child in Renal Failure: Emotional Impacts on the Child and His Family." Specifically studied is the handicapping effect which such medical advances can cause on the child and his family:

> Recent medical science and technological developments create social and emotional problems that necessitate new adjustments on the part of society, and an individual's inability to adapt may result in an increasing number of emotional problems due specifically to such medical advances. Kidney transplants and chronic hemodialysis (treatment by an artificial kidney machine) are two sources of concern on the part of mental health professionals (p. 464).

Although transplant operations and hemodialysis are usually successful from a medical point of view, the psychological impact on the family and the individual patient may be severe. Gramone (1971) studied the impact of transplantation and dialysis on the family finding that chronic illness and treatment for the diseases were sources of severe strain even in the most secure and well-

adjusted families (p. 464). Quite often, families developed an overprotective attitude toward the child, fostering a feeling of fragility and dependency. Although most children can return to school within three months of surgery, the majority of children do not. This apprehension about returning to school is often due to feelings of inferiority, altered body image and identity problems. During this time of adjustment, school committees are still providing and paying for special educational programs while the child is at home.

The sophistication of modern medical technology makes these situations more common. A home or hospital placement, especially if unexpected, is a costly expenditure for a school committee to absorb. Sampson's research lends support to the notion that many of these children may return to school much sooner, and the fact that they are not in school may be harmful to their psychological and social development. Family therapists may assist in returning these children to school sooner while saving the school district money.

The brain-damaged patient. Todd and Satz (1980) present a case study of an adolescent and his family in an attempt to provide a detailed description of the multitude of problems created by an adolescent's verbal memory deficits and to foster greater collaboration between neuropsychologists and family therapists in their efforts to help families resolve their problems (p. 431). This study discusses various memory deficits associated with traumatic injury, in

addition, to a discussion of typical family responses to a brain-damaged family member.

The case study involved a brain-damaged person who was 17 years old at the time of the motorcycle accident that caused the injury. Two years after the injury, the boy was able to overcome (with tremendous support and assistance from his family) paralysis below the waist and regained his speech and short-term memory. The family had totally centered its life style around the boy to the detriment of family members. It was two and one-half years after the injury that the family finally accepted family therapy.

The family therapy sessions were held on a bi-monthly and monthly basis over a period of one year. Therapy resulted in assisting the parents and sister to resume a more typical life style (comparable to their pre-injury life style). The brain-injured patient became less cautious and passive, and he began to manage a modest budget, and to cook and shop for groceries. He became responsible for remembering various appointments and important information by using a calendar, his tape recorder and notebook for remedies (Todd and Satz, 1980, p. 437). This article provides some valuable information on the general issue of brain-injured patients, but more specifically, it provides an excellent example of the impact this type of injury can have on the functioning of an entire family. The results of the family therapy should be viewed with some caution as it would be difficult to determine if the family therapy was the variable that resulted in the change in the identified client and/or family.

The epileptic patient. Another special health condition is represented by epileptic children who can induce their own seizures; many of these children often have poor performance in school. Epilepsy is a nuerological symptom pattern with seizures that can take the form of brief absences of consciousness, motor or sensory symptoms with or without disruptions or consciousness or full generalized "grand mal" seizures (Libo, Palmer, Archbald, 1971, p. 506). These seizures are self-induced usually by rapid blinking or by waving a hand in front of the eyes to produce the flicker frequency that initiates the paroxysimal activity of the brain. Libo, Palmer and Archbald (1971) found in working with two families that both mothers were anxious and guilt ridden, unable to impose any limits or demands on their children for fear that such discipline would precipitate seizures. These were the different children in both families and neither had any duties or responsibilities commensurate with their age or ability . . . (p. 507). Although the researchers did not mention the number of sessions, specific techniques used, etcetera, the researchers concluded that both children showed improvement in functioning socially in school, and expressed more positive feelings about themselves (Lito et. al., 1971). The researchers' conclusions about why family therapy was successful are paraphrased as follows: first, the family therapy reduced guilt and anxiety enough to permit change in the family's pattern of handling the child's symptoms. Secondly, the involvement of all significant family members, especially fathers, is essential in bringing about effective change in the

family's structure.

Summary of Research

The research appears to demonstrate that there are two special needs categories where family therapy has strong treatment effects. In the first instance, it appears that these treatment effects are evident with psychosomatic disorders in children. The research conducted by Minuchin, Rosman, and Lubman (1974, 1975) is most notable. In the second instance, there appears to be a strong treatment effect when family therapy is used in cases of soft juvenile delinquency (juvenile status offenders). Gurman and Kniskern (1981) state:

> Family therapies are often more effective than individual psychotherapy even for problems that are not presented as interpersonal and which often are presented as individualized or intrapsychic.
>
> At present, no conclusive assessment can be made of the general comparative efficacy of behavioral vs other marital and family treatment methods. Such studies are nearly non-existent.
>
> Structured family therapy (Minuchin, 1974) thus far had received very encouraging empirical support for the treatment of certain childhood and adolescent psychosomatic symptoms, i. e., anorexia (Minuchin et. al., 1975, 1978, Rosman et. al., 1976) and asthma (Minuchin et. al., 1975) . . . (p. 749).
>
> The "systems-behavioral" family therapy of Alexander et. al. which incorporates both interventions derived from social learning theory and interventions based on family systems theories, has accumulated impressive outcomes in the treatment of families with adolescents involved with soft juvenile delinquency (p. 750).

However, as with most family therapy outcome studies, both of these areas of research require a great deal more investigation as well as a word of caution before accepting the research conclusion. The main problem with family therapy outcome studies is the lack of consistent

research design methodology among researchers. In the majority of studies, researchers and clinicians alike seem to conclude that family therapy was the variable that produced the treatment effect. However, the literature reflects little control on other variables that may effect treatment outcome. Wells and Dezen (1978) state:

> Uncontrolled single-group studies are the weakest method of outcome evaluation yet continue to be frequently reported in the literature. Such studies do have certain uses. In addition to their general legitimizing function, they offer a means of assessing the quality of service offered by a particular practitioner, clinic or agency. Most importantly they may identify specific techniques that merit further investigation. However, the results of such studies are virtually meaningless unless data on either spontaneous recovery rates or improvement rates from alternative treatments are available (p. 255).

At present, none of the research reviewed include as part of the research design that would generate data on either spontaneous recovery rates or improved rates from alternative treatments.

In addition, the literature also seems to point out the disruptive effect a special needs child may have on an entire family. Vellani (1980) states:

> The attitudes and emotional reactions of parents of a handicapped child are of critical importance in planning for the child's effective education. The birth of a handicapped child strikes at the vital emotional core of the parent. From the very outset parents may become frightened and concerned, guilty and anxiety ridden. They worry about the diagnosis, where to go for treatment, the slowness of progress, costs of medical expenses or about any of the hundreds of problems that can arise when they attempt to assist in the education of the child. Not only is the child involved, but each member of the family is affected by the complexity and severity of the handicap. A major portion of the therapeutic attention should be directed toward helping

> parents to see their children with sufficient realism to provide appropriate day to day care and plan for such eventualities as prolonged habitative treatment, special schooling, or residential placement (p. 47).

An understanding of the effect that a handicapped child may have on the family may serve a useful purpose to educators interested in doing preventive work with children--especially the siblings of a handicapped child. This information is particularly valuable in understanding, and eventually helping families with children manifesting orthopedic and special health conditions. These conditions have the potential to impose heavy costs on public schools by requiring a disproportionate amount of time, personnel, and money. Also, the results of this review seem to indicate that family therapy may assist in minimizing some of the adverse effects these various special needs conditions may impose on a family's emotional, physical, and financial resources.

Limitations of the Research

There are two major characteristics that emerge from reviewing family therapy outcome studies. First, the majority of the studies were written after the 1960's with each year reflecting an increasingly larger number of published works. Secondly, the quality of the outcome studies reflects numerous methodological problems in research design. The first characteristic of the research may easily mislead researchers into assuming that family therapy is a recent psychotherapeutic phenomena. However, as indicated previously, family

therapy began in this country with the birth of social work at the end of the 1800's. Despite family therapy's long history, it has only recently come to the forefront as a well-known and frequently used psychotherapeutic treatment and the literature reflects this recent interest.

Olson (1971) found that approximately 20 articles were published before 1959, and about 60 were published during the 1950's. A rapid increase in productivity occurred during the 1960's when over 250 articles were published (pp. 241-242). The past ten years, in particular have shown tremendous growth in the number of research outcome studies in family therapy. Wells, Dilkes, and Trivelli (1972), in one of the first reviews of outcome studies, found only "13 relevant reports with a total sample of 290" (p. 190). Gruman and Knisken (1978) presented the most comprehensive analysis of outcome research in marital and family therapy to date and were able to examine over 200 reports, with a total N approaching 5,000 (p. 742).

The second characteristic has to do with the quality of the research. Without question, there are numerous problems with the research which render many of the outcome study conclusions almost useless. This position has been supported numerous times by researchers concerned with the quality of family therapy outcome research. Pinsol (1981) states that the family therapy field is characterized by a plethora of theories about the nature and relative effectiveness of different techniques and by a dearth of research testing these clinical theories (p. 699). A statement by Ro-Trock, Wellish and Schoolar

(1977) provides more specificity to the criticism of family therapy outcome studies. Ro-Trock et. al. (1977) state:

> Currently, however, systematic evidence for the efficacy of family therapy lags behind interest in its use. An extensive review of family therapy studies and programs reveals a variety of methodological problems, including inappropriate experimental design, selection bias, unreliable or invalid measures, and failure to assess important variables at pre, post and follow-up points, all of which leave the outcome data in question (p. 514).

It appears that the quality of family therapy research has not made much progress in the last twenty years as reflected in two statements made by Olson (1967), and Parloff (1961). Olson states:

> The fields of marital and family therapy are youngsters in the professional world. Judged by the rigorous and rigid standards used in the physical sciences, they are found to be lacking in many of the fundamentals. The professional gaps between therapists, theorists, and researchers has not been effectively bridged so there is a dearth of research or empirical facts to built upon. Little is actually known about the process or effectiveness of the clinical approaches now in use. As a result the two fields are still operating with principles which are largely unverified and generally unrelated to their theoretical formulations (p. 270).

In the early 1960's Pardoff (1961) makes a statement that is strikingly similar to Pinsof's statement made in 1981. Pardoff (1961) refers to the field of family therapy when he states that the relevant literature is vast, yet very little of it would be classified by the investigation as research. Most of the contributions to the area have been clinician-naturalists who, having perhaps a Freud-like vision of themselves, have made salutory advances from observations to conclusions with a maximum of vigor and a minimum of rigor (p. 450).

Thus, several statements made over the past twenty years reflect

a tendency on the part of family therapy researchers to generate data that is frequently incomplete and unverified through empirical study. This is certainly true, in general, of the research identified in this study. If research can be directed or guided by systematic theory, this increases the likelihood that the results will contribute to the further development and organization of that theory. In other words, theory and research should ideally be integrated, and this integration would prove mutually beneficial. Theory could stimulate research and enhance the value of the findings, whereas research could test theoretically derived postulates and facilitate the development of improved ones (Olson, 1967, p. 266).

In summary, family therapy outcome studies must be viewed with caution due to problems associated with the experimental research designs. However, it is important to note that despite the numerous problematic research design issues, family therapy seems to be one of many psychotherapeutic treatments that may benefit special needs children and their families. Research conducted by Gruman and Kniskein (1978) found that 73% of family cases improved (p. 747). The data from uncontrolled investigations reveal a trend toward better outcome when the identified patient is a child or adolescent (71% improved) than when the identified patient is an adult (65% improved). Existing data do not allow a further discrimination between the outcomes of family therapy for child versus adolescent patients (p. 748).

CHAPTER III

METHOD AND DESIGN

Introduction

As was noted in Chapter II of this study, family therapy seems to be one of many psychotherapeutic treatments that may benefit special needs children and their families. In this chapter the method and design used to test the hypothesis that special needs students who have had family therapy written in as a component of their individual educational plans will experience a lowering of program category (prototype) will be described. Because there is presently little data available which indicate if family therapy is used by the schools, how it is used, and under what conditions, self-designed surveys will be used to gather information. These surveys will identify precisely the extent and/or limitation of the use of family therapy in the individual educational plans of special needs students in three public schools of the Commonwealth of Massachusetts.

Because the type of handicapping condition is not labeled or clearly identified on the individual educational plan (and is often not available any place in the student record), students will be categorized according to the amount (hours and minutes per week) of special education services received. The term prototype (program category) will be used as a coding system. Prototypes range from 502.1-502.6 (see pp. 7-8). The amount of time a student spends in

special education is an important variable because it affects the costs of special education--the cost increases as the amount of services increases, with few exceptions.

Focus of the Research

This study used a non-equivalent group design in which the control group and the experimental group did not have pre-experimental sampling equivalence (Campbell and Stanley, 1966, p. 47). The experimental group represents those special needs students who did not have family therapy as a component of their individual educational plans prior to the 1978-1978 school year, but for whom it was a component by the end of the 1978-1979 school year. The control group represents those whose individual educational plans lacked any component of family therapy during the 1978-1979 school year.

Each student of the experimental and control groups was identified with whatever prototype was available in September 1978. The results of the research focus, however, on a comparison of the original identifying prototype and the next program classification obtained as a result of an annual review or re-evaluation during the 1979-1980 school year.

Hypotheses of the Research

It was anticipated that the students who comprised the experimental group, when compared with the students of the control group, would experience a lowering of prototype after participating in family

therapy during the 1978-1979 school year; no difference or less of a trend was expected for the control group. It was also expected that there would be no percentage difference between the two groups with regard to the distribution of biographic data. Prototype 502.1 should have the smallest frequency of family therapy, and 502.4, the highest.

The following hypotheses are presented for the purpose of analysis:

HYPOTHESIS I — There is no mean percentage difference between the experimental and the control groups in the distribution of biographic data. Age and grade differences will be tested by a t-test; sex and primary special need differences will be tested by a chi square.

HYPOTHESIS II — At the time of the first observation of prototype for the experimental group, a larger percentage of subjects at the higher prototype levels will have participated in family therapy than those at the lower prototype levels. At the time of the second observation of prototype, there will be a decrease in subjects in the higher prototype levels.

HYPOTHESIS III — At the time of the second observation of prototype the mean prototype of the experimental group will have a significantly lower mean prototype than for the control group as tested by a t-test. The probability of this difference being due to chance is less than .05.

HYPOTHESIS IV During the 1978-1979 and the 1979-1980 school years, there was a direct relationship between the per pupil expenditures and prototype such that the lower the prototype, the lower the per pupil expenditure.

Research Design

An archival research approach was conducted to review the individual educational plans for all special needs students in three public school systems for the school years 1978-1979 and 1979-1980, for purposes of pre- and post- test analysis.

An analysis of covariance (Brunning and Kintz, 1977) was done to compare the 1979-1980 prototypes for the experimental and the control groups to determine if there was significant difference because, even if the hypothesis appeared to be valid for the 1978-1979 school year, one could not conclusively determine that a family therapy component in the individual educational plans was exclusively responsible for the lowering of prototypes. This covariance analysis controlled for the fact that there existed a significant difference between prototypes to begin with in the 1978-1979 school year, in terms of the original prototype. In order to make suggestions for program and budget change, a 25-30 percent decrease in prototype would be needed.

Schools selected. Three public school systems were selected for their willingness to allow an archival research project which would avail itself of student records. The three public school systems are:

1. Agawam Public Schools, Agawam, Massachusetts
2. Gateway Regional School District, Huntington, Massachusetts
3. Amherst Schools, Amherst, Massachusetts

These three public school systems represent the towns of Agawam, Amherst, Blandford, Chester, Huntington, Middlefield, Montgomery, Pelham, Russell, and Worthington. Each town is located in the western part of the Commonwealth of Massachusetts.

Years selected. So that this study could be applicable and replicable outside of the Commonwealth of Massachusetts, the school years selected for research (1978-1979 and 1979-1080) represent the school years when Public Law 94-142, The Education of All Handicapped Children, was to be implemented across the country. As a result of this federal public law, all public school systems, nationally, were required to provide special education students with appropriate educational services as well as implement all aspects of this public law:

> . . . for all handicapped children aged three through eighteen within the State and not later than September 1, 1978, and for all handicapped children aged three through twenty-one within the State not later than September 1, 1980 (Federal Register, 1977, p. 42481. Public Law Regulation 121 a. 122 Time Line and Ages for Free Appropriate Public Education).

Subjects selected for review. The subjects selected for review included those students who met the following criteria:

1. The ages of the subjects may range from three years old through twenty-one years old. This criterion is based on the same age criteria as both Chapter 766 and Public Law 94-142.

2. The subjects must have a special education individual educational plan signed and approved (signed by either parents or guardians) for the 1978-1979 school year. A signed and approved individual educational plan will identify the student as a special needs student.

3. Participation in family therapy by the subject and one adult member of the family

4. Attendance in at least one family therapy session

Data Collecting Instruments. Data for this study was collected using the following two surveys:

1. Survey I. Student Data. Appendix B

2. Survey II. Local Education Agency (LEA) Data. Appendix C

These surveys were pilot tested by the researcher in the fall of 1981 for the purposes of determining their clarity and usefulness in researching the stated purpose of this study. At that time the constructive comments and suggestions made by several public school special education administrators regarding the refinement and simplification of the surveys were incorporated into the present form.

Research Procedure. The random selection of the control group was designed to correspond in terms of the proportion to the various prototypes in the experimental group. The only constant, therefore, was prototype. Each special needs student who had family therapy written in his/her individual educational plan for the 1978-1979 school year in the school district under review was identified. The prototype for each student was noted for the 1978-1979 and 1979-1980 school

years. The group of students identified as having family therapy written into their educational plans was subdivided. Those students who actually participated in family therapy with an adult member of the family one time comprised the experimental group. The same number of students for each prototype identified as belonging to the experimental group was randomly selected to form the control group, the group which did not receive family therapy; e.g., if fifteen 502.2 special needs students with family therapy written into their 1978-1979 individual educational plans were identified, fifteen 502.2 special needs studens who did not have family therapy as a component of their individual educational plans for the 1978-1979 school year were randomly chosen.

Survey I, Student Data. This survey was used by the researcher when reviewing each subject's special education file with a focus on the individual educational plan. The researcher first identified all individual education plans which included family therapy as a component during the 1978-1979 school year; he then completed the survey, identifying those students who actually participated in family therapy. Secondly, the researcher identified the control group by randomly selecting the same number of subjects by prototype who did not have family therapy written into their individual educational plans.

Biographic data was collected to include age, grade, program category (prototype), primary educational special need and sex for each subject identified. This data was analyzed by each school system

resulting in a compilation of data for all the school systems. The above data was examined in the following ways:

1. Subject breakdown by age, grade, program category, primary educational special need and sex by school system
2. Compilation of biographic data for the three school systems
3. Breakdown as to the manner family therapy was written into individual educational plans as well as the means public schools used to determine effectiveness

Survey II, LEA Data. The researcher completed this survey for each of the public school systems used in this study. The purpose of this survey was to collect information related to the number of regular and special education students, special education per pupil expenditures per program category, number of special education students per program category and number of special education students receiving family therapy. Survey II was designed to collect subject specific data.

Data collected with Survey II enabled comparisons between the three different school systems. The data collected with this survey was examined by means of the following:

1. A compilation of the total number of both special and regular education students enrolled in the three school systems; percentage of special education students in the regular education student population; number and percentage of special education students with family therapy written on the individual educational plan as well as the number of stu-

dents participating in family therapy

2. A compilation of per pupil expenditures for each program category--prototypes 502.1-502.6 in each school system; number of special education students in the various program categories--prototypes 502.1-502.6

Limitations of the Study

The primary hypothesis of this study was that the experimental group of special needs students would experience a lowering of special education program category when family therapy was a component of their individual education plans. This was studied by ascertaining whether family therapy was or was not an actual component of the individual educational plans and by identifying the program classifications before and after family therapy. However, there were many uncontrolled variables which might limit our knowledge of the full effectiveness of family therapy with special needs children and their families, such as the personality and training of the therapist, the theoretical approach and techniques used in therapy, the influence that the handicapping conditions may have on the therapeutic outcome. The researcher assumed that student records were complete in and of themselves; however there was no guarantee that this would be the case. Although the primary researcher double-checked all data collection, the possibility exists that errors in the compilation of data may have existed.

There also exists an unavoidable limitation to the study in respect to its size, despite an estimate that well over 1,000 indivi-

dual files were researched. The population research survey was restricted to special needs public school students in three western Massachusetts communities; the results may or may not be related to a national population. It must also be remembered that the instruments used with this investigation were created to elicit answers to the specific questions of this study, and have not, except for pilot-testing, been previously field tested.

Implications of this Study

It was expected that this study would reveal how many special needs students and their families received family therapy as a component of their individual educational plans in the school systems studied.

Further, it was hoped that educators, especially special education administrators would be encouraged to view family therapy as a possible psychoeducational treatment that might be used by school personnel who have been properly trained and supervised. This in turn, may encourage quality in-service training for school counselors and school psychologists in lieu of spending monies for out-of-district placements which do not improve the quality of services to the majority of special needs students who are not in out-of-district placements. Additionally, special educators should become more aware of the need to evaluate the effectiveness of individual educational plans in order to determine the quality and outcome of educational services for special need students.

Finally, we hoped to prove that family therapy might be an additional option which public school educators and special education administrators might use to keep down the costs of educating handicapped children as well as to assist in their mainstreaming, as required both by Chapter 766 and Public Law 94-142. The use of family therapy might provide a preventative therapeutic intervention for siblings of the special education child as well.

CHAPTER IV

RESULTS

In Chapter IV the results of this investigation are presented as they apply to each of the hypotheses stated in Chapter III. Comparisons between experimental and control groups are presented with regard to the differences in age, grade, sex and primary special need of the students evaluated; differences in percentage of students in the experimental group at the upper prototypes in comparison to lower prototypes are determined; a comparison is made of the experimental and control groups in terms of the changes in prototypes at the time of the second observation, with identification of the number of subjects having family therapy written into their individual educational plans as well as the number who participated in family therapy and related biographic data; finally, a comparison is made between experimental and control groups as related to per pupil expenditures and prototypes during the 1978-1979 and 1979-1980 school years, with the use of family therapy as an alternative to more restrictive educational placements and the monetary savings resulting from the use of family therapy are determined. This chapter concludes with a summary of the findings.

It was predicted that there would be a reduction in special education services (as reflected by prototype classification) that a student would receive as a result of the introduction of family therapy during a given school year. This reduction in prototype would corre-

education population) were identified as having family therapy written into their individual educational plan. Fourteen of the nineteen (74%) had met the criteria for participation in family therapy.

1,850 students were enrolled in public school system A-III during the 1978-1979 school year. During this first period of observation, 159 (9% of the total school population) were special education students. Thirteen special education students (8% of the special education population) were identified as having family therapy written into their individual educational plan; of the thirteen, ten (77%) met the criteria for having participated in family therapy.

Table 4

Distribution of Subjects by Public School Systems
Total and Special Education Enrollment

Public School System	Students Enrolled (Total)	Special Education Students (Total)	Percentage Special Ed Population
A-I	5,240	510	10%
A-II	3,846	420	11%
A-III	1,850	159	9%
TOTAL ENROLLMENTS	10,936	1,089	AVERAGE 10%

Special Education Enrollment Group Division

The experimental (E) group represents those special education students who had family therapy written into their individual educational plans during the pre-observation period (the 1978-1979 school year). In addition, those subjects (the E group) must have actually participated in family therapy at least one time with an adult member of the family. The control (C) group were special education students who did not have family therapy written into their individual educational plans during the pre-observation period. The control group (C) is matched to the E group by prototype and subjects.

Number of Individual Educational Plans Which Contain a Family Therapy Component

Family therapy was written into the individual educational plans for forty-one subjects at the time of the pre-observation period, the 1978-1979 school year. During this same period of time the total enrollment of special education students in the three school systems investigated was 1,089. Only 4% of the special education enrollment during the 1978-1979 school year, then, had family therapy written in as a component of their individual educational plans. Table 5 reflects these figures.

Table 5

Distribution by Public School Systems of Special Education Enrollment and of those Subjects with Family Therapy Written into their Individual Educational Plans

PUBLIC SCHOOL SYSTEM	SPECIAL ED ENROLLMENT	SUBJECTS WITH FAMILY THERAPY WRITTEN INTO INDIVIDUAL ED PLAN
A-I	510	9
A-II	420	19
A-III	159	13
TOTALS	1,089	41

Number of Family Therapy Sessions Attended by Subjects in E Group

Family therapy was written into the individual educational plans of forty-one subjects at the time of the first observation (during the 1978-1979 school year). The researchers were able to confirm verification of participation for thirty-two subjects. The criterion established for participation was two-fold: 1) participation in family therapy by the subject and one adult member of the family; and 2) attendance in at least one family therapy session. The researcher confirmed compliance with the established criterion in one of three ways; verification by 1) parent; family therapist; or by paid purchase orders of the school department. As is reflected in Table 6, 78% (thirty-two) of the subjects who had family therapy written into their individual educational plans actually participated in family therapy.

Table 6

Identification of E Group Subjects and Number of Family Therapy Sessions attended by Subjects in E Group at the Post-Observation Period (1979-1980 School Year)

SUBJECT	PROTOTYPE	NUMBER OF FAMILY THERAPY SESSIONS ATTENDED
1	502.3	10
2	502.3	4
3	502.2	6
4	502.2	16
5	502.2	4
6	502.2	7
7	502.4	24
8	502.4	24
9	502.4	2
10	502.3	36
11	502.4	4
12	502.2	75
13	502.2	36
14	502.2	15
15	502.4	2
16	502.2	2
17	502.5	50
18	502.5	35
19	502.2	40
20	502.2	9
21	502.6	32
22	502.2	7
23	502.4	24
24	502.3	24
25	502.3	75
26	502.3	20
27	502.2	75
28	502.3	16
29	502.2	5
30	502.2	37
31	502.1	7
32	502.3	13
N=32		MEAN 23

The mean number of family therapy sessions in which the E group subjects participated was twenty-three, ranging from two to seventy-five sessions attended. Subject participation in family therapy, for some subjects, continued into the next school year, 1979-1980. Three students each attended two sessions while the same number attended seventy-five sessions. Identification of students by number, prototype and number of sessions attended is listed in Table 6.

Results of this Investigation by Hypothesis

HYPOTHESIS I There is no mean percentage difference between the experimental and the control groups in the distribution of biographic data. Age and grade differences will be tested by a t-test; sex and primary special need differences will be tested by a chi square.

Distribution of subjects in the E and C groups by age. There was an eleven year spread of years between the youngest and the oldest subjects in the E group. The determination of age was based on the nineth month (September) of the 1978-1979 school year (the first month of the pre-observation period). Each subject's age was rounded off to the nearest year to determine age. The distribution of E group subjects by age appears to have a clustering effect (Table 7). There were fifteen subjects of the thirty-two constituting the E group (47% of this group) ranging in age between ten and thirteen years old. It may be speculated that the onset of pubescence is one of the factors which contributes to a student's being referred to family counselors since student changes during this period of time may result in negative

experiences for both the home and the school. In addition there may be significant adjustment difficulties for the student as he or she leaves the elementary school and its curricula and encounters a new environment.

In the C group there is a ten year spread of age between the youngest and the oldest subjects. The C group differs from the E group in that there is less of a clustering effect; instead there is a much greater distribution between the ages of six and eighteen.

There was a significant difference between the ages of the subjects in the two groups [$t(60)=2.24$; $p < .05$]. The mean age of the students in the E group was 11.625 years; in the C group it was 9.866 years. The data does not support the hypothesis that there is no mean difference between the two groups.

Table 7

Distribution of Subjects in the Experimental and Control Groups by Age

AGE	EXPERIMENTAL SUBJECTS	CONTROL SUBJECTS
NOT AVAILABLE	0	2
5	0	3
6	2	2
7	1	3
8	4	6
9	1	0
10	4	2
11	2	2
12	4	3
13	5	6
14	2	1
15	4	2
16	2	0
17	1	0
18	0	0
TOTAL	32	32

Distribution of subjects in the E and C groups by grade. All grades except K and the first have representation of E group students. Grades two, six and nine are the grades with the highest number of students, each having four. The distribution between grades Pre-school to grade six is identical for E (fourteen students) and C (fourteen students) groups. Distribution of students from grades seven to twelve is almost identical for E (twelve students) and C (ten students) groups as is reflected in Table 8.

An analysis of the data demonstrates that there was no significant difference between the grade levels of the E group and the C group [$t(47)=1.488$; $p > .05$]. The mean grade for the E group was 6.48 and for the control group it was 5.17.

Table 8

Distribution of Subjects in the Experimental and Control Groups by Grade at the Pre-observation Period (1978-1979 school year)

GRADE	EXPERIMENTAL GROUP	CONTROL GROUP
Pre	0	0
K	0	1
1	0	3
2	4	3
3	2	0
4	1	3
5	3	3
6	4	1
7	1	3
8	3	4
9	4	2
10	1	0
11	2	1
12	1	0
UNGRADED	0	0
NOT AVAILABLE	6	8
N=	32	32

Distribution of subjects in the E and C groups by sex. Of the thirty-two subjects identified as having family therapy written into their individual educational plans in the E group there were five females (16%) and twenty-seven males (84%). Of the thirty-two subjects randomly selected in the C group except for matching prototype to the E group prototype there were twelve female subjects (38%) and twenty male subjects (62%). It is clear that males (78% of the subjects) are more likely to have family therapy written into their individual educational plans than are the female subjects (22%). Analysis of the data demonstrates that there was no significant difference between the E group and the C group in regard to the distribution of males and females in each group [$X^2(1)=2.86$; $p > .05$].

Table 9

Comparison of Distribution by Sex in the E and C Groups

	EXPERIMENTAL GROUP		CONTROL GROUP
SEX	SUBJECTS WITH FAMILY THERAPY WRITTEN INTO INDIVIDUAL EDUCATIONAL PLANS	SUBJECTS WHO PARTICIPATED IN FAMILY THERAPY	SUBJECTS WITHOUT FAMILY THERAPY WRITTEN IN IEP
FEMALE	9	5	12
MALE	32	27	20
N=	41	32	32

Distribution of subjects in the E and C groups by primary special need. As is reflected in Table 10 there was a significant difference between

the E group and the C group in regard to the types of special needs. Emotional disturbances represented the primary special need in the E group, twenty-two subjects (69%), while six subjects (19%) were learning disabled; three (9%) were classified as having a combination of special need conditions; and one subject (3%) was visually impaired. In contrast to the E group, the C group had learning disability as the primary special need, twenty-two subjects (69%). Further distribution of primary special need in the C group was as follows: combination of emotional disturbance and learning disabled, three subjects (9%); emotional disturbance, three subjects (9%); mental retardation, two subjec-s (6%), hearing impaired, one subject (3%); data was not available on one subject (3%).

Analysis of the data reveals almost a reversal in distribution between E and C groups in the categories of emotional disturbance and learning disabled--6% of the E group and 9% of the C group were classified as having emotional disturbance as the primary special need while 69% of the C group and 19% of the E group were learning disabled. The fact that the E group had the highest percentage of subjects in the emotionally disturbed category seems logical since one would assume that family therapy would be recommended to those students and families manifesting problems of an emotional nature.

In short, emotional disturbances seem to represent the primary special need among the majority of subjects in the E group while learning disabilities predominate in the C group [$X^2(4)=25.914$; $p < .01$]. The proposed hypothesis of no mean difference is supported in regard

to the grade and sex of the subjects; however, the hypothesis is not supported in regard to primary special need and age.

Table 10

Distribution of Subjects in the Experimental and Control Groups by Primary Special Need at the Pre-Observation Time (1978-1979 School Year)

PRIMARY SPECIAL NEED	EXPERIMENTAL GROUP	CONTROL GROUP
Mental Retardation	0	2
Emotional Disturbance	22	3
Learning Disability	6	22
Visual Impairment	1	0
Hearing Impairment	0	1
Combination of Factors	3	3
Not Available	0	1
N =	32	32

HYPOTHESIS II At the time of the first observation of prototype for the E group, a larger percentage of subjects at the higher prototype levels will have participated in family therapy than those at the lower prototype levels. At the time of the second observation of prototype, there will be a decrease in subjects at at the higher prototype levels.

Distribution of subjects in the E group by prototype at the time of the first observation. Massachusetts Public Law, Chapter 766 has defined prototype classification as follows:

Prototype 502.1: Regular education with modifications (no

direct special education).

Prototype 502.2 Regular education program with no more than 25% time in special education.

Prototype 502.3 Regular education with no more than 60% in special education.

Prototype 502.4 Substantially separate program (little or no regular education.

Prototype 502.5 Day school program (private day school)

Prototype 502.6 Residential school program (24 hour, seven days a week placement).

Prototypes 502.1, 502.2, 502.3 represent the lower prototype level while 502.4, 502.5 and 502.6 denote the higher prototype level. As is demonstrated in Table 11, at the time of the first observation (the 1978-1979 school year) 75% of the E group (twenty-four subjects) constituted a lower prototype level and 25% (eight students) composed the higher prototype level.

Table 11

Distribution of the Experimental Group Subjects by Prototype at the Time of Pre-Observation (1978-1979 School Year)

PROTOTYPE	EXPERIMENTAL GROUP
502.1	1
502.2	15
502.3	8
502.4	6
502.5	2
502.6	0
N =	32

Distribution of the subjects in the E group by prototype at the time of the second observation. At the time of the second observation (the 1979-1980 school year), there were 69% of the E group students (twenty-two subjects) in the lower prototypes and 31% (ten subjects) in the higher prototype levels (Table 12).

Table 12

Distribution of the Experimental Group Subjects by Prototype at the Time of Post-Observation (1979-1980 School Year)

PROTOTYPE	EXPERIMENTAL GROUP
502.1	0
502.2	15
502.3	7
502.4	5
502.5	4
502.6	1
N =	32

Comparison of the prototype distribution of subjects in the E group at the Time of the Pre- and Post-Observation. There is a 6% decrease (two subjects) in the distribution of the lower level prototypes at the time of the second observation and a corresponding increase of 6% (two subjects) for the higher prototypes. The data does not support the hypothesis.

HYPOTHESIS III At the time of the second observation of prototype the mean prototype of the experimental group will have a significantly lower mean prototype than for the control group as tested by a t-test. The probability of this difference being due to chance will be less than .05.

Distribution of subjects in the experimental and in the control group by prototype. It had been assumed that at the time of the second observation (the 1979-1980 school year) that the introduction of the independent variable--family therapy--would result in a lower mean prototype for the experimental group than for the control group. Table 13 provides an overview of the distribution of students by prototype at the time of both the pre- and post-observation. During the post-observation period, prototype 502.2 had the highest number of subjects for both the *E* (eleven subjects) and the *C* (fifteen subjects) groups; prototype 502.3 had the next highest number of subjects for both *E* (ten subjects) and *C* (seven subjects) groups. At the time of the pre-observation period, 75% of the subjects in both the control and experimental groups had prototypes in the lower prototype levels. At the time of the second observation period, 72% of the control group and 69% of the experimental group had prototypes in the lower prototype levels. The assumption that family therapy would lead to a lower mean prototype for the experimental group than for the control group was not supported by the data. There was no significant difference between the mean prototype for the experimental group and the control group after the subjects had participated in family therapy for those subjects in the experimental group [$t(62) = .44$; p .05].

Table 13

Distribution of Subjects by Prototypes between the Pre- and the Post-Observation Periods for the Experimental (E) and the Control (C) Groups

Prototype	1978-79 School Year First Observation			1979-80 School Year Second Observation		
	Control	Experimental	Total Enrollment by Prototype	Control	Experimental	Total Enrollment by Prototype
502.1	1	1	84	2	0	64
502.2	15	15	595	11	15	711
502.3	8	8	189	10	7	190
502.4	6	6	120	6	5	128
502.5	2	2	27	3	4	36
502.6	0	0	11	0	1	19
TOTAL	32	32	1026	32	32	1148

Data Source: Survey II, LEA Data

Table 13 reflects only those special needs students classified in prototypes 502.1 through 502.6. There are several other prototypes under Chapter 766. Those prototypes, however, are not related to this research project.

Changes in prototype for the experimental and the control groups between pre- and post-observation. There was no change in prototype from the period of first observation (the 1978-1979 school year) to the second period of obsercation (the 1979-1980 school year) for twenty-three subjects in the experimental group who did participate in family therapy. Seven subjects increased in prototype. Conversely, two subjects decreased prototype.

In the control group there was no change in prototype from the pre- and post-observation period for twenty-eight subjects. Four subjects increased in prototype. There were no subjects in the *C* group who decreased in prototype.

Analysis of the data (Table 14) suggests that differences in the *E* group between the first and second observations were not significantly different from the differences in the *C* group for the same time period. Family therapy produced no more change in prototype over the year than did no family therapy (*C* group treatment) [$t(31) = .53$; $p < .05$].

Table 14

Change in Prototype by Subject from First Observation (1978-1979 School Year) to Second Observation (1979-1980 School Year)

Subject	Control Group			Experimental Group		
	Pre 1978-1979	Post 1979-1980	Change	Pre 1978-1979	Post 1979-1980	Change
1	502.3	502.3	0	502.3	502.3	0
2	502.3	502.3	0	502.3	502.3	0
3	502.2	502.2	0	502.2	502.2	0
4	502.2	502.2	0	502.2	502.5	-3
5	502.2	502.2	0	502.2	502.2	0
6	502.2	502.2	0	502.2	502.2	0
7	502.4	502.4	0	502.4	502.3	1
8	502.4	502.4	0	502.4	502.4	0
9	502.4	502.5	-1	502.4	502.5	-1
10	502.3	502.3	0	502.3	502.4	-1
11	502.4	502.4	0	502.4	502.4	0
12	502.2	502.2	0	502.2	502.4	-2
13	502.2	502.2	0	502.2	502.2	0
14	502.2	502.2	0	502.2	502.2	0
15	502.4	502.4	0	502.4	502.4	0
16	502.2	502.2	0	502.2	502.2	0
17	502.5	502.5	0	502.5	502.5	0
18	502.5	502.5	0	502.5	502.6	-1
19	502.2	502.4	-2	502.2	502.2	0
20	502.2	502.3	-1	502.2	502.2	0
21	502.2	502.2	0	502.2	502.2	0
22	502.2	502.3	-1	502.2	502.2	0
23	502.4	502.4	0	502.4	502.2	2
24	502.3	502.3	0	502.3	502.3	0
25	502.3	502.3	0	502.3	502.3	0
26	502.3	502.3	0	502.3	502.5	-2
27	502.2	502.2	0	502.2	502.2	0
28	502.3	502.3	0	502.3	502.3	0
29	502.2	502.2	0	502.2	502.2	0
30	502.2	502.2	0	502.2	502.2	0
31	502.1	502.1	0	502.1	502.2	-1
32	502.3	502.3	0	502.3	502.3	0

HYPOTHESIS IV During the 1978-1979 and the 1979-1980 school years, there was a direct relationship between the per pupil expenditures and prototype such that the lower the prototype, the lower the per pupil expenditure.

During the 1978-1979 and 1979-1980 school years there was a direct relationship between per pupil expenditure and prototype. However, during the 1978-1979 school year, the hypothesis that the lower the prototype, the lower the per pupil expenditure was supported only for prototypes 502.2 ($2,438 per pupil cost), 502.3 ($4,077 per pupil cost) and 502.4 ($7,700 per pupil cost). The hypothesis was not supported for prototypes 502.1 ($2,534 per pupil cost--which was slightly higher than prototype 502.2) and prototype 502.6 ($6,328 per pupil cost--which was lower than prototype 502.5). The lower prototypes (502.1, 502.2 and 502.3) represent 31% of the total per pupil expenditure ($9,169 out of $29,549 total cost). The higher prototypes (502.4, 502.5 and 502.6) represent 69% of the total per pupil expenditure ($20,480 out of $29,549). Table 15.

Table 15

Relationship between Prototype and Mean Per Pupil Expenditures among all three School Systems

Prototype	1978-1979 School Year	1979-1980 School Year
502.1	$ 2,535	$ 2,067
502.2	$ 2,458	$ 2,545
502.3	$ 4,077	$ 3,195
502.4	$ 6,452	$ 4,618
502.5	$ 7,700	$13,906
502.6	$ 6,328	$22,585

Source: Massachusetts Department of Education Bureau of Data Collection and Reporting Special Education Programs

Per pupil expenditure for the students' 1979-1980 school year prototype when compared to the 1978-1979 school year prototype. The data to answer this concern was provided by the Massachusetts Department of Education Bureau of Data Collection and Reporting. Table 16 reflects the data for the 1978-1979 school year and Table 17 provides the same for the 1979-1980 school year.

Overall, there is generally a consistent trend for per pupil expenditures to increase as prototype goes from the lowest (502.1) to the highest (502.6--private residential program). During the 1978-1979 school year in school system A-I, per pupil expenditures changed from prototype to prototype as follows: prototype 502.2 increased $7.00 over prototype 502.1; prototype 502.3 increased $403 over prototype 502.2; prototype 502.4 increased $641 over prototype 502.3; prototype 502.5 increased $2,648 over prototype 502.4. Prototype 502.6 decreased $45 over prototype 502.5

During the 1979-1980 school year, school system A-I's per pupil expenditures changed by prototype to prototype as follows: prototype 502.2 increased $268 over prototype 502.1; prototype 502.3 increased $737 over prototype 502.2; prototype 502.4 increased $1, 272 over prototype 502.3; and prototype 502.5 increased $8,006 over prototype 502.4. Prototype 502.6 decreased $435 over prototype 502.5

During the 1978-1979 school year, school system A-II's per pupil expenditures changed by prototype to prototype as follows: prototype 502.2 increased $815 over prototype 502.1; prototype 502.3

increased $3,350 over prototype 502.2; and prototype 502.4 increased $4,803 over prototype 502.3. Prototype 502.5 decreased $6,481 over prototype 502.4. There was no per pupil expenditure available for prototype 502.6

School system A-II's per pupil expenditures changed by prototype to prototype during the 1979-1980 school year as follows: prototype 502.2 increased $906 over prototype 502.1; prototype 502.3 increased $299 over prototype 502.2; prototype 502.4 increased $2,242 over prototype 502.3; prototype 502.5 increased by $1,298 over prototype 502.4; and prototype 502.6 increased by $27,379 over prototype 502.5

The change by prototype to prototype in school system A-III during the 1978-1979 school year was as follows: prototype 502.2 decreased $1,051 over prototype 502.1; prototype 502.3 increased $1,104 over prototype 502.2; prototype 502.4 increased $1,680 over prototype 502.3; prototype 502.5 increased $ 7,578 over prototype 502.4; and prototype 502.6 increased $1,078 over 502.5

During the 1979-1980 school year, school system A-III's per pupil expenditures changed by prototype to prototype as follows: prototype 502.2 increased $263 over prototype 502.1; prototype 502.3 increased $914 over prototype 502.2; prototype 502.4 increased $753 over prototype 502.3; prototype 502.5 increased $18,561 over prototype 502.4; prototype 502.6 decreased $906 over prototype 502.5

The more special education services a student receives the more costly the educational program. The myriad of special education services available to students--such as speech therapy, adaptive physical education, physical therapy, occupational therapy--all contribute to increasing the cost of educating a special education student. Therefore, it is obvious that if a public school system can reduce the amount of special education services a student requires (while still providing an appropriate education), then the public school will realize a net saving. The data clearly supports the notion that a reduction in special education services is a reduction in prototype and, hence, a reduction in per pupil expenditure. However, the research does not support the case of family therapy as a psychoeducational service which will guarantee a reduction in program prototype. Although the research does not demonstrate a relationship between family therapy and a reduction in prototype, the benefits to the participants may be significant. Public schools must continue to seek alternatives to costly private day and residential schools because the cost of them is prohibitive.

Resultant monetary savings from decreases in prototype. There is clearly a relationship between per pupil expenditure and prototype with a consistent trend being as follows: the higher the prototype, the higher the per pupil expenditure; the lower the prototype, the lower the per pupil expenditure. The 1978-1979 school year mean per pupil expenditures for the three school systems are as follows:

prototype 502.1, $2,535 per pupil costs; prototype 502.2, $2,458; prototype 502.3, $4,077; prototype 502.4, $6,452; prototype 502.5 $7,700; and prototype 502.6, $6,328. The exceptions to the trend that a decrease or increase results in a corresponding decrease or increase in per pupil costs are prototypes 502.1 and prototype 502.5. Prototype 502.1 is $77 more than prototype 502.2 and prototype 502.5 is $1,372 more than prototype 502.6. However, this is in contrast to the 1979-1980 school year. There is a corresponding increase in per pupil costs for all categories of prototype as the prototype increases. The 1979-1980 school year mean per pupil expenditures for the three school systems are as follows: 502.1, $2,067 per pupil cost; prototype 502.2, $2,545; prototype 502.3, $3,195; prototype 502.4, $4,618; prototype 502.5, $13,906; and prototype 502.6, $22,585. Table 16 reflects the average per pupil expenditure by prototype for the 1978-1979 school year while Table 17 reflects the same for the 1979-1980 school year.

Table 16

Average Per Pupil Expenditure by Prototype, 1978-1979 School Year

School System	Modified 502.1	25% 502.2	25%-60% Special Ed 502.3	Substantially Separate 502.4	Private Day School 502.5	Private Residential 502.6
A-I	$ 1,734	$ 1,741	$ 2,144	$ 2,785	$ 5,433	$ 5,388
A-II	$ 2,663	$ 3,478	$ 6,828	$11,631	$ 5,150	N/A
A-III	$ 3,207	$ 2,156	$ 3,260	$ 4,940	$12,518	$13,596

Table 17

Average Per Pupil Expenditure by Prototype, 1979-1980 School Year

School System	Modified 502.1	25% 502.2	25%-60% Special Ed 502.3	Substantially Separate 502.4	Private Day School 502.5	Private Residential 502.6
A-I	$ 1,511	$ 1,779	$ 2,516	$ 3,788	$11,794	$11,359
A-II	$ 2,676	$ 3,582	$ 3,881	$ 6,123	$ 7,421	$34,800
A-III	$ 2,012	$ 2,275	$ 3,189	$ 3,942	$22,503	$21,597

Source: Massachusetts Department of Education Bureau of Data Collection and Reporting Special Education Programs

Analysis of the data is based on comparing the increase or decrease in per pupil expenditures (as related to prototype) which occurred between the pre-period of observation (the 1978-1979 school year) and the post-period of observation (the 1979-1980 school year) for the subjects in both the experimental and the control groups (Table 18). Of the thirty-two students in the experimental group who partook in family therapy sessions twenty-one students (66%) experienced a resultant increase in per pupil expenditure while 11 students (34%) experienced a decrease. The change in per pupil expenditure for the 1978-1979 school year to the 1979-1980 school year represents a total increase of $51,566 for the E group.

The changes in per pupil expenditure for the subjects in the control group are as follows: there was an increase in per pupil expenditure for twenty-one subjects of the thirty-two in the control group (66%) and a decrease for eleven subjects (34%). The change in per pupil expenditure from the 1978-1979 school year to the 1979-1980 school year represents a total decrease in per pupil expenditures of $10,247 for the control group.

The total per pupil expenditures for the thirty-two subjects in the E group was $122,432 for the 1978-1979 school year (pre-observation period). The per pupil expenditures for the E group increased to a total expenditure of $173,998 for the 1979-1980 (post-observation period). This resulted in a per pupil expenditure difference between the pre- and post-observation periods of an increase of $51,566 for the experimental group. The control group total per

pupil expenditure for the 1978-1979 school year (pre-observation period) was $127,582. The total per pupil expenditure for the C group at the time of the 1979-1980 school year (post-observation period) was $117,335. The C group experienced a decrease in per pupil expenditure of $10,247. Further analysis of the data reveals that the E group had three significant per pupil cost increases not experienced by the C group. E group subject # 4 increased $10,053, subject # 18 increased $29,650, and subject # 26 increased $19,243. These three increases resulted in a total increase of $58,946 for the E group. These increases were unusual as there were no comparable increases for the C group. The three largest per pupil expenditure increases resulted in a total increase of $7,187 in the C group.

Table 18

Comparison of Per Pupil Expenditure Differences by Subjects in the Experimental and Control Groups

Subjects	Control Group			Experimental Group		
	1st Observation	Second	Change	First	Second	Change
1	$ 2,144	$ 2,516	+ 373	$2,144	$2,516	+ 372
2	2,144	2,516	+ 373	2,144	2,516	+ 372
3	1,741	1,779	+ 38	1,741	1,779	+ 38
4	1,741	1,779	+ 38	1,741	11,794	+10,053
5	1,741	1,779	+ 38	1,741	1,779	+ 38
6	1,741	1,779	+ 38	1,741	1,779	+ 38
7	2,785	3,788	+1,003	2,785	2,516	- 269
8	2,785	3,788	+1,003	2,785	3,788	+ 1,003
9	11,631	6,123	-5,508	11,631	7,421	- 4,210
10	6,828	3,881	-2,947	6,828	6,123	- 705
11	11,631	6,123	-5,508	11,631	6,123	- 5,508
12	3,478	3,582	+ 104	3,478	6,123	+ 2,645
13	3,478	3,582	+ 104	3,478	3,582	+ 104
14	3,478	3,582	+ 104	3,478	3,582	+ 104
15	11,631	6,123	-5,508	11,631	6,123	- 5,508
16	3,478	3,582	+ 104	3,478	3,582	+ 104
17	5,150	7,421	+2,271	5,150	7,421	+ 2,271
18	5,150	7,421	+2,271	5,150	34,800	+29,650
19	3,478	6,123	+2,645	3,478	3,582	+ 104
20	3,478	3,881	+ 403	3,478	3,582	+ 104
21	3,478	3,582	+ 104	3,478	3,582	+ 104
22	3,478	3,881	+ 403	3,478	3,582	+ 104
23	4,940	3,942	- 998	4,940	2,275	- 2,665
24	3,260	3,189	- 71	3,260	3,189	- 71
25	3,260	3,189	- 71	3,260	3,189	- 71
26	3,260	3,189	- 71	3,260	22,503	+19,243
27	2,156	2,275	+ 119	2,156	2,227	+ 119
28	3,260	3,189	- 71	3,260	3,189	- 71
29	2,156	2,275	+ 119	2,156	2,275	+ 119
30	2,156	2,275	+ 119	2,156	2,275	+ 119
31	3,207	2,012	-1,195	3,207	2,012	- 1,195
32	3,260	3,189	- 71	3,260	3,189	- 71
			-10,247			+51,566

CONTROL GROUP: - $10,247 = decrease in expenditure at the time of second observation

EXPERIMENTAL GROUP: + $51,566 = increase in expenditure at the time of second observation

In conclusion the data have supported some of the hypotheses and not others. Hypothesis I was supported for the biographic categories of grade and sex between the two groups. The hypothesis was not supported in regard to the distribution of subjects in the E and C groups by primary special need and age. The experimental group had the majority of subjects identified as being emotionally disturbed, while in the control group the majority of subjects was identified as being learning disabled. This difference in primary special need between the two groups will be further discussed in Chapter V. However, it appears that the E and C groups were not matched in that the subjects had distinctly different characteristics in regard to primary special need. There was also a significant difference between the mean age of subjects in the E group (11.625 years) and subjects in the C group (9.866 years.

It was anticipated that at the time of the first observation period, that there would be a larger percentage of subjects at the higher prototype levels who had participated in family therapy than those at the lower prototype levels. At the time of the second observation period, a decrease in the number of subjects in the higher prototype levels occurred. At the time of the first observation period, there were twenty-four subjects in the lower prototype levels and eight subjects in the higher prototype levels. At the time of the second observation period, there were twenty-two subjects in the lower prctotype levels and ten in the higher prototype levels. The data does not support Hypothesis I.

The assumption that the experimental group would have a significantly lower mean prototype than the control group at the time of second observation (the 1979-1980 school year) was not supported. There was no significant difference between the mean prototype for the two groups at the time of second observation. It had been anticipated that there would be a relationship between those subjects participating in family therapy in such a manner that a decrease in prototype would be the identifiable factor. Thus, Hypothesis III was not supported by the data.

During the first and second observation periods, there was a direct relationship between prototype and per pupil expenditures. However, it was anticipated that for those subjects who participated in family therapy that there would be a decrease in prototype. As a result, per pupil expenditures would decrease for the subjects in the _E_ group at the time of the second observation period (1979-1980 school year). The _E_ group experienced an increase of $51,566 and the _C_ group experienced a decrease of $10,247 at the time of the second observation (the 1979-1980 school year). Analysis of the data suggests that family therapy produced no more change in prototype over the year than did no family therapy. Hence, Hypothesis IV was not supported.

Family therapy in lieu of a more restrictive educational program and/or as a means to return students to a less restrictive educational placement. On question # 7 of Survey II, LEA Data Question-

naire, Directors of Special Education of the three school systems studied were asked the question: "Was family therapy recommended in lieu of out-of-district placements? Yes or No or Unable to determine." The director of Special Education for school system A-I responded "No," meaning that family therapy was not recommended for that specific purpose. The Directors of Special Education for school systems A-II and A-III responded "yes." These two directors recommended family therapy specifically for the purpose of assisting subjects to remain within the public schools instead of being sent to an out-of-district program (prototypes 502.5 and 502.6). Two of the three directors responded in the affirmative to this aspect of the question.

Question # 8 of Survey II. LEA Data Questionnaire asked, "Was family therapy recommended for students in out-of-district placements as a means to return those students to a less restrictive educational category in 1978-1979?" The Director of Special Education for school system A-I responded to the question negatively. The Directors of Special Education for school systems A-II and A-III responded affirmatively.

Analysis of the data demonstrates that family therapy has been recommended by public school officials as an attempt to keep students in a less restrictive program or return them to a less restrictive program. It appears that prior to this study there was no formal evaluation process other than annual reviews, to determine if family therapy actually achieved the goal of keeping these students within the public school setting. It would appear that the merits of family

therapy must be apparent to school officials in regard to individual students, or family therapy would not be included as part of an individual educational plan.

1979-1980 school year) and private residential school ($22,585 mean cost per student per year of the three participating school systems in the 1979-1980 school year) was expensive.

The dilemma confronting public school officials such as school psychologists and special education administrators is that special education services must be provided regardless of the financial resources available to the public schools as mandated by both state and federal law. However, a second major mandate involves an equally unique requirement to school officials such as school psychologists and special education administrators responsible for the educational placement decisions of special needs students--that special education students be educated, whenever possible and appropriate, with regular education students in a regular education setting. The lack of research available to assist special educators to meet these dual mandates provided the impetus for this research project. Since special education administrators (at least in Massachusetts) and/or designees such as school psychologists have the authority to decide where a student will receive his/her education, it is not always imperative that a student need be placed in a private day or residential program as long as the educational services identified by the student's evaluation team are provided. Thus, it seems logical that special education administrators must become more creative and practical in identifying alternatives to private day and residential school placements and that these services fulfill three basic public school needs: 1) meet the mandates of state and federal special

from requiring more costly special education services in the future.

The literature also supports the use of family therapy by the public schools in that there is a trend toward positive therapeutic results when the identified patient is a child or adolescent. However, caution must be exercised in reviewing family therapy outcome studies because very little of the literature can be considered as research as was discovered in the review of the literature for this study. For example, it was difficult to add clarity to the various studies as the models of family therapy used were seldom mentioned in the individual studies. Family therapy studies, generally, demonstrate numerous research design problems that leave the outcome data in question. Many family therapy advocates sometimes claim that the use of systemic and not linear views of individual psychological problems negate the use of traditional linear research designs. However, while this may be true, there is still a need for evidence supporting the efficacy of family therapy. Unfortunately, this information is lacking in the research literature.

It is also important to note that the investigation of family therapy as an alternative to more restrictive programs in not intended to blame the family for the subject's problems. It is, however, a realistic attempt to find an alternative that will permit the student to remain in the natural environment of family and school peers and friends. Quite often, students need private school placement not because of the school situation, but because of major difficulties within the home. In turn the public schools are forced to

to secondary school programming. This change to the secondary school level is often associated with large school buildings and student populations, departmentalization and a corresponding decrease in program flexibility and personal attention. Learning disabilities represented the primary sepcial need among the majority of children in the control group. The fact that the two groups had different primary special needs represented by the majority of subjects may have contaminated the results. Therefore, the subjects of the two groups did not have all the same characteristics at the onset of the study.

However, in Massachusetts, public schools are not required to categorize special education students by their special needs conditions. Public schools are required only to categorize special needs students by prototype classification. Because special education students are not classified by special need condition, this researcher did not deem the classification of primary special need as reliable for this investigation. In fact, upon reviewing individual student files, it was necessary to synthesize the available information (relying primarily on education and psychological reports) to derive a primary special need category. This data was matched to the definitions established by the Council for Exceptional Children of special education conditions. Although care was taken to identify the primary special need for each subject identified, there was concern over the reliability of classifying students because it was the researcher who determined the category because none was available in the individual student files. School reports appeared to be written with the intent

to-date on the progress or outcome of the therapy. If clearly identified treatment goals were agreed upon by the therapist, school and family, goals which related to school issues, then family therapy could have a greater impact on prototype. The family therapist, in consultation with school authorities, could have conjointly developed a treatment plan which could have been monitored on at least a bi-yearly basis to assess progress. The obvious lack of direction by school authorities may have resulted in family therapists not specifically addressing the issue of reducing the need for additional special education services.

Treatment goals were not available in student records or individual educational plans. It was not anticipated at the onset of the research project that there would not be goals and objectives established for each subject with family therapy written into their individual educational plan. However, as a result of this research, it is highly recommended to special education administrators that clearly established goals be agreed upon by the school authorities, family therapists, and as appropriate, the family. Then these goals could be written into the student's individual educational plan as is any other special education service and reviewed at least annually. It is also recommended that referrals be made to family therapists with a reputation for competence.

The issue of "who owns the therapy"--the therapist or the school--may turn out to be a common problem. However, if public schools are referring students to family therapy with the expressed goal of keep-

ing students in a mainstreamed educational environment, the administrators should clearly write out goals and objectives of the therapy. If that is unacceptable to the family therapist, then another therapist should be contacted. It is strongly recommended that public school administrators adopt a formal procedure whereby goals, objectives and progress reports are written out and monitored on a regular basis. This would enhance the accountability of schools and the family therapists and should be made available to the family.

Hypothesis III. At the time of the second observation, the mean prototype of the E group will have a significantly lower mean prototype than the C group. It was anticipated that the independent variable of family therapy would cause a decrease in mean prototype for the E group. This hypothesis was not supported. The obvious lack of change in either group suggests that prototypes do not change easily. This may have been related to the fact that the amount of time allotted for change (one year) was not sufficient for family therapy to have had an impact. Prototype may also have not been a sensitive enough measure to account for a therapeutic change taking place for the subject. Two additional possibilities exist, namely, 1) that family therapy was not an effective psychotherapeutic treatment; 2) that family therapy was an effective psychotherapeutic treatment for the subjects, but not as a reducer of prototype. Future research may focus on establishing family therapy goals that clearly delineate the reduction of prototype as a major focus fo the therapy.

($22,585 mean per pupil expenditure for the 1979-1980 school year). These programs are more restrictive educationally because there is no involvement in either the regular education setting nor are the students being educated with the regular education students. In both settings, all students are identified as being special education students. The most expensive prototype within a public school setting is prototype 502.4 (substantially separate) with a mean cost of $4,618 per student. This still represents $17,967 less than a private residential school program.

Due to the large financial expense associated with private special education schooling, special education administrators might utilize not only family therapy as a viable alternative to more restrictive, namely private day and residential programs. They might also explore other types of services such as outward-bound adaptive physical education, twenty-four hours a day, seven days a week counseling and recreational services, or a multitude of psychotherapeutic treatments to include behavior analysis and chemotherapy. School psychologists and counselors are encouraged to participate in family therapy classes or in-service programs to at least obtain a basic understanding of the major theoretical models. Special education administrators are encouraged to develop more effective evaluation procedures to determine if the services provided special needs students are effective. The economic realities of the day necessitate that other alternatives be sought even though they may be more expensive in and of themselves; they are generally much less expensive than traditional placements

in a private day or residential program.

Although family therapy was the focus of this research, it does not preclude the fact that schools need to be more responsive to student needs. Public school officials should not look to the student and/or family as the source of the student's problems. It is quite conceivable that the school may be involved in an interaction pattern that is harmful to the education of the student. At some future point in time, this researcher speculates that there will be "organizational therapists" skilled at working with the major subsystems that a special needs student has membership in such as schools, welfare, protective services. Future research should be conducted to investigate the area of organizational therapy. To emphasize a critical issue, family therapy should not be viewed as a means to place blame on the family. It is one of many services to assist a student to receive an appropriate education. Likewise, the mere fact that family therapy has been recommended should not distract from the public schools' obligation to examine its own organization or system to determine if changes are needed within the school setting.

Future research should attempt, if possible, to use data that have already standardized and formalized the classification of special needs subjects by appropriate categories. An additional implication is that there appears to be a great deal of inconsistency in the way that the various public schools define special needs students. It is recommended that schools establish their own clearly defined definitions and evaluation procedures for identifying special needs students

and their handicapping conditions. This would allow some consistency between school systems (however limited) and, more importantly, within each public school system. It would make the task of identifying and programming special education students easier and possibly more effective.

In summary, family therapy with special needs children and families merits further research. It is a psychotherapeutic approach that has a great deal of promise both as a viable treatment approach to select special needs students and as an alternative to costly private special education placements.

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APPENDIX A

THE USE OF FAMILY THERAPY WITH

SPECIAL NEEDS STUDENTS AND THEIR FAMILIES

RESEARCH PROJECT

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This research project is part of a dissertation for a doctorate in education. The prupose of this project is to determine the use of family therapy among school aged special needs children and their families as indicated on an individual educational plan. Your cooperation in assisting the researcher to obtain this information is greatly appreciated. Information provided by your school district is entirely voluntary and will be handled by research personnel only. The privacy of your students, families, and school system will be respected.

APPENDIX B. SURVEY I

STUDENT DATA

Student Number: Research Date(s):____________

1. Date of Birth: / / Local Education Agency:____________

2. Sex: MALE FEMALE School Year Reviewed: 1978-1979

3. Grade: K 1 2 3 4 5 6 7 8 9 10 11 12

PLEASE CIRCLE THE APPROPRIATE ANSWER WHERE POSSIBLE. IF YOU HAVE INFORMATION TO ADD, WRITE IT WHERE APPLICABLE.

4. Was family therapy written into the student's individual educational plan for the 1978-1979 school year? YES NO

5. What was the subject's school year program category in September of 1978? Indicate the total hours of special education per week.

   502.1 502.2 502.3 502.4 502.5 502.6 Hours per week________

5a. If there was a change in program category during the 1978-1979 school year, indicate the new program category and when it occurred.

   502.1 502.2 502.3 502.4 502.5 502.6 Date of Change / /

6. What was the subject's program category during the 1979-1980 school year? Indicate the total hours of special education weekly. PLEASE NOTE CHANGE OF SCHOOL YEAR.

   502.1 502.2 502.3 502.4 502.5 502.6 Hours per week________

7. If the subject's primary educational special need was identifiable, what was it?

   Mental Retardation, Emotional Disturbance, Learning Disability, Visual Impairment, Hearing Impairment, Speech Impairment, Orthopedic Handicaps and Special Health Conditions, Combination of the Above, Other

8. Who provided the family therapy? School Personnel, Public Mental Health Clinics, Private Mental Health Clinics, Hospitals, Private Mental Health Professionals, Other

9. Who paid for the family therapy?

   Public School, Third Party Payment (e. g., insurance), Subject's Family, State Social Service Agencies, Combination of the Above, Other

APPENDIX C. SURVEY II

LEA DATA

School Year 1978-1979 Source of Data: ______________

AGAWAM PUBLIC SCHOOLS Research Date(s): ______________

1. Local Education Agency: ______________

2. Total number of students enrolled in Agawam Public Schools during 1978-1979: ______________

3. Total number of special needs students enrolled in Agawam Public Schools during 1978-1979: ______________

4. Percentage of special needs students: ______________

5. Number of special needs students enrolled in Amherst Public Schools who had family therapy on their individual educational plans during the 1978-1979 school year: ______________

6. Percentage of special needs students with family therapy on their individual educational plans during 1978-1979: ______________

7. Was family therapy recommended in lieu of out-of-district placements? YES NO UNABLE TO DETERMINE

   A. If yes, for which out-of-district prototypes? 502.5 502.6

8. Was family therapy recommended for students in out-of-district placements as a means to return these students to a less restrictive educational program category in 1978-1979? YES NO UNABLE TO DETERMINE

9. Number of special needs students in each program category (502.1-502.6) during the 1978-1979 and 1979-1980 school years:

	502.1	502.2	502.3	502.4	502.5	502.6
1978-1979						
1979-1980						

10. Per pupil expenditures per program category (502.1-502.6) during the 1978-1979 and 1979-1980 school years:

	502.1	502.2	502.3	502.4	502.5	502.6
1978-1979						
1979-1980						