Exploring the Use of Contracting as a Tool in Family Therapy with Families Whose Children Are In Foster Care

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A Practicum
Presented to the Faculty of Graduate Studies
in partial fulfillment of the requirement for the degree
Master of Social Work

University of Manitoba

Winnipeg, Manitoba

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ACKNOWLEDGEMENTS

I wish to thank Professor Addie Penner for serving as my practicum advisor. Her support,guidance & feedback provided me with a valuable learning experience.

I also wish to thank Ms. Elaine Gelman for her supervision and encouragement which were very helpful.

I would like to thank Dr. Kathryn Saulnier for her interest and stimulating ideas.

I appreciated Dr. Michael LeBow for his feedback and positive reinforcement.

I am also grateful to the staff at the Children's Aid Society and the families who participated so willingly during this practicum.

Finally I would especially like to thank my family and friends for their loving support and prayers which were invaluable to me in completing this practicum.

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INTRODUCTION

The child welfare system is presented with a paradoxical task in attempting to preserve family identity and continuity while, at the same time, separating the child from its family in neglect or abuse situations. In thus protecting the child the family unity is severed. Connecting the family once separation has occurred is a process that seems to lack definition. Through my experience in child welfare I saw a need for a more clearly defined interventive strategy with families once the child was in foster care. I saw many children remain in care indefinitely with no permanent plans for the future. There were other children who returned to families that inevitably reverted to previous neglectful and abusive behavior. These children enter foster care many times during their developing years. It is my contention that to deal more effectively with the problem of child abuse and neglect, the interventive approach needs to be family-oriented with a focus on behavioral changes.

Purpose

The main purpose of this practicum was to work with families whose children were in foster care, toward improved family functioning. Current family therapy and behavioral theories provided a useful framework and focus for this purpose. The "ecological perspective", "problem-centred systems theory" (Epstein & Bishop, 1981), and "contracting" were the assessment and interventive approaches used in this practicum. The ecological perspective provided the theoretical framework used in analyzing the dynamics of the maltreatment of children. This perspective emphasized the transactions of families within their environment rather than individual pathology. Problem-centred systems theory was used to assess family functioning and to delineate areas for change. This theory emphasizes mutuality between the social worker and the family and provides a problem-solving focus to the assessment and intervention process. Behavioral contracting was the specific interventive technique, used in working with families toward change. Contracting facilitates the worker and the family in specifying goals, tasks and time-limits. The integration of the ecological perspective, the problem-centred systems model and behavioral contracting considers the transactions of the family within the environment and emphasizes mutuality of goals and clarity of purpose between the worker and the families whose children were in foster care.

LITERATURE REVIEW

The Historical Development of Child Welfare Services Child Welfare practices in the Western World evolved out of a need to provide for and protect children who were abandoned, mistreated or abused by their parents. "Historically society has not been troubled by the maltreatment of children" (Kempe, R. S., & Kempe, C. H., 1978). Children were often disposed of when they were not wanted. Abortion, infanticide, abandonment and selling children into slavery were some of the methods used to get rid of unwanted children. These solutions became ideologically unacceptable under the influence of Christian and Humanitarian philosophies of the enlightenment (Kadushin, 1980). In response to the problem of abandonment, children were placed in foundling hospitals and parish workhouses where they died at alarming rates. The solution seemed no better than the problem. Contributing to the problem of the solution was child labor instituted in England in 1535. The economic position of the family and society encouraged early independence and children were forced to enter the work force as early as six or seven years of age. Unawareness of the developmental needs of children contributed to the development of this practice. Children were viewed as chattels with no rights or status in society. Scientific advancements, along with economic and

political changes in British society, influenced the recognition of the rights and developmental needs of the child (Kadushin, 1980).

Laws and Child Welfare services developed in the United States and Canada reflected the change in attitude toward children. This development began in the United States just over one hundred years ago. The incident initiating legal action for this protection of children was the rescue of a little girl, named Mary Ellen from her abusive adoptive parents by a group of church workers. Their only legal recourse at that time was through the Society for the Protection of Cruelty to Animals. Following this action, the New York Society for the Prevention of Cruelty to Children was established in 1875 (Kempe & Helfer, 1972). In Canada, in 1893, the Ontario Act for the Protection of Children from Cruelty was enacted. Sine then child welfare laws and services have been established throughout the United States and Canada.

Current Practice: The Need for a Family Focus

The emphasis on protecting children has evolved into a much too prevalent practice of separating families in the attempt to solve Child Welfare problems. In reference to current practice, Minuchin (1970) states that the "family is studied and respected as a viable socialization unit when it is working; when trouble arises, the response is to split

it")cited in Laird, 1981, p. 99). Foster placement, intended as a "... stop on a circular path to the reunion and rehabilitation of the natural family, has become a straight and narrow road toward substitute care" (Laird, 1981, p. 100). Splitting up families leads to the treatment of individuals rather than the family as a system. The problem has become one of reuniting families.

There is no doubt that certain child welfare situations require the removal of the child from the natural family. Wilkes (1980), in proposing separation as a therapeutic option, states that the psychological effect on children who are not separated from their families must be considered. Another major consideration, of course, is the physical safety of the children. When deciding whether or not separation is an option, Goldstein, Freud & Solnit (1973) propose the principle of "the least detrimental alternative for safe-guarding the child's growth and development" (p. 53). This guideline for placement and procedure "maximizes ... his or her opportunity for being wanted and for maintaining on a continuous basis a relationship with at least one adult who is or will become his psychological parent" (Goldstein, et al., p. 53). Jenkins and Norman (1975) found that for some mothers placement of their children was an option that helped get them back on their feet. Separation can at times, be an alternative that is less detrimental for the family than remaining intact.

If intervention necessitates separating families as a therapeutic alternative it remains essential to work with the family as an interacting system. This family focus involves understanding the relationships between families and their ecological environments. Intervention involves identifying areas of interchange between the family and the environment, and between family members where there is stress, conflict or insufficient exchange (Laird, 1981). The purpose of intervention in this practicum was to work with the family toward improved functioning in those areas by identifying specific goals and tasks and by developing time limited contracts.

Methods of Intervention

In working with families whose children were in foster care the use of the ecological perspective provided a broad framework within which the family was the focus of intervention. The use of contracting as a specific interventive technique was explored within this framework. From the ecological perspective the etiology of the maltreatment of children is seen as a complex transactional process between individuals and their environments. The use of the problem-centred systems model led to an assessment of the major areas of family functioning and involved the family in the process of problem identification and solution. Contracting is a tool which can be used to work with families toward spe-

cific, concrete goals. These three approaches used together can provide, I believe, a comprehensive, practical framework for practice.

The Ecological Perspective

In applying the ecological perspective in the child welfare field, the focus of intervention becomes not just the parent or the child but the various systems with which they interact. An assessment of the family using this perspective "... examines the developing individual, the individual's dynamic, immediate and broader physical and social environments and the interactions and relationships among these variables during a specific period of time" (Hess & Howard, 1981, p. 501). Bronfenbrener (1979) provides a useful model of the ecological environment in describing it "topologically as a nested arrangement of structures, each contained within the next" (p. 514). Each of the larger structures contains the smaller ones and involves a dynamic interchange, each structure affecting the other. Individuals actively attempt to find a "goodness-of-fit" with their environments (German, 1979). The individual's continual struggle to achieve mastery within the various levels of the environment is influenced by factors within those levels in interaction with individuals qualities such as age, sex, culture, and temperament. This generally defines the ecological perspective.

Analysis of the Process of Child Maltreatment.

The ecological perspective provides the broader focus needed to bring about a more complete and systematic understanding of the complexities of child abuse and neglect. The levels of analysis described by Belsky (1980) include 1) ontogenic development; 2) the microsystem; 3) the exosystem; and 4) the macrosystem. These will be discussed as they relate to the etiology of child maltreatment. All of these systems and the transactions occurring within them are viewed as interdependent and any disturbance in one affects the balance of the others.

1) Ontogenic Development

There are a number of factors in the ontogenic development of the parents that play a significant role in the process of child abuse and neglect. The individual life cycle and the biological development comprise the ontogeny of the individual's development. Factors in this development that contribute to child maltreatment include aspects of the parents' socialization history and lack of experience in caring for children. Strong consensus among scholars and practitioners indicates that one characteristic common to many abusers is a history of maltreatment in their own Childhood (Kempe, R. S., & Kempe, C. H., 1978). In other situations the parents own rearing may not have been abusive, but Belsky (1980) cites many studies that indicate simple exposure

to or experience with violence as a child may lead to aggressive strategies in coping with conflicts with one's own children. Parental rejection and the resulting absence of the experience of being parented (coupled) emotional deprivation are also factors that contribute to mistreatment of children. Poor parental role models may man that the parent has never learned how to care for children. Emotional deprivation in childhood may result in role reversal in which the maltreating parents expect their emotional needs to be met by their children (Belsky, 1980; Kempe, R. S., & Kempe, C. H., 1978). The parents may also lack knowledge and experience in caring for children which results in unrealistic developmental expectations (Kempe, R. S., & Kempe, C. H., 1978). Ontogenic development, though a significant component in the dynamics of child maltreatment must be viewed in its interactions with other systems.

2) The Microsystem

Influences within the family in interaction with ontogenic development of the parents may activate the process that leads to the maltreatment of children. Foces that lead to child abuse may occur within the victim-perpetrator dyad. Belsky (1980) considers possible risk characteristics which contribute to the maltreatment of children in situations where the child is premature, colicky, hyperactive or lethargic. The role of these characteristics in eliciting abuse can only be considered in relation to the parent's attributes (Belsky, 1980).

Forces outside the victim-perpetrator dyad also play a role in the dynamics of child abuse and neglect. In studies of maltreatment it has been found that "marital conflict and discord run high in abusive households" (Belsku, 1980, p. 326). This may result in misplaced aggression or may simply have a negative influence on other relationships within the family. Various adjustments are required in the spousal relationship at different stages of the life cycle of the family, creating stress that may lead to the mistreatment of children. Another factor creating stress and possibly leading to abuse is the overextension of personal and financial resources that occurs in low socioeconomic and/or large families. Abuse may occur when the levels of stress surpass the family's ability to cope. An intervening variable may be the organization of the family and the members' ability to cope with stress since not all poor or large families abuse their children (Belsky, 1980). Household organization in terms of effectively assigning roles and rules and in utilizing resources within the family will increase the tolerance of stress. These factors interacting within the microsystem and with factors in other systems may stimulate child maltreatment.

3) The Exosystem

The formal and informal social structures of the exosystem encompass and interact with the individual in his/her immediate settings (Bronfenbrenner, 1977). Included at this

level are the social network and the service and work organizations. The concept of social network from an ecological perspective includes not just the "aggregate of the individual's social relations" but also the "set of communication paths and relational linkages such that the individual's behavior is influenced by the connections between individuals in the network" (Germain, 1979, p. 14). These communication paths and relational linkages allow information to be carried to the individual that s/he is valued and cared for and this information influences his/her behavior. Services and work organizations are the salient features of the environment created to meet people's needs. There is a reciprocal relationship between the social network and the service and work organizations. These support systems (or lack of them), in interaction with the individual and the microsystem play a major role in the process of child maltreatment.

Isolation from strong support systems is a major factor in families where there is violence toward children (Garbarino, 1977). A strong network of social supports is essential in providing emotional and material assistance to families that are experiencing stress. These support systems can also provide feedback, role models for parenting, and help in handling emotions and controlling impulses (Belsky, 1980). Isolation from support systems may be due to the family's inability to utilize what is available. They may be unable or unwilling to make friends or to associate with

the extended family. Isolation may also be due to mobility patterns which disrupt social networks, the developmental history of the parents or social stresses that cut the family off from supports (Garbarino, 1977).

Service and work organizations within the exosystem are a part of the process of maltreatment. The service network may contribute to the process because of its fragmented approach to families. The stigma and labels attached to families involved with child welfare or public welfare agencies often isolates them from other social supports. Unemployment, or factors related to employment such as dissatisfaction, frustration, conflicts or burnout may lead to violence depending on other interactional variables. The influences of the exosystem on the process of child maltreatment must be understood in relation to its reciprocal interaction with the other systems.

4) Macrosystem

In the fourth level of analysis the family is studied in relation to the connecting fibres of society that are woven into the other structures of the individual, the microsystem and the exosystem. These fibres form the pattern for the activities at all levels. Attitudes of society contribute to the pattern evident in child maltreatment. Belsky (1980) asserts that high levels of violence in our society "set the stage for the occurrence of family violence, one form of

which is child abuse" (p. 329). Also apparent in our society is a general attitude which devalues children and denigrates parental responsibilities. This attitude works against efforts to prevent child abuse (Belsky). Within the macrosystem intolerance toward different sub-cultures may also contribute to the process of child abuse. The beliefs and attitudes of the sub-cultures may differ from the larger society, leaving them vulnerable to the judgments of those enforcing society's "norms". Unacceptance of these differences, along with the pressures the family may experience in adjusting to a foreign culture can create enormous stress which may lead to abuse. The role of society's attitudes can be seen in its effect on the individual, the family and the community.

The ecological perspective brings a broad clear focus to practice with families where there is child abuse or neglect. In considering factors at all levels of the environment, the dynamics of child maltreatment can be more clearly understood. Understanding the transactional dynamics within the family and between the family and the environment leads to more meaningful and effective intervention.

The Family Therapy Approach

Within the broad framework of the ecological perspective family therapy provides useful assessment and interventive strategies in working with families whose children are in

foster care. The development of family therapy theory and its application to work with these families will be discussed. The specific approach of the problem-centred systems theory (Epstein and Bishop, 1981), used in this practicum, is described.

The development of family therapy theory in the last thirty years has shifted the emphasis of intervention from the intrapsychic to the interrelations between individuals within the family system and between the family and its social environment. The "family therapy movement" grew out of the general field of psychiatry and was founded in the decade 1952-1961 (Broderick and Shrader, 1981). The field of social work recognized the relationship between individuals and their environment from its earliest beginnings. Mary Richmond (1922), one of the main organizers, defined social work as "those processes which develop personality through adjustments consciously effected individual by individual between man and his environment" (cited in Kadushin, 1980, p. 2). With the impact of psychiatry, social work practice shifted its focus toward the individual but has recently begun, along with the development of family therapy, to again treat the individual in the context of his/her environment.

It is essential that this shift in focus be applied in work with families in which child maltreatment has occurred. Halperin (1981) asserts that assessment and treatment models to date deal with particular parts of the abusive family.

Some approaches have focused on the individual abusing parent. Others have focused on the transactions between the parents and the resulting abuse of a child. Several treatment approaches deal with the psychological problems of the abused child. These approaches, however, do not deal with the family as a whole. Halperin emphasized that: "A comprehensive assessment and treatment plan for abusive families must also consider the family itself as the entire interacting system" (p. 91). Individuals or subsystems may need to be worked with separately in order to resolve feelings or relationship problems. It may be very threatening for the abused child to express his/her feelings or to discuss the abuse or neglect with the parents present. The siblings who remain in the home may feel uncomfortable in sharing negative feelings about their parents in conjoint sessions. It may also be necessary to work with the parental spousal subsystem separately. Halperin suggests that the "survival and recovery of the entire system depends on the level of health of the parents and their spousal relationship" (p. 94). Though family members and subsystems may be seen individually it is essential to bring the family together to reintegrate the changes made by the various subsystems. In this way the transactions involed in child maltreatment are assessed and treated within the context of the family.

Problem-Centred Systems Theory.

In working with the family as a system,Epstein and Bishop (1981) provide a pragmatic, problem-focused structure for assessment and intervention. As a part of this structure, culture, ethnicity and crisis theory will be addressed.

The problem-centred systems theory is based on a systems approach and draws on the concepts of communication theory, learning theory and transactional approach. Epstein and Bishop (1981) state that the assumptions essential to this model are as follows:

1. The parts of the family are interrelated.
2. One part of the family cannot be understood in isolation from the rest of the system.
3. Family functioning cannot be fully understood by simply understanding each of the parts.
4. A family's structure and organization are important factors determining the behavior of family members.
5. Transactional patterns of the family system shape the behavior of family members (p. 447).

To understand family functioning Epstein and Bishop use the McMaster model in which there are six dimensions of focus: problem-solving, communication, roles, affective responsiveness, affective involvement and behavior control. The major stages of treatment consider all these dimensions and are termed 'macro stages'. These are the sequential steps in the treatment process and include assessment, contracting,

treatment and closure. Epstein and Bishop state that in all of these stages the therapist acts as a "catalyst, clarifier and facilitator" and establishes a therapeutic contract which emphasizes mutual commitment with the family to work at the therapy (p. 450). The objective of the therapy is to work with the family toward openness, clarity of communication and development of problem-solving skills. Each of the macro stages includes the 'micro moves' which are the specific intervention skills necessary in carrying out the steps of the treatment process. The macrostages will be described below.

A. Assessment

Assessment is the first macro stage and includes the following four steps: 1) orientation; 2) data-gathering; 3) problem description; and 4) clarifying and agreeing on a problem list.

1) Orientation: The orientation involves clarifying the family's expectations for the interview. The beginning of the interview is a 'social stage' in which introductions are made and the family is helped to feel comfortable (Haley, 1976). The therapist begins to observe the family's interactions and to gather information about the family.

2) Data Gathering: Data-gathering occurs in four steps: a) presenting problems: b) overall family functioning; c) additional investigations; and d) other problems. Following

these steps the family and the therapist develop clear definitions of the problems to be worked on.

a) The Presenting Problem

The presenting problem is defined by the family and clarified by the therapist. This problem definition is essential to the success of the intervention. Jay Haley (1976) states - "If therapy is to end properly, it must begin properly - by negotiating a solvable problem and discovering the social situation that makes the problem necessary. Haley advises the therapist to get a clear focus on the problem and use it as a lever in achieving other goals.

b) Overall Family Functioning

Once the presenting problem is clear, the focus changes to assessment of the overall family functioning based on the six dimensions of the McMaster model - problem-solving, communication, roles, affective responsiveness, affective involvement and behavior control. A detailed assessment is obtained in each dimension with the therapist feeding back his/her understanding of the family's strengths and weaknesses and emphasizing the strengths. Each dimension is evaluated on a scale from least effective to most effective family functioning. In the descriptions below, the most effective and the least effective functioning are postulated for each of the six dimensions.

i. Problem-solving

Problem-solving is defined as a family's ability to deal with problems in a way that maintains effective family functioning. The family's ability is assessed in how they deal with instrumental (mechanical) problems and affective (feeling) problems. The process of the family's attempts to problem-solve is clarified by the steps of problem identification, communication of the problem, alternative action, decision on a suitable course of action, action taken, monitoring the action and evaluating the success of actions. Epstein and Bishop postulate that the more of these steps the family is able to carry out the more effective they are at problem-solving.

ii. Communication

The next step in evaluating family functioning is to look at communication, which addresses the question of how information is exchanged within the family. Communication is examined in instrumental and affective areas. This dimension is assessed in terms of whether the communication is clear or masked, direct or indirect. The authors identify four styles of communication: clear and direct, clear and indirect, masked and direct, masked and indirect. The most effective style in terms of family functioning is postulated to be clear and direct, and the least effective seen as masked and indirect.

iii. Roles

Roles, the third dimension, is defined as "the recurrent patterns of behavior by which individuals fulfill family functions" (Epstein & Bishop, 1981, p. 460). This dimension is also divided into affective and instrumental areas and divided further into necessary family functions and other family functions. Necessary family functions include provision of resources, nurturance and support, sexual gratification of marital partners, life skills development and maintenance and management of family system. These can be adaptive or maladaptive. Role allocation and role accountability functions are also looked at in terms of the assignment of roles and the process of monitoring these roles. The most effective family functioning occurs when all necessary functions are carried out with appropriate assignment and monitoring of roles. At the other extreme of the scale the family is unable to effectively complete even the basic functions.

iv. Affective Responsiveness

The area of affective responsiveness is defined as "the ability of the family to respond to a range of stimuli with the appropriate quality and quantity of feeling" (Epstein & Bishop, 1981, p. 463). In assessing the responses two areas are looked at: "welfare" feelings and "emergency" feelings. Welfare feelings are characterized by responses of love, caring and happiness. Emergency feelings include fear, anger, disappointment and depression. In evaluating function-

ing in this dimension it is determined whether the affective response is appropriate to the situation in relation to quality and quantity. For example, to respond with rage to a family member's sadness would be inappropriate. To respond with happiness to another member's expression of caring would be appropriate. Effective family functioning would be the ability to respond with the full range of feelings and with the appropriate intensity and duration. Families who respond with an extremely narrow range of emotions, or whose responses are consistently inappropriate in quality and quantity are seen as the most ineffective.

v. Affective Involvement

This dimension refers to the extent to which the family shows interest and appreciation for the activities and interests of family members. The degree of involvement is based on the following range: absence of involvement, involvement devoid of feelings, narcissistic involvement, empathetic involvement, overinvolvement and symbiotic involvement. Empathetic involvement is viewed as the most effective and the two extremes, absence of and symbiotic involvement, as the least effective.

vi. Behavior Control

The behavior control dimension is defined as the pattern a family adopts for handling behavior in situations involving physical danger, psychobiological needs and drives, and interpersonal socializing behavior. The four styles of be-

havioral control are rigid, flexible, laissez-faire and chaotic. Flexible behavior control is viewed as the most effective and chaotic behavior control as the least effective.

The six dimensions of the McMaster model provide a useful guide in the data-gathering stage for understanding and evaluating the function of a family. A careful exploration in all of these areas yields information regarding the family's strengths as well as difficulties that were not originally defined.

c) Additional Investigations

The area of additional investigations in the process of data-gathering is left wide open to include individual psychological and biological variables as well as assessment of the family's broader social system. Thought this step is not as specific as the other steps in gathering information it is essential to understanding the functioning of the family. Pertinent information regarding the developmental history, intelligence, and physical status of the child may need to be investigated. Psychosocial or psychological assessments of the parents may also be useful. Assessment of network support may occur at this stage.

The influence of culture needs to be considered when assessing the family and will be elaborated on at this point. The importance of culture and ethnicity is seen in the "formation of self-concept, development of family identity and

the development of historical continuity (an experience of family immortality)" (Rivera and Velaquez, 1983, p. 360). Ethnicity defines the family's cultural activities, attitudes, beliefs and patterns of behavior. Conflicts may arise when the family is faced with having to compromise their cultural identity in some way in order to adapt to the environment. Canadian Indians are an example of a group whose way of life differs from the mainstream of society. Their child rearing beliefs and practices exemplify this difference. They encourage children to make decisions much earlier in life than children in the dominant society (Blanchard, no date). This may be viewed by non-Indians as too permissive or even neglectful. Another practice that may be viewed as neglectful is the sharing of parental responsibilities with other tribes people. Each child has many caretakers. This encourages group identification and an opportunity to observe and be taught by many people (Blanchard). The view by the larger society that the natural parents have the major responsibility for their children's development is not entirely appropriate when applied to Indian families. It is important to recognize the family's transactions with the larger societal structure and how these may be creating stress and/or influencing the activities of the family and is members.

d) Other Problems

In this final step of data-gathering the family is asked if there are any other significant difficulties to be explored. If there are, these are discussed. If there are no further problems the therapist moves on to the final steps of the assessment phase.

3) Problem Description: In this step the family and therapist compile a list of the major issues that they have identified and which is as comprehensive as possible.

4) Clarifying and Agreeing on a Problem List: In this final step of assessment the objective is to reach an agreement among the family members and with the therapist on the problem list. Disagreements are negotiated by discussing and clarifying the problem further and achieving either an agreement or an agreement to disagree. The therapeutic process cannot continue unless major disagreements are resolved in this way.

B. Contracting

The second macro stage in the model is contracting. In this stage a written contract is prepared that "delineates the mutual expectations, goals and committments regarding therapy" (Epstein & Bishop, 1981, p. 469). First, the family is oriented to the change in focus from data-gathering to defining a problem to work on. Secondly, the therapist outlines treatment options such as not continuing with therapy, obtaining treatment for only part of the family or continu-

ing to work together on the problems as a family. If family treatment is chosen the process moves on to negotiating expectations. In this step the family negotiates among themselves what changes they want in the family. The family members define their expectations and the therapist clarifies and helps each member define his or her expectations in concrete behavioral terms. Contract signing is the final step in this stage. The problems selected to work on, the expectations for behavioral change and the signatures of the therapist and family members are included on the contract. All agree to work together toward change.

Since contracting was the treatment method explored in this practicum its various uses will be discussed in a later section of the literature review.

C. Treatment

Treatment is the third macro stage and includes orientation, clarifying priorities, setting tasks and task evaluation. The orientation is similar to the other stages. The second step involves priorizing the problem list according to the order in which the family wants to approach the problems. The therapist intervenes only if an urgent problem such as anorexia, alcoholism or suicide potential is overlooked. In setting tasks, the family negotiates a task in attempting to work out the first problem on their list. may suggest tasks if the family is unable to do so. The general principles of assigning tasks are explained to the family.

Some of these are: describing the task in concrete behavioral terms; the task should be reasonable and have maximum potential for success and should be aimed at increasing positive behavior rather than decreasing negative behavior. Family members are assigned to monitor and report on the performance of the tasks. The last step is to evaluate whether or not the task was accomplished. Positive reinforcement is very important when the task is completed. If the task is not completed it is discussed, clarified and renegotiated. The process of task setting, evaluating and recontracting continues until the family's expectations are met. The family takes responsibility for working on their problems but the "success of outcome in most cases directly reflects the degree of rigor and thoroughness that the therapist maintains in family sessions" (Epstein & Bishop, 1981, p. 473).

D. Closure

Closure, the final macro stage involves four steps: 1) orientation; 2) summary of treatment; 3) long-term goals; and 4) follow-up (optional). In orienting the family to this final stage it is pointed out that their expectations have been met and there is no need for further treatment at this time. This is discussed with the family and they are encouraged to return for therapy at any time. The family and therapist then summarize what has occurred in the sessions. In the third step the family identifies long-term

goals and issues that they feel may come up in the future. The therapist reinforces the family's ability to cope with problems. The follow-up step is optional and simply involves monitoring the family's progress.

IV. EVALUATION OF THE MODEL

The problem-centred systems model establishes a concrete, problem-focused framework within which to work. There are several advantages in applying this model to working with families whose children are in foster care. The problem-solving focus assures the family that the problems they bring to therapy will be directly addressed. The model actively involves the family in problem-solving so they learn and practice the skills and apply them to further problems. Many families are overwhelmed and immobilized by the problems. Involving them in a systematic analysis of the problems and in steps toward solving them can help the families move in a positive direction. Having the family work together in solving problems encourages and reinforces them in identifying interactional rather than individual sources of problems. The model also offers a clear, concrete assessment guide which enables the therapist to identify strengths as well as difficulties. The families have often lost sight of where their strengths lie and these need to be reinforced to give the family the strength and hope they need to work on their problems. The contracting stage of this model is useful in providing focus, clarity and mutuality in working

with the family toward solving problems. Negotiating, clarifying and reaching an agreement on the priority issues and then obtaining a written contract helps the family to be clear and open about their expectations. The contract elicits commitment from the therapist and the family members in working toward solutions. Another advantage to the model is the task-setting step in the treatment stage. Defining problems and tasks in concrete, behavioral terms gives clear direction for action in solving problems. This active participation in problem-solving will enable the family, immobilized by problems, to start taking concrete steps toward solving them.

In using the problem-centred systems model the therapist also needs to be sensitive to the family or family member in crisis. Often in child welfare situations it is important to deal with the immediate problem causing the stress and not to adhere rigidly to the structure of the model. Focusing on the crisis is an ideal opportunity to assess family functioning but also to effect change since the family is motivated to accept help. Caplan's (1961) definition of crisis is a situation in which "'... a person faces an obstacle to important life goals that is, for a time, insurmountable through utilization of his customary methods of problem-solving'" (cited in Golan, 1978, p. 62). Removal of a child from the family precipitates an acute crisis which needs to be dealt with immediately. Dealing with the crisis

is not only necessary to relieve the stress but to effect change in the way the family copes with problems. The family may resolve this crisis and return to a steady state but may encounter various other crises throughout the course of treatment.

Baldwin (1968) provides a useful framework for crisis-focused intervention. The first step is to identify the stress. In this step the focus is on why the crisis occured now. The therapist explores what happened to upset the equilibrium by eliciting the environmental and emotional factors that are contributing to the stress (p. 28). Often the child who has been removed is identified as the problem but in exploring the family's experience the focus is taken off the individual and on to each member's way of functioning in the family. Once the source of the stress is identified the family is encouraged to talk about the crisis. The therapist works towards a solution with the family by supporting them in facing the crisis and by reinforcing their adaptive defenses. The family needs to be helped in communicating clearly about the problem and in working together toward the solution. Each member's task in this process must be clear. Once the family has returned to a state of equilibrium further problem-solving can continue. In this practicum crisis intervention theory was used in conjunction with the problem-centred systems model when deemed appropriate.

Contracting

Contracting is the specific technique that was used where appropriate, within the family therapy model. In the assessment phase of the problem-centred systems model the family delineates areas for change. In working toward change contracting provides focus an clarity and involves the participants in a mutual commitment to work together. There are two general categories of contracting discussed in the literature--those that involve long range goals and those that involve short range goals. These areas will be referred to as primary contracting and secondary contracting. Though primary contracting was used to some extent in the practicum, secondary contracting was the major intervention tool employed.

In working toward specific, short range goals behavioral contracting is especially applicable. The literature discusses its use in areas of practice such as behavior therapy (Stuart, 1971), family and marital counselling (Gootnick, 1976; Rosenberg, 1978), and problem-solving counselling (Blechman, 1976). Behavioral contracting has also been applied to families with children in foster care (Harejsi, Vandeberg and Clark, 1981; Stein :& Gambrill, 1976). The use of behavioral contracting will be explored in this practicum.

Definition of Contracting

Essential to the effective use of contracting as a tool in working toward change in the development of a clear definition and conceptual framework. Maluccio and Marlow (1974) trace the origins of the term "contract" as applied to social work back to the writings on group work in the 1940's and 1950's. These writings refer implicitly to agreements involving group formation, the group worker's role and the terms of help available from the agency. Maluccio and Marlow (1974) describe the term "contracting" as it appears in the theoretical approaches of Perlman, Rapport, Schulz, Thomas, and Smalley. These approaches emphasize the participation of the client in making active choices in the use of helping agencies. As the definition of contracting becomes clearer its potential value and use in the intervention process becomes more evident.

There are various definitions in the literature which help to make clear the use of contracting. Webster's New World Dictionary defines contracting as, "An agreement between two or more people to do something, especially one set forth in writing and enforceable by law; compact; covenant." In the social work literature contracting is referred to as a mutual decision-making process (Pincus & Minahan, 1973; Rappaport & Horrell, 1972; Seabury, 1979). A more specific definition of the use of contracting in social work is the "explicit agreement between the worker and the client concerning the target problems, the goals and the strategies of

social work intervention, and the roles and tasks of the participants" (Maluccio & Marlow, 1974, p. 30). The use of contracting in a behavioral approach is defined by Stuart (1971) as a "means of scheduling the exchange of positive reinforcements between two or more persons" (p. 2). This definition refers to specific behavioral changes made within a limited time period involving reciprocal exchanges between family members or between a family member and the social worker. Maluccio and Marlow's definition refers to a long term agreement regarding the responsibilities of the service agencies and the client. It is useful to differentiate between short term (secondary) contracting and long term (primary) contracting. These two major areas of contracting will be further described.

Primary Contracting.

Primary contracting involves long term, major goals and involves agreements between the client and the social worker and/or the major service agency. Stein, Gambrill and Wiltse (1974) state that the source for selection of goals in long term contracts with parents whose children are in foster case is either the original allegations that lead to the removal of the child or the presenting problems of the parents in a voluntary placement. Such a contract would specify particular agreements between the agency and social worker and the client. It would include statements of the client's objectives, the goals for treatment, the agency and worker's

agreement to support the parent's objectives and the potential consequences if the parent does not participate in meeting the objectives. Examples of long term goals are the elimination of drinking by both parents, the securing of steady employment and the demonstration of appropriate parenting skills.

Also included in the area of primary contracting is what Horejsi, Bertsche & Clark (1981) refer to as a "service agreement". The American Public Welfare Association (1979) defined a foster care related service agreement as a "written document which specifies the behavioral objectives of service and describes, in concrete terms, the actions that will be taken within established time frames to facilitate accomplishment of the objectives" (cited in Horejsi, et al., p. 113). The service agreement describes the services to be provided and the actions necessary to secure those services. Horejsi, et al. distinguish between "hard" and "soft" services. Hard or concrete services include homemaker services, financial assistance, job training, employment and housing. Soft services are such activities as counseling, psychotherapy, family therapy, mutual support groups and behavior modification. In summary, primary contracts specify treatment objectives and who is to do what, within a specified time period.

There are two major factors to be considered in setting up a service agreement with families whose children are in

foster care. First, the agreement must reflect a consensus between the worker and the family and secondly it must also address the obstacles that keep the child from returning home (Horejsi, et al., 1981). The agreement on how the family's objectives are to be met should not be a list of tasks or expectations that the worker dictates. It is important for the family to participate in selecting treatment goals and in deciding who is to provide what service. "When the client assumes responsibility for choosing among alternatives and using his own skills and resources to deal with his agreed-upon tasks, this enhances his motivation, investment, and self-esteem" (Malucio & Marlow, 1974, p. 32). Reaching a consensus is an essential aspect of the service agreement.

Equally important in developing the service agreement is the focus upon the reasons for the original removal of the child (Stein, et al., 1974). This focus clarifies what has to be changed before the child can be returned. In establishing the criteria the parents' abilities at that time and what is reasonable for the child's well-being and safety must be considered (Horejsi, et al., Stein, et al.). The service agreement brings clarity, focus and consensus in working with families whose children are in foster care.

Secondary Contracting.

Secondary contracting differs from primary contracting in that it involves specific treatment methods, short term goals and agreements between participants other than the worker or agency and the client. Seabury (1978) refers to secondary contracting an an "ancillary agreement that supports or facilitates the primary contract between worker and client" (p. 37). The secondary contract is an agreement between the parents and significant others or other service network people, and involves steps to be taken in achieving goals outlined in primary contracts. For example, the parent whose goal is to stop drinking may contract to receive substance abuse counselling twice a week. Or, the parent who has been unable to control an aggressive child may contract with a family service agency to receive counselling in child management skills. Contracts may also be set up in either the extended family or the immediate family to change interactional patterns. For example, parents who are constantly in conflict may set up a contract to listen to each other's definition of the problem rather than just defending their own point of view. The goals in secondary contracting are short term and are small, specific steps in reaching the larger, primary goals. Various treatment methods are used in working with clients toward specific goals. Behavioral contracting is one such method and its use with families whose children are in foster care is explored in this practicum.

Behavioral Contracting

Behavioral contracting is a technique used within various frameworks of practice. DeRisi and Butz (1975) define contracting as a "technique to structure behavioral counselling by making each of the necessary elements of the process so clear and explicit that they may be written into an agreement for behavior change that is understandable and acceptable to everyone involved" (p. 1). Fatis and Konewko (1983) discuss the use of contracting as an adjunct to family therapy in the "explicit process of setting rules and making agreements" (p. 161). Jacobson (1978) asserts that contingency contracting (a form of behavioral contracting), is most effective when used together with problem-solving training. A family contract game was conceived by Blechman (1974) to be used in guiding families through problem-solving steps by writing behavioral contracts. Stein and Gambrill (1976) applied behavioral contracting to the problems of parents with children in foster care. Behavioral contracting has various applications within different theories of practice.

Behavioral Concepts

The behavioral concepts of contracting are based on theories of social learning. These theories are derived from the "concept of a functional relationship with the environment in which changes in individual behavior produce changes in the environment and vice versa" (Herbert, 1980, p. 109). This reciprocal exchange between people and their environ-

ment is consonant with the ecological perspective discussed earlier. Social learning theory asserts that "much of our behavior represents the outcome of what we have learned from other people" (Patterson, 1971, p. 12). An example that Patterson uses to illustrate this process is a mother teaching her child a new word. The mother rewards the child with praise and a hug when he says the right word and he, by his correct response, rewards her for being a good teacher. This simple example illustrates the reciprocal exchange that occurs in the process of learning behavior.

Changing behavior deals with "objectively defined and observable behavior occurring as a function of antecedent and consequent environmental events" (LeBow, 1973, p. 313). The environmental events (independent variables), must be manipulated to produce change in behavior (dependent variable). Abnormal or problem behaviors are seen as exaggerations, deficits or handicapping combinations of behavior patterns that are common or normal in others (Herbert, 1980). The therapeutic task involves "increasing or strengthening skill in areas of behavioral deficits or decreasing or eliminating problem behavioral excesses" (Gibbs & Lachenmeyer, 1982, p. 273). In summary, behavioral theory states that behavior is learned through reciprocal exchanges with the environment. Antecedent and consequent events can be manipulated to change the target behavior.

The Behavioral Approach with Families

A behavioral approach is relevant and effective in working with families toward change. Liberman (1970) states, "Since the family is a system of interlocking, reciprocal behaviors (including affective behavior), family therapy proceeds best when each of the members learns how to change his or her responsiveness to the others" (p. 330). Ways of responding to each other can be translated into "consequences of behavior or contingencies of reinforcements" (Liberman, p. 329). This approach to changing behavior within families facilitates the use of family members and significant others such as teachers, guardians and friends as important change agents. Training parents in the use of behavior management techniques has been demonstrated to be effective in its application to behavior problems in children (Gordon & Davidson, 1981). Patterson (1971) outlines the concepts and procedures of behavior change in his book, Families. He asserts that an understanding of the social learning process "puts the individual in the position of partially controlling his own behavior -- a position of some dignity" (p. 7). Each family member can learn how to change his or her own behavior and the behavior of those in the immediate environment.

Behavioral Assessment and Intervention Techniques

In working toward change the social worker and family members assess problem areas, specify target behaviors and set up a treatment and evaluation program. The family as-

sessment includes a social and developmental history and a functional analysis of the family members' interactions and feeling(Herbert, 1980). The family and the worker identify areas for change and select specific target behaviors. Herbert advocates use of the ABC sequence (antecedent events, behavior, consequent events), in determining what is reinforcing the behavior. Focusing on the behavior allows for quantification and measurement and for evaluation of the effects of the treatment program (Gibbs & Lachenmeyer, 1982). Evaluation involves observing and recording the frequency of the target behavior before, during and after treatment.

The treatment program includes specific techniques for increasing or decreasing behavior. The three techniques for increasing behavior are reinforcement, contingency contracting and token economies. Reinforcement involves the presentation or continuation of a desirable event or condition. Reinforcement also occurs when an undesirable event is removed or discontinued. Social reinforcers found in the behavior of another person on particularily powerful (Patterson, 1971). These are seen as the most important source of motivation for human behavior (Liberman, 1970). Social reinforcers are such behaviors as a touch, a smile, a kiss or words of approval. Contingency contracting is the use of a "negotiated and clearly specified agreement" which outlines the behaviors expected and the rewards received if the behavior increases (Gibbs & Lachenmeyer, 1982). To increase

desirable behavior tokens can be used to exchange for objects or events that are reinforcing. Techniques for reducing undesirable behavior are extinction and punishment. Extinction eliminates behavior by withholding reinforcing events that maintain behavior. Extinction of undesirable behavior can be combined with reinforcement for alternative desirable behavior. For example, aggressive behavior would result in loss of a privilege and non-aggressive behavior would be rewarded with an extra privilege. Punishment to reduce behavior is used in four factors: 1) presentation of a physical noxious stimulus; 2) intensive practicing of correct responses; 3) removal from a reinforcing situation and 4) removal of a positive reinforcer in the form of a penalty (Gibbs & Lachenmeyer, 1982). In using the behavioral approach the social worker provides the family with tools to assess and delineate problem areas to bring about change through the manipulation of environmental events.

Behavioral Contracts

Based on the concepts and techniques of a behavioral approach, contracts "structure reciprocal exchanges by specifying: who is to do what, for whom, under what circumstances" (Stuart, 1971, p. 3). Contracts enhance the likelihood that responsibilities will be met by making roles specific for family members. The specific behaviors and reinforcing arrangements are negotiated by the parties involved and written down. For example, if the target behavior is a

child's tardiness in coming home after school, the expected behavior and the reward for compliance are agreed on and written down. For being home by 5 p.m. the child may be given points which (s)he can exchange at the end of the week for privileges such as an outing with Dad or purchase of a toy. Specifying and writing down reciprocal exchanges within families contributes to interactional stability (Stuart, 1971). Members know what behavior to expect from the other member under what circumstances.

Behavioral contracting with families involves four assumptions as outlined by Stuart (1971):

1. Receiving positive reinforcements is a privilege rather than a right.
2. Effective interpersonal agreements are governed by the norm of reciprocity. A norm is a behavioral rule that is agreed on, at least in part, by the participants. Reciprocity refers to the rights, duties and items of equal value to exchange of each member.
3. The more positive reinforcement that one gives, the more reinforcements one will receive.
4. Rules create freedom in interpersonal exchanges. That is, individuals have the opportunity to make behavioral choices knowing the probable outcome of each alternative. These assumptions provide a useful guideline in setting up contracts with families.

Stuart (1971) also lists five elements that are contained in good contracts: 1) the privileges expected after fulfilling responsibilities; 2) the responsibilities necessary to obtain each privilege; 3) the consequences for not meeting responsibilities; 4) a system to monitor responsibilities fulfilled; and 5) a bonus clause to assure positive reinforcement for compliance. These five elements ensure that the contract makes the behavioral exchanges clear and specific.

Advantages and Difficulties of Contracting

Contracting in its application with families whose children are in foster care has many advantages but also some difficulties. Before looking at the advantages which make contracting a useful tool, the factors that make contracting difficult will be discussed.

Seabury (1979) discusses situations in which contracting may be difficult. Contracting is impossible to employ in a situation where there is little or no chance of any significant agreement between worker and client. If a marginal working agreement is reached, contracting will be problematic and often fails to achieve positive results. Seabury also states that contracting is contraindicated in a severe crisis which requires the worker to act quickly. Contracting may also be difficult with the involuntary client because it involves full client participation and mutuality in negotiating goals. For example, in situations with abusive

parents the "terms of the legal arrangements must be distinguished from the stipulations of the social work contract" (Seabury, p. 36). That is, the client must know which problems, goals and procedures can be negotiated with the social worker and which are determined by a court order. Another difficulty to be aware of in the use of contracting is the possibility of implicit goals behind the stated ones. Beall (1972) refers to this difficulty as a "corrupt" contract. The worker, client or other participants may pursue a goal that is not explicitly stated. For example, the worker may agree with the parents to work on the child's problem but covertly intend to work on the marital relationship. Or, the client may conceal goals that oppose those agreed on with the social worker. It is important, therefore, that objectives be clearly and openly stated to enhance the possibility of working toward mutual goals.

In setting up behavioral contracts there are specific issues that need to be addressed. Objections to behavioral techniques include the ethical questions of who decides what behavior is undesirable, and does it really need to be changed? (Herbert, 1980). To alleviate these concerns it is important for the social worker to share thoughts and information with the family and to democratically negotiate treatment objectives. Another difficulty is in obtaining accurate observation, measurement and recording of behavior. The behavior must be clearly specified and easy to observe

and count or the measurement will not be accurate. Behavior changes are gradual and require many reinforcements given consistently over a long period of time (Patterson, 1971). It may be difficult for the participants to persist if the results are not immediate. The workers must be supportive and encouraging to assist the family to persist in order to bring about long-lasting changes.

The use of contracting with families whose children are in foster care has advantages that counter balance the difficulties. Maluccio & Marlow (1974) delineate many advantages:

> The use of a contract can help facilitate worker-client interaction, establish mutual concerns, clarify the purposes and conditions of giving and receiving service, delineate roles and tasks, order priorities, allocate time constructively for attaining goals and assess progress on an ongoing process (p. 30).

Contracting maximizes mutuality between the worker and the client and maximizes the participation of clients in establishing goals and treatment plans. The contract also helps to delineate the tasks and roles of the worker and the client. The client is responsible for "choosing among alternatives and using his own skills and resources to deal with agreed-upon tasks" (Maluccio and Marlow, 1974, p. 32). This enhances his/her motivation investment and self-esteem. Study (1968) states that the worker's responsibility is "to provide the conditions necessary for the client's work on his task" (cited in Maluccio and Marlow, 1974, p. 32). An-

other great advantage in the use of contracting is its quality of being specific, clear and open. The contract provides the opportunity to formulate explicit and specific goals and makes clear the steps in reaching them.

Behavioral contracting in its focus on specific, behavioral goals forces participants to operationalize problems so they can be observed, measured and progress evaluated. This procedure provides a systematic, manageable method of problem solving. Fatis ond Kanewko)1983) observe that in "distressed families (there are) low rates of reciprocal reinforcement, high rates of punishment (and) negative expectations regarding the likelihood of change" (p. 161). Use of behavioral contracts provides opportunities for rewards, limits the use of punishment and enhances the likelihood for change. The steps in reaching goals are set within the capacity of the client's ability so some measure of success is obtainable. In observing and measuring specific behavior, progress can be seen in concrete terms. In other works, the "successfully implemented written contract provides evidence of personal mastery" (Rappaport & Harrell, 1972, p. 162). In summary, contracting facilitates the worker and client in the process of mutual goal-setting, clarifying objectives and specifying ideas and tasks.

Summary

The literature review serves to build the framework upon which the practicum is based. The need for a family ap-

proach in working with families where there is neglect or abuse is demonstrated. The ecological perspective provides an analysis of the process of the maltreatment of children in the context of the family in its transactions with the environment. Problem-centred systems theory is used as a structure in assessing family functioning and in providing a problem-solving focus to the intervention process. Contracting is the specific interventive tool to be explored in working with families towards goals they select.

Using the framework described in the literature review, the practicum involved work with families whose children were in foster care. It is my contention that intervention with this client group is particularily lacking in a structured, family-oriented approach. Intervention with families whose children are in foster care, requires immediate and purposeful intervention. To this aim, the use of contracting within a family therapy approach is described and illustrated in the practicum.

THE PRACTICUM

The Setting

The practicum was conducted at the Children's Aid Society of Winnipeg within a Family Services Unit. This agency provides a range of services for the purpose of providing care and protection to children and in supporting the preservation of the family system when at all possible. There are four Family Services Units which provide ongoing assessment and intervention as required by families. The families have children in foster care or require intervention to prevent the placement of children.

The Clients

Families were referred to me by the social workers from two of the Family Services Units. The referrals were screened by me in conference with the unit supervisor, using the following criteria:

1. The family had one or more children in foster care;
2. the children had come into care within three months of the referral;
3. there was no family counselling actively in progress; and

4. the family was receptive to counselling.

Families that met the first three criteria were contacted to explain the purpose and the mode of intervention and to obtain a verbal agreement from the family to work together. It was important, because of the limited time frame and the family focus of the intervention, that agreement was established from the beginning. The philosophy and the importance of working with the whole family and the use of behavioral contracting were briefly explained.

Ten families were referred for counselling: six were selected and provided with intervention during the practicum. Of the four families not selected, two were unprepared to proceed with counselling at that time. In one family the parents felt they could do no more until their teen-age son made some changes. The parents in the second family were ambivalent about receiving counselling and decided to enlist other services after requesting their teen-age daughter be returned home. The situations of the remaining two of these four families were too unstable to proceed with counselling. In contracts made with them by the referring worker it was clear that they were not receptive to family intervention. Of the six families who participated in the practicum, each had one child in care when initially referred for counselling. The sizes of the families ranged from two members to six members. The financial and marital status of the families varied somewhat. Four of the families were parented by

divorced or separated mothers. Three of those mothers were receiving social assistance and one was gainfully employed. A fifth family had two parents and was supported by the father's income. The sixth family was parented by a mother and a step-father who had recently married and who both worked full-time.

The problems presented by these families had often evolved from patterns of functioning in the parent's family of origin. Family structure and functioning was affected by the family's interaction with the extended family and the community. The families were experiencing a multitude of problems and some had a long history of child welfare involvement. The presenting problems the parents identified involved issues relating to behavior control of the one child. In families with more than one child, the eldest was identified as the problem and placed in foster care. The ages of the children in care varied from seven years to sixteen years. Four of these children were either physically abused by the parent or at risk of being abused. The other two children, ages fourteen and twelve, were out of control in the home and faced juvenile charges in court. In four of the families the parents were unable to cope and requested Children's Aid Society to place the child in foster care. In another family, the child was removed from the home by the Children's Aid Society because of physical abuse. In the sixth family, the child left home and refused to return.

Two of the children were returned to the parents' care during my involvement.

The duration of the practicum was three and a half months and the number of sessions with each family ranged from six to fourteen. This number included some individual interviews with the children in foster care and with the parents. Several of the interviews were conducted in the families homes, some were conducted at the agency office and one family was seen at the treatment institution where the child was placed. All of the families were receptive to counselling and only one family did not continue to the end of the practicum. The specific steps of the intervention are described in the following section.

The Procedures

The ecological perspective in analyzing the process of child maltreatment was used as a guide in the assessment and intervention phases. The problem-centred systems model was used to structure the assessment process and to bring a problem-solving focus to the intervention. The use of contracting as one of the interventive tools is described in detail. The other interventive strategies within the family therapy approach are briefly addressed.

The Assessment

The ecological perspective and the problem-centred systems model were used in assessing each of the families. Though a structured assessment was conducted in the initial interviews, intervention began at the first interview and ongoing assessment occurred in conjunction with the intervention process. That is, assessment and intervention were not mutually exclusive phases. In applying the ecological perspective, geno-maps (see Appendix A) and eco-maps (see Appendix B), were used to assess the structure and the interaction with the extended family and the community support systems. The problem-centred systems model provided a structure for gathering information and facilitated the selection of the goals.

The Intervention

Contracting: Treatment goal contracts (see Appendix C), were used when deemed appropriate in working toward the goals the family identified. The contracts included the goals that were important to the family, the tasks that acted as outcome measures and the rewards selected to motivate change. The contracting guide formulated by DeRisi and Butz (1975) was used in developing the contracts. The procedural steps they identify are: 1) selecting treatment goals; 2) describing, observing and measuring treatment goals; 3) identifying rewards; 4) writing the contract; and 5) reviewing the contract. These steps will be described in detail.

1) Selecting Treatment Goals. Specific criteria were used in the selection of goals. It was important that the first goal selected to work toward was one which was likely to be met with success. Success in reaching the first goal was a factor in working toward other goals. In selecting further treatment goals it was essential to consider those in which there was some possibility of change within the three and a half month time frame of the practicum. The goals selected did not necessarily address the presenting problem directly but affected it through changing family communication and interaction patterns. Treatment goals were used as levers in effecting change in the presenting problems. A final factor in goal selection was that no more than two or three goals were worked on with each family.

2) Describing, Observing and Measuring Treatment Goals. The treatment goals were specified in terms of behavior that could be observed and measured. The description included information as to what the specific behavior was and what other people did before and after the behavior occurred. For example, in describing a child's aggressive behavior at school information was collected as to what happened at home and at school leading up to and following a particular incident of aggression.

Once the behavior was described in terms that could be measured (e.g., number of fights at school), they were observed and counted by a family member or by self-report. It

was not always possible to collect data prior to the intervention because of the time restraints of the practicum and the need for immediate intervention in some situations. For example, spending time gathering baseline data in a family where the mother's low tolerance level put the children at risk of abuse would likely have exacerbated the situation. Intervention had to begin immediately to avert a crisis. If baseline data was not available, an estimated count of the behavior was given.

Goal Attainment Scaling (Kiresuk & Garwick, 1975), was used to measure the client's progress in reaching the goals specified (see Appendix D). On the G.A.S. Follow-Up Guide (see Appendix E), specific predictions for a series of outcome levels for each goal were described in conjunction with the client. For example, for the goal to reduce the number of fights the child had at school, the "expected level of treatment success" was to have no more than two fights in one week. Three or four fights was the "less than expected success" and more than four fights was the "much less than expected outcome". The "more than expected" and "most favorable outcome" were defined as the child having either one or no fights at all for one week. The client's level of functioning before the intervention was indicated on the Current Level of Functioning form (see Apendix F) and charted each time the contract was reviewed. The level of functioning attained at the end of treatment was indicated on the Follow-Up Guide.

3) Rewards. Rewards were crucial in motivating the clients to accomplish the tasks in reaching their goals. Family members identified incentives such as special activities, praise, money, treats or other rewards. These were administered by the parents or by the therapist. For the children in foster care, a visit with their families was not used as a reward since it was viewed as a right not a privilege. Instead rewards such as special activities, treats and praise were used during family visits.

4) Writing the Contract. The contract was reviewed with the client on a specified date and rewritten if necessary. If there was little or no improvement in the problem area, the contract was discussed with the client in an attempt to correct, improve and clarify it. In locating the trouble spots in the contract, the following questions were addressed:

1. Was the treatment goal clear and specific?
2. Were the tasks (outcome measures) manageable?
3. Were the rewards given immediately, consistently and in appropriate amounts?
4. Did everyone involved in the contract understand it?
5. Was the observer reliable in counting the behavior?

Once the trouble spots were located, the contract was rewritten to incorporate the changes. If the client had made progress in reaching the goal, another review date was set.

Once the client achieved the "expected level of outcome", another goal was selected to replace the previous one and the process of monitoring, reviewing and rewriting continued to the end of the practicum.

Other Interventive Strategies

Contracting was viewed as one treatment tool within a family therapy approach. It was at times difficult to employ and not always applicable. Alternate techniques were used in conjunction with contracting. Family members were seen individually when it was deemed beneficial to the treatment process. For example, a mother was seen individually to discuss her personal problems and child management skills. This was a manoeuvre to separate the parent and child sub-systems because of the unclear boundaries between them. The children in foster care were also seen individually. "A Child's Guide To Understanding Foster Care", written by the author, (see Appendix G) was used in working with two of the children around issues related to being in foster care.

Other techniques were used to work with the families to develop problem-solving skills or to understand and modify certain communication and interaction patterns. Techniques were used to work with the families in expressing their feelings openly and in discussing family problems in ways that led to resolutions rather than to conflicts. Tasks

were used that were not always written into contracts but were verbally agreed upon by the family. Examples of such tasks were to have the family engage in specific activities together, to have the parents give their daughter praise or to have family members practice active listening. These were some of the techniques used along with contracting within the framework of family therapy. The client's progress, when these strategies were used, was based on subjective measures derived from client and superior feedback and worker observation.

Termination

In terminating with the families the goals they worked toward were summarized and changes identified and evaluated. Other goals or areas for change that had been identified but not resolved, were discussed and suggestions made for further work. Referrals to community resources were discussed with the families before termination and contents were made to connect them with appropriate resources. The Children's Aid Society worker attended the last session so that continuity of contact was maintained.

The case illustrations will demonstrate the procedures that have been outlined.

Case Illustrations

In the following case illustrations assessment and intervention with three of the families are described briefly. The remaining three are described in detail. All names and identifying information have been altered to ensure confidentiality.

The Jones Family

Mrs. Jones was a forty-four year old Native woman and a single parent of twelve year old Ann. Mrs. Jones and Ann were seen together for seven weekly sessions at the Children's Aid Society. Mrs. Jones was seen in her home once and Ann was seen individually twice. Mrs. Jones had a long history of Children's Aid Society involvement because of her heavy drinking and resulting abuse and neglect of her children. She had eight children, two of whom were placed by the Children's Aid Society for adoption and five who were raised by relatives. Ann, her youngest daughter, had been in and out of foster care for about eight years and had rescently been removed from her mother's care because of physical abuse. She remained in foster care during my involvement.

Assessment.

Presenting Problems: Mrs. Jones stated that the problems were that Ann should listen more, come home when she was told and always tell her where she was going.

Family Functioning: Problems were not resolved in this family. Mrs. Jones identified Ann as the source of the problems and expected her to change. Mrs. Jones and Ann experienced a great deal of sadness. Mrs. Jones said she prayed, tried to think of good things and watched television when she was sad or lonely. Ann's sadness was evident in her quiet withdrawal and silent tears but she did not verbalize her feelings. Mrs. Jone's anger was uncontrolled at times and resulted in harsh physical punishment. Mrs. Jones looked to Ann for nurturance and support and said she "lived just for Ann". Mrs. Jones attended well to instrumental functions and kept her house exceptionally neat and clean.

Further Investigations: Mrs. Jones was the fourth child in a family of eight children and was raised in a tuberculosis sanitorium until she was twelve years of age. Her extended family lived in another province and many of them had a history of drinking problems. Mrs. Jones had some contact with the extended family and her adult children. Ann had visited the family and met some of her siblings on one occasion. Mrs. Jones was not drinking to excess and had cut off her contact with her drinking friends. She was starting to make new friends in the community but had few contacts with service agencies.

Intervention.

When the family was first seen, Ann had not wished to visit her mother since her removal from the home two months before. She felt ambivalent about seeing her mother because of the physical abuse and wanted the Children's Aid Society worker to attend the first family session. Initially Mrs. Jones showed Ann very little physical affection and talked about what Ann had done to make her worried or angry. After a discussion of owning one's feelings, Mrs. Jones was confronted with the need for her to take responsibility for her own feelings. Ways of dealing with feelings without blaming were discussed and practiced in the sessions. Problem-solving steps were also discussed in relation to the problems Mrs. Jones had identified in Ann's behavior. Mrs. Jones was encouraged to see the "good" in Ann's behavior and not just the "bad". She began to bring up examples of good times they had together and of good things Ann had done. As Mrs. Jones consciously thought more positively about Ann, and as Ann became more comfortable in the sessions, Mrs. Jones showed much more affection through hugs, smiles and praise.

Mrs. Jones began to visit friends in the community more and said that helped her to feel less lonely. She was interested in developing some of her interests in crafts and the Native culture. This was seen as important in helping Mrs. Jones to be less dependent on Ann in dealing with her feelings of sadness and loneliness. A contract was set up to increase her involvement in personal and social inter-

ests. Her task was to contact the Indian-Metis Friendship Centre and to attend one activity there. Mrs. Jones did not initiate this contact so I arranged an appointment with a counsellor and went with her to the first interview.

Ann was seen individually to read and discuss parts of "A Child's Guide to Understanding Foster Care". Sections dealing with reasons for being in foster care and with feelings foster children have were of particular interest to Ann. She found it difficult to talk about the physical abuse by her mother. It was emphasized that the abuse was not her fault and that her mother needed help to change. In helping Ann to talk about her feelings, we discussed how she felt in situations in which she received praise from her teacher, had an argument with a friend or was punished by her mother. We discussed ways she could express her feelings and find solutions to problems.

In one of our last interviews Mrs. Jones brought a list of things she had been thinking about. Her points were that she needed to be more patient with Ann, not expect so much of her and to accept her the way she was. This seemed to indicate a significant change in Mrs. Jones from blaming Ann for her worry and loneliness to identifying changes she needed to make.

Termination.

The family assessment and the progress I had observed was shared with Mrs. Jones and Ann. Areas for further work such as behavior management and the use of problem-solving steps were discussed. Mrs. Jones was seeing the counsellor from the Indian-Metis Friendship Centre. The Children's Aid Society was aware of the goals that were worked on and was providing follow-up. Ann was having longer visits with Mrs. Jones with the goal to return home in two or three months.

Discussion.

Contracting was difficult to employ in addressing Mrs. Jones' feelings of worry, sadness and loneliness. These findings were indirectly addressed through mobilization of community support. To this aim, the contract set up to increase Mrs. Jones' involvement in personal and social interests was helpful. In areas of behavior management and problem-solving, contracting would be particularily useful when Ann returns home and specific behavioral issues arise. Alternatives to expressing anger through yelling and physical punishment were discussed with Mrs. Jones but were not written into a contract.

The McKenzie Family

The McKenzie family was a blended family of six members. The family was comprised of Mrs. McKenzie's three children, Mary, age twelve; Nick, age eleven; John, age nine and Mr.

McKenzie's daughter, Chris, age nine. Mrs. McKenzie had been divorced for one year and had lived common-law with Mr. McKenzie for about three months before marrying him. Mr. McKenzie worked as a truck driver; Mrs. McKenzie worked at a fiberglass plant and the family lived in a low-cost housing development. The family was seen six times at the institution where Mary had been placed. Not all the members attended every session because of summer vacations and Mr. McKenzie's work schedule. Mary was in foster care during my involvement because of her out-of-control behavior and juvenile charges.

Assessment.

Presenting Problems: Mr. and Mrs. McKenzie identified the problem as Mary's belligerent attitude and non-compliant behavior. The problem Mary defined was that her mother did not listen to her.

Family Functioning: The discussion of problems in this family usually ended in blaming statements. Feelings were not talked about, especially angry or sad ones. Mrs. McKenzie stated that she and Mr. McKenzie discussed rules and roles and ensured that they were carried through but that Mr. McKenzie took the more active role. It was my assessment that Mrs. McKenzie was very passive in her parenting role and because of her own needs had difficulty providing nurturance and support to the children.

Further Investigations: Some of the problems the family identified related to conflicts and custody battles between Mr. and Mrs. McKenzie and their ex-spouses. Mrs. McKenzie's siblings and parents were very supportive and her children visited their grandparents on the farm during holidays. Community support was gained mainly through socializing with friends.

Intervention.

Throughout the sessions attempts were made to change the focus to a family view of the problem. An active listening exercise was used in one session to help the members to understand each other's perspective of a problem. Mary stated that she felt Mrs. McKenzie did not have time to listen to her. Both Mr. and Mrs. McKenzie responded by defending and blaming. They discussed possible solutions in coming to a resolution of the problem.

Mary's need to belong in this family was seen in the family picture she drew. She included her grandparents, the dog and the cat but crossed herself off the picture. When asked about this she said she did not belong in the family because she did not live with them. In the sessions Mary was able to express her caring for the family, her fear of rejection and, with some difficulty, her anger toward Mrs. McKenzie. Mrs. McKenzie talked about her feelings of guilt in not protecting Mary from verbal and physical abuse by Mr. Lowden, Mrs. McKenzie's first husband.

Another problem Mrs. McKenzie identified was that Mary did not believe anything positive about herself. A task was assigned for Mr. and Mrs. McKenzie to say good things about Mary and Mary was to accept the compliments without saying anything derogatory about herself. In the sessions with the McKenzies there was a great deal of difficulty in delineating goals for change. Mr. and Mrs. McKenzie identified Mary's past behavior as the problem and Mary kept saying things would be different now because she had changed. Attempts were made to extract concrete issues from the interaction in the sessions in a way that the family members could work together in resolving them.

Termination.

Many issues and feelings in the McKenzie family were left unresolved but counselling was continuing with the social worker at the treatment institution. The family needed help in recognizing Mary's need for acceptance within the family. Issues around organization and building relationships within a blended family needed to be addressed.

Discussion.

The McKenzie family was only seen for six sessions and not all the members attended each session. This made it difficult to come to a consensus on a problem list and to delineate concrete goals for treatment. The problems identified in the sessions related to Mary's fear of rejection,

Mrs. McKenzie's feelings of guilt and Mr. McKenzie's relationship with Mrs. McKenzie's children. It was difficult to develop concrete behavioral goals in order to contract around affective and relationship issues. Contracting would be more appropriate when Mary begins to spend more time at home and specific behavioral issues arise.

The Ross Family

The Ross family consisted of Mrs. Ross and her two children, Linda, age fourteen and Jim age eleven. Mrs. Ross was a Native Indian who lost her treaty status when she married Mr. Ross who was of German descent. Mr. and Mrs. Ross had been separated for ten years and divorced for five years. Mr. Ross had little contact with the children and the family was supported by social assistance. The family was seen in the home on four occasions and Linda and Mrs. Ross were each seen twice individually.

The Children's Aid Society had been involved with this family periodically over a period of 7 years and both children had been in care several times. Mrs. Ross drank heavily on many occasions, had experienced severe bouts of depression and had attempted suicide several times. She was unable to cope with Linda's acting-out behavior and contacted the Children's Aid Society to have her placed in foster care. Linda had been in care two months at the time I became involved with the family.

Assessment.

Presenting Problems: Both Mrs. Ross and Jim identified the problem as the fighting that occurred in the family. Linda felt the family needed to talk more openly about their problems and to spend more time together.

Family Functioning: Problems were seldom resolved in this family because the members avoided confronting them or blamed someone else for them. Feelings were not communicated clearly or directly. Anger was expressed in explosive outbursts by all members of the family. Mrs. Ross did not take an active role in allocating responsibilities and maintaining accountability. The role reversal between Mrs. Ross and Linda was seen in the responsibility Linda had in caring for Jim and the fact that Mrs. Ross confided in Linda about her boyfriend.

Further Investigations: Mrs. Ross' boyfriend was a positive support for her and he had a fairly good relationship with Jim. Mrs. Ross had few supports within the community. She saw her famly doctor regularily and her psychiatrist irregularily but did not always follow their advice in dealing with her medical problems and depression. Jim was seen by a counsellor at school and had a Big Brother.

Intervention.

The problem that was first identified in the family sessions was Jim's physical aggression at school. He was expelled for two days because of a fight with another boy and his physical aggression toward a teacher. Mrs. Ross' response was to blame the school staff for how they handled the problem and to accuse the other boy of starting the fight. I confronted Mrs. Ross with the blaming and suggested that the problem should be dealt with rather than avoided. Jim agreed that he would like to stop fighting at school and the family agreed to set up a contract to decrease the fights. Jim's tasks were to ignore other children if they called him names and to tell a teacher if anyone tried to start a fight with him. Mrs. Ross was to check with the school every day to see if Jim had fought and to give him a point for each day he did not fight. Linda suggested his reward for earning three points could be to visit her at the group home. I spoke with the school counsellor and principal to gather more information about Jim's behavior and to provide continuity in working with the family. The staff was concerned about the family and would have participated in the contract but school was soon out for the summer. I was also unable to review the contract because Mrs. Ross cancelled and missed appointments following that interview. The contract needed to be reviewed and rewritten because it seemed the tasks were too difficult for both Mrs. Ross and Jim.

An attempt was made to draw Mrs. Ross into counselling by being supportive and suggesting that it was an opportunity for her to find ways of dealing with her depression. Mrs. Ross however, chose not to continue with counselling. Linda was doing well at the group home and the visits home were going well. There was no crisis confronting the family and they did not see a need to change.

Termination.

In terminating with the Ross family, their strengths and areas of difficulties were discussed in conjunction with the Children's Aid Worker. Mrs. Ross agreed that it was very difficult for her to confront problems and to take necessary steps to solve them unless motivated by a crisis. The worker from the Children's Aid Society was continuing to monitor the family.

Discussion.

Contracting was unsuccessful because of this difficulty in maintaining the family's involvement. Mrs. Ross cancelled several appointments and was not at home for two of the appointments. Mrs. Ross was very absorbed in problems related to her ill health, depression, and relationship with her boyfriend and thus, it appeared was unable to deal with parental responsibilities. The contract that was developed to deal with Jim's aggressive behavior involved tasks that were too difficult for both him and Mrs. Ross. Intervention

was difficult because of the established pattern of denying or avoiding problems and thereby never reaching a solution.

The Bergen Family

The Bergen's were a family of five members consisting of Mr. Bergen, age forty-one; Mrs. Bergen, age forty; Cindy, age sixteen; Karen, age ten and Debbie, age eight. The family was seen in the home on seven occasions. Cindy was seen twice individually. Karen and Debbie were only able to attend two sessions because the times were arranged around Mr. Bergen's work schedule and they were in school at these times. Mr. Bergen had been employed as a guard at a penitentiary but had recently retired to start his own business. Mrs. Bergen worked in the home full-time. Cindy was in a receiving home when the family was first referred to me but returned home soon after.

The Children's Aid Society first became involved with the Bergen family in the fall of 1983 when Cindy refused to return home. She claimed that her parents always yelled at her and that her father hit her and was extremely unreasonable. There were also severe conflicts between Mr. and Mrs. Bergen. As a result of physical discipline and her refusal to return home, Cindy was placed in a receiving home on this and two other occasions. Each time she ran from the placement and returned home. Initially, Mr. Bergen was very hostile toward the Children's Aid Society for their involvement

and had refused any services offered to the family but had agreed to my involvement.

Assessment.

The problem-centred systems model was used in the first two interviews to structure the assessment of the family's functioning.

Presenting Problems: Mr. Bergen identified the family problems as being Cindy's incooperative, demanding attitude and felt that she must change. Mrs. Bergen identified the problem areas as her inability to manage Karen and Debbie's behavior and the inability of the family to talk openly about their problems. Cindy felt that her father's rules were too strict and unreasonable.

Family Functioning: Problem-solving patterns had evolved in this family that maintained the problems rather than resolved them. Mrs.Bergen avoided talking about problems because that caused more fights. Mr. Bergen claimed that problems involving finances were not open for discussion with other family members. In affective areas Mr. Bergen stated that each member's feelings were his or her own problem. There was a great deal of anger expressed in this family through yelling, arguing, accusations and name-calling. Feelings of caring were expressed through playful bantering and doing things for and with each other. Feelings were not directly or openly talked about. In communicating feelings

the family often used covert actions or symbols. For example, in an incident in which Cindy, Karen and Debbie were arguing about how they were rearranging the furniture, Mrs. Bergen stepped in and moved the furniture back the way it had been. Mrs. Bergen said this action was meant to show Cindy that she was in control.

In discussing roles with the family, Mr. Bergen said his area was to provide financially for the family, his wife was responsible for the tasks in the home and the children were to do what he said. Mrs. Bergen was to consult him on any decisions she made. Cindy often went with her dad on his business calls in the city and visited him at his office a few times. In the area of behavior control, Mr. Bergen said it was up to Mrs. Bergen to discipline Karen and Debbie and to keep them from fighting. He made the rules in the family and everyone was to obey them. Cindy often challenged his rules and argued and manipulated until she got what she wanted. This family reflected problems unique to a traditional patriarchal family structure.

Further Investigations: In terms of the ecological perspective, the extended family and community supports were assessed. A genogram was used in obtaining information about the family background and about the extended family. Mr. and Mrs. Bergen were married in 1966 in Malta and moved to Canada soon after. There were no extended family members in Canada. Mr. Bergen's two older sisters died in their

early teens and his father deserted the family when he was a child. Mr. Bergen's mother had sometimes dressed him like a girl and made him wear dirty clothes. According to the Maltese culture, the father should have a strong authoritarian role and the women and children were to be submissive. There were few support systems outside the nuclear Bergen family. Mrs. Bergen "coffeed" with a neighbor friend and Mr. Bergen gained some personal satisfaction and validation through his business contacts. Cindy socialized with friends and tended to get involved in the gossip and conflicts between warring neighbors.

Intervention.

Intervention began at the first interview in conjunction with the assessment. In the initial interviews a problem that Cindy identified was that Karen and Debbie did not listen to her when she babysat them. Mr. and Mrs. Bergen made an agreement with Cindy to send the girls to bed fifteen minutes earlier the next night if they did not do what Cindy said. It was suggested to the parents that it was important for them to enforce the discipline so Cindy did not get involved in the parenting. In reviewing the results of this agreement, Cindy said the girls listened to her better but still fought with each other.

Cindy was seen individually once because Mr. Bergen had left for work and Mrs. Bergen had gone to the neighbors to

babysit. Cindy was expected to stay at home for the interview and commented that her parents always left her with the responsibility.

It was very difficult throughout the sessions to keep Mr. Bergen involved. The appointments were arranged around his schedule and the importance of his involvement was stressed. Mrs. Bergen confronted Mr. Bergen on several issues during the sessions and felt these were times she was able to say what she was feeling. One issue she brought up was that she was getting no support in the family. She related how Karen and Debbie yelled and fought in the morning and Mr. Bergen and Cindy yelled at her for not keeping the girls quiet so they could sleep. She told Mr. Bergen that she would like more support from him. He responded that he did give her support -- he told her she had done a good job refinishing the table and chairs. Ways they could support each other were discussed and Mrs. Bergen suggested that she and Mr. Bergen spend more time together. Mr. Bergen felt they did do things together and would not discuss the issue further. In support of Mrs. Bergen in the issues she identified, Mr. Bergen felt threatened. Mr. Bergen phoned the next week to cancel the family session and said they would not need further counselling. In exploring this further with Mr. Bergen he openly stated he was getting more pressure at home because his wife had started challenging him. Attempts were made to align with Mr. Bergen and to reframe his control of

the family as concern for their well-being. He, however, opted out of the next session.

In the session with Mrs.Bergen and the three girls, Mrs. Bergen again expressed her frustration in not being able to manage Karen and Debbie so that there was less fighting and talking about. A contract was set up to decrease the fighting (see Fig. 1).

The contract was reviewed the next week but it had not been implemented successfully because of confusion regarding the tasks and rewards. The contract was not rewritten because the sessions were terminated at that time.

Termination.

It was my assessment that the real issue in this family was one of power distribution and if Mrs. Bergen was not given more authority to make and enforce the rules, the behavior management problems could not be resolved. In discussing this assessment with the family, I attempted to reframe the issue of power in a way that would support Mrs. Bergen but would not be a threat to Mr. Bergen's position in the family. It was suggested to Mr. Bergen that he was under alot of pressure in attempting to maintain a "smooth-running family" (Mr. Bergen's words), all by himself. In assigning some of the decision-making authority to other members, there would be less pressure for him and Mrs. Bergen would have more power to carry out her responsibilities.

Figure 1. Treatment Goals Contract

Goals	Tasks	Rewards
Decrease teasing between Karen and Debbie; decrease talking back to Mrs. Bergen	No talking back. No teasing. Time Periods: a.m. to 12 p.m. 12 p.m. to 5 p.m. 5 p.m. to 10 p.m.	5 points for each girls for time period they did not tease or talk back. Bonus: 10 points - Mrs. Bergen will play cards with them. - for example, 5 points - they can go to bed 5 minutes later

Consequence: Bedtime 5 minutes earlier for each time period they teased or talked back.

Mr. Bergen asserted that he was "not about to give anyone anymore authority." He directed his comment to Mrs. Bergen and the three girls who were seated together on the couch.

It was mutually agreed during this interview to terminate the family counselling. I advised the family that the purpose of the interview was to discuss my assessment of the family and to either contract to continue treatment or to terminate. Because an agreement was not reached on the goals to be worked toward, treatment was not continued. Another factor leading to termination was that the family was moving out of the province and were very busy with the preparations. Mr. Bergen felt that counselling was no longer necessary because Cindy was helping around the house and was being more cooperative.

Discussion.

Contracting was difficult to employ with the Bergen family due to the differing agendas and the difficulty in reaching a consensus of goals. To proceed would possibly have led to corrupt contracting since my agenda was different from Mr. Bergen's. My agenda was to effect change in the distribution of power within the family and Mr. Bergen's agenda was that all members obey his orders. The contract written to decrease the fighting between Karen and Debbie needed to be rewritten to make the tasks simpler and to give the rewards immediately and in larger amounts. It may have

been helpful to continue contracting around child management issues and thereby possibly draw Mr. Bergen back into therapy. This was not possible, however, because of the family's move to another province.

The Brown Family

Mrs. Brown was a thirty-two year old single parent of three children: Joan, age eight; Bradley, age six; and Vicki, age four. Three individual sessions with Mrs. Brown were held, one family session in the office, and six family sessions in the home over a three month period. Joan was returned home at the time the family sessions started. The family lived in a low-cost housing development and were financially supported by social assistance. Mrs. Brown was attending school to upgrade her high school and planned to continue her education to become a laboratory assistant.

The Children's Aid Society had provided support services to the Brown family on an occasional basis for approximately three years. Mrs. Brown was a concerned parent who was having difficulty coping with Joan's aggressive, acting-out behavior. She was near an emotional breakdown and was afraid of losing control and abusing Joan. At her request, the Children's Aid Society placed Joan in a foster home. The family was referred to me at the time of Joan's removal from the home.

Assessment.

Initially the crisis precipitated by Joan's placement was dealt with in order to relieve some of the stress the family was experiencing. Mrs. Brown stated that she was feeling guilty and anxious about the action she had taken. Joan brought up many concerns because of the unfamiliarity of her new surroundings. These issues were discussed and once the initial stress was somewhat dissipated it was possible to discuss factors that led up to the crisis and to assess the family functioning.

Presenting Problems: Mrs. Brown identified the presenting problem as her need to have more control in the family. She had difficulty, not only with Joan but in getting Bradley and Vicki to listen to do what she said. She felt it was a constant battle in trying to assert her authority. Other areas for change that Mrs. Brown identified were a need for emotional support, some time for herself away from the children and to have less yelling and screaming in the family. Her feelings of inadequacy and rejection as a result of an abusive childhood were other issues Mrs. Brown identified.

Family Functioning: The family functioning was assessed using the six dimensions of the McMaster Model. The family used no systematic steps in dealing with problems. Mrs. Brown tended to argue, threaten and scream in attempting to get the children to comply. In dealing with affective prob-

lems, Mrs. Brown was able to identify the feelings but was uncertain what steps to take in resolving the problems.

The range of emotions experienced by the family members was limited and often inappropriate in terms of quantity and quality. Mrs. Brown experienced severe mood swings which affected her emotional responses. At tims she was extremely easy-going and patient and at other times she would explode angrily after very slight provocation. The children expressed a great deal of anger and frustration through yelling, crying, banging walls and throwing things when they did not get what they wanted or received a minor consequence. There were feelings of caring, warmth and happiness experienced in this family but they were dominated by the angry, frustrated feelings. Mrs. Brown said she found it very difficult to demonstrate affection toward the children in physical was such as kissing, hugging or touching. Feelings were not talked about but were acted out which resulted in masked and indirect communication. Instrumental issues were talked about directly and clearly most of the time.

Mrs. Brown managed her parental role in the area of instrumental functioning but had more difficulty in the affective areas. Providing nurturance and support for the children was a difficult task for Mrs. Brown because of her own emotional needs. The behavior control was chaotic with little structure or consistency. The style of control was determined by her mood swings. When she was in an "up" mood

she tolerated a great deal of misbehavior but when she was in a "down" mood her methods of discipline were often harsh and punitive. Mrs. Brown was careful in not allowing the children to do things that put them in danger such as straying a long way from home, playing outside late at night or riding their bicycles on busy streets.

Further Investigations: In applying the ecological perspective, the extended family and community supports were assessed. A genogram was used to obtain information about the family background and the extended family members. Mr. and Mrs. Brown were married in 1974 and separated in 1981. Mr. Brown visited the children on an irregular basis but shouldered none of the financial or parental responsibilities. Joan, however, included him in the family picture she drew and all the children spoke of him as part of the family.

Mrs. Brown was the only child of a brief interlude between her mother and a boyfriend while her mother's husband was in jail. She was scapegoated as a result and suffered emotional and physical abuse by her mother. As an adolescent her father and two uncles had made sexual advances toward her. Mrs. Brown's mother was deceased and she had no contact with her siblings. The family had occasional contact with the maternal grandmother's third husband and the children called him "Grandpa".

Within the community, the family's supports were few. The most significant supports for Mrs. Brown were her contacts at school. There was only one friend whom Mrs. Brown felt was a positive support for her. She preferred to limit her social contacts with the neighbors but was "swapping" babysitting with them. The Big Sister agency was a source of support for both Joan and Mrs. Brown. The Child Guidance Clinic had provided some child management counselling and Joan had undergone psychological and psychiatric assessments.

Intervention.

Crisis intervention was the focus of the first interview. Mrs. Brown was seen individually for 3 sessions following the family assessment. These sessions involved giving her support and encouragement. She talked about her insecurities about herself and in setting limits for the children and showing them affection. Her parenting skills were discussed in relation to the parenting she received as a child. She did not remember her mother giving her praise or affection and she felt that she was never good enough. Now even when she got an A in school, she felt she should have received an A+. Throughout the individual and family sessions, Mrs. Brown was given positive support. Mrs. Brown also felt she would feel better about herself if she lost some weight. A contract was set up to meet this goal. The task was to follow a diet plan prescribed by the doctor and

the level of weight loss she expected in one month was 4 lbs. Her reward was to buy a new eyelash curler. She lost three and a half pounds and decided she deserved the reward since she was so close to her goal.

Mrs. Brown's major concern was to have "peace in the home". She wanted to be able to get the children to do what they were told without all the arguing and screaming. There were constant "battles" in getting them to do simple tasks. A contract was developed with the goal of increasing the children's cooperation in completing tasks (see Fig. 2). The rewards were decided on between Mrs. Brown and the children. The levels on the Follow-Up Guide were described (Fig. 3). The current level of functioning for each child was indicated as follows:

Joan - much less than expected

Bradley - less than expected

Vicki - much more than expected.

These levels were based on Mrs. Brown's recollection of the past week therefore were not necessarily accurate. The contract was reviewed each week and each child was given a "scratch 'n sniff" sticker if he or she attained a higher level (tasks completed more times), than the week before. The progress fluctuated over the three-week period and at termination, had reached the following levels:

Joan - less than expected

Figure 2. Treatment Goals Contract

Goals	Tasks	Rewards
To increase the children's cooperation in completing tasks.	1. make beds in the a.m. 2. put dirty clothes in hamper 3. hang up clean clothes	Each child gets 1 point for each task completed. For 3 points: Joan - can go to the park Bradley - can watch a favorite T.V. program. Vicki - can go for a walk with Mom.

Bonus: 1 scratch 'n sniff sticker for each week if more points were earned than in the week before.

Figure 3. Follow-Up Guide

Scale attainment levels	Scale 1
Most unfavorable outcome	Completes all 3 tasks less than 3 times in one week
Less than expected success	Completes tasks 3 or 4 times
Expected level of success	Completes tasks 5 times
More than expected success	Completes tasks 6 times
Most favorable outcome	Completes tasks 7 times

Bradley - much more than expected

Vicki - more than expected.

In addressing Mrs. Brown's concern about having peace in the home, a second contract was set up to decrease the yelling between Joan and Mrs. Brown (see Fig. 4). The contract was reviewed in three days. It was felt this contract would also give Joan a chance to earn more rewards. Mrs. Brown felt her reward would be less yelling and arguing. Both improved in the three-day period. Joan had three points for not yelling and fifteen points for not repeating her demands. Mrs. Brown earned three points for not yelling. Mrs. Brown continued to use this contract although there were no further sessions.

It was observed that Mrs. Brown continually got pulled into power struggles with the children. There was usually an argument over anything she asked them to do. In order to break this cycle, the use of time-out was suggested. Mrs. Brown was to make the expectations and consequences clear to the children and then follow through in enforcing them. The expectation was that the children do what she asked and if they yelled and complained or if she had to repeat the request more than twice, they had five minutes time-out in their bedroom. One minute was added for each minute they refused to comply and for each time they yelled or banged the wall. Mrs. Brown used this technique and found it was

Figure 4. Treatment Goals Contract

Goals	Tasks	Rewards
To decrease the number of times Mrs. Brown and Joan yell.	1. To talk quietly without yelling	1 point for each one for each hour they do not yell
To decrease the number of demands Joan repeated	2. For Joan to ask Mrs. Brown only once for something	Joan - 5 points for each time she does not repeat a demand

Bonus: Scratch 'n sniff sticker if Joan earns 3 points

effective with Bradley and Vicki but Joan always ended up with two-or three-hour time-outs. The situations in which time-out was used were reviewed and Mrs. Brown was encouraged to be consistent and firm.

During the family sessions in the home, it was observed that Mrs.Browns interaction with the children was very negative. She rarely praised the children or noted their good behavior. The importance of rewarding good behavior and ignoring the bad was discussed with Mrs. Brown. A contract was also set up to increase her use of social reinforcement such as hugs, smiles, and praise (see Fig. 5). The Follow-Up Guide was completed (see Fig. 6) and her current level of functioning was estimated at the less than expected level. She improved her use of social reinforcements to the most favorable outcome at the time of termination.

A second contract was set up to increase the positive interaction within the family (see Fig. 5). Mrs. Brown agreed that this was an area she would like to see improved. The Follow-Up Guide was completed (see Fig. 6), and the current level of functioning was at the less than expected level. The number of outings was improved to the expected level of functioning during treatment. The use of the "Glad Game" (saying things they were glad about), was used but its success was not measured.

Figure 5. Treatment Goals Contract

Goals	Tasks	Rewards
#1 To increase the use of social reinforcements	Give at least three social reinforcements every day to each child	If both goals are completed Mrs. Brown will be given $7.00 for a haircut
#2 To increase positive time spent with the children	1. 15-20 minute outing with the children every day 2. during the outing everyone talk about things that make them glad.	

Figure 6. Treatment Goals Contract

Scale Attainment Levels	(Social Reinforcements) Scale # 1	(Outings) Scale #2
Most unfavorable treatment outcome	less than 3 social reinforcements for each child every day	no outings in one week
Less than expected success	3-4 social reinforcements	1-3 outings in one week
Expected level of treatment success	5 social reinforcements	4-5 outings in one week
More than expected success	6-7 social reinforcements	6 outings
Most favorable treatment outcome	more than 7 social reinforcements	7 outings

To involve the children in the sessions a "radio show" was used in which the children talked about the tasks they had done and the rewards they had earned. One radio show was also used to talk about feelings. Mrs. Brown and the children talked about how they felt in different situations and practiced what they could say and do in those situations.

During the home visits many situations presented themselves in which behavior management techniques could be used. In one situation the children were continually coming in and out of the house while Mrs. Brown and I were trying to talk. To increase the amount of time the children stayed outside without interrupting, an agreement was made to give a scratch 'n sniff sticker to each child who stayed outside for fifteen minutes. Only Bradley got a sticker but the amount of time without interruptions was increased. Rewarding the children's good behavior was a method that was strongly emphasized and reinforced.

Termination.

The Children's Aid Society worker attended the final interview to maintain continuity of contact. The goals worked toward and the progress in reaching them were reviewed. The areas that needed further work were discussed and a referral was made for further family counseling. Though Mrs. Brown had increased her use of social reinforcements with the

children and felt the children were more cooperation, it was only a beginning in resolving the problematic functioning in this family. Mrs. Brown's mood swings were discussed and a recommendation made to see a psychiatrist about the possibility of medical intervention to control her mood swings.

Discussion.

Contracting was a useful tool in working with the Brown family because of its focus on behavioral goals. It provided constructive steps in approaching the innumerable problems this family faced. Mrs. Brown felt that the contracts gave her direction and ideas in child management. With the number of personal problems she faced and her lack of knowledge in child management, she was uncertain where to start in gaining control within the family. The contracts gave her concrete goals and steps to take in reaching these goals. The contracts also helped to engage the children in the therapy sessions.

The Hart Family

The Hart family consisted of Mrs. Hart, age thirty-five and her daughter, Judy, age ten. Mrs. Hart and Judy were seen once in the home and six times at the Children's Aid office. Mrs.Hart was also seen five times individually and Judy was seen once. Judy had been placed in a foster home one month prior to my involvement. She remained in the fos-

ter home for the duration of my involvement but had regular weekend visits home. Mrs. Hart worked as a claims adjuster for an insurance firm and owned her own home.

Mrs. Hart approached the Children's Aid Society because of the behavior problems she was experiencing with Judy and was referred to the Child Guidance Clinic where Judy received individual counselling. She was also assessed by a psychologist because of her extreme acting-out behavior at home and at school. Mrs. Hart was seen by the counsellor for some guidance in parenting. The counsellor did not see the family during my involvement. Mrs. Hart continued to have a great deal of difficulty coping with Judy's behavior and would enter into power struggles that resulted in verbal and physical fights. A homemaker was placed in the home but the fighting increased and Mrs. Hart finally requested placement.

Assessment.

Presenting Problems: The presenting problems Mrs. Hart identified were losing her temper, and stress arising from poor physical health and fighting with Judy. Judy felt the problem was her mother did not listen to her. Another problem Mrs. Hart identified was that Judy was not able to talk about her feelings especially in relation to her father.

Family Functioning: In using the six dimensions of the McMaster Model, a number of strengths and difficulties were

delineated. The Hart family had difficulty resolving problems systematically and to a level that maintained effective family functioning. Problems were identified but talking about them often led to conflict. In looking for solutions, Mrs. Hart gave Judy too many choices and found it difficult to limit her daughter to one alternative. There was a fairly wide range of emotions experienced in this family. There were times when they experienced caring and happiness. There was, however, a great deal of anger and sadness experienced. The anger was often explosive resulting in verbal attacks and sometimes in physical aggression. The sadness Mrs. Hart felt was evident in that tears were often near the surface. Judy did not often let her sadness show but was sometimes quiet and withdrawn. Mrs. Hart and Judy were able to talk about their feelings of caring for each other but had more difficulty talking about their anger, sadness and fear.

Very evident in the relationship between Mrs. Hart and Judy was role reversal. Mrs. Hart was uncertain in her parental role and in need of support. As a result she often depended on Judy for help in making decisions and for emotional support. Judy said her role in the family was to be the child. The style of behavior control was chaotic because of the inconsistency in enforcing rules and expectations. At times Mrs. Hart was flexible and allowed Judy to have control. At other times she was firm about the limits

for Judy's behavior saying, "I'm the mother, you have to listen to me". Becuase of the uncertainty of the limits Judy was confused and often reacted by testing and challenging them. Judy did not relate well with pers and was often aggressive toward them.

Further Investigations: The extended family and community supports were assessed. Mr. and Mrs. Hart had been separated for eight years and divorced for one year. Mr. Hart had recently remarried. He did not provide any financial support for Judy and his contact with her was irregular. Mr. Hart had two sons, age twenty-one and eighteen from a previous marriage. They were a positive support especially for Judy.

Mrs. Hart's parents were very supportive but they had health problems and the responsibility for helping them fell on Mrs. Hart. Judy had a very positive relationship with these grandparents. Mrs. Hart felt they gave Judy the attention they were not able to give her. As a child her father had had a severe alcoholic problem (he ws now recovered) and the family had been very poor. Thus, she had many responsibilities as she was growing up.

The main support systems for Mrs. Hart were her friends. She enjoyed social activities such as parties, poker games and barbecues. These friends were personally valiedating for Mrs. Hart but they did not provide the support and mod-

elling she needed for parenting Judy. Judy was involved in many of these adult activities but did not have a peer group for support.

Mrs. Hart enjoyed her work and found the people very supportive but she was sometimes under a great deal of pressure. Adding to this pressure was the problem of a breast abscess which required surgery.

Intervention.

As with the other families, intervention began during the first interview with Mrs. Hart and Judy. An attempt was made to develop a contract for the goals they had identified for the next weekend visit. Mrs. Hart's goal was "not to lose her cool" and Judy's goal was to "do what Mom says right away." In discussing the behavior expected of Judy, she became very upset and left the interview to watch television. When she refused to turn off the television after repeated requests, Mrs. Hart shut it off saying, "You have to listen to me -- I'm the mother." Mrs. Hart finally threatened to take her back to the foster home before giving her super. This caused an outburst of crying, screaming and throwing things but Mrs. Hart followed through with her threat.

Following this interview I felt it was important to emphasize the changes Mrs. Hart needed to make by meeting with her individually and setting up contracts for her ini-

tially. This tactic was also important to create a boundary between the parent and the child. It was difficult for Mrs. Hart to delineate specific goals for herself but she decided organization was an area she needed to work on. A contract was set up (see Fig. 7) and the Follow-Up Guide completed (see Fig. 8). Her current level of functioning was estimated at the less than expected level. Mrs. Hart was reluctant to suggest rewards for herself and felt that praise from me and satisfaction in completing the tasks were enough reinforcement. Her progress was evaluated each week and showed rather erratic movement up and down the scale. The completion of tasks depended on the events of the week which often interfered with her efforts at organization.

Another goal Mrs. Hart identified was to have fewer arguments with Judy on the weekend. The need to enforce firm, consistent limits for Judy was discussed and a contract to increase Mrs. Hart's effectiveness in gaining Judy's cooperation was set up (see Fig. 7). It was decided that her progress would be measured by the number of arguments she had with Judy on weekend visits and the Follow-Up Guide was completed accordingly (see Fig. 8). The current level of functioning was at the most unfavorable level (i.e., 3-4 arguments). A five-minute time-out was the technique Mrs. Hart used rather than arguing when Judy did not cooperate. Judy was also given rewards such as praise of treats for her cooperative behavior. The first time Mrs. Hart used the

Figure 7. Treatment Goals Contract

Goals	Tasks	Rewards
#1		
To keep up with weekly tasks and to complete projects	Complete 7 of the 11 household tasks listed. Complete one project a week.	Feedback from the therapist
#2		
To increase effectiveness in gaining Judy's cooperation	Use 5-minute time-outs as a consequence for Judy's non-compliance instead of arguing	

Figure 8. Follow-Up Guide

Scale Attainment Levels	(Organization) Scale #1	(Parent effectiveness) Scale #2
Most unfavorable outcome	- less than 4 weekly tasks completed - no projects attempted	- more than 3 arguments on weekend
Less than expected success	- 4 to 6 tasks - project attempted	- 2 arguments on the weekend
Expected level of success	- 7 tasks - 1 project completed	- 1 argument
More than expected success	- 8 or 9 tasks - 2 projects completed	- 1 argument
Most favorable outcome	- 10 or 11 tasks - more than 2 projects	- no arguments and uses positive rewards

time-out Judy vehemently objected and a verbal and physical battle ensued. The procedures were reviewed at the next interview and Mrs. Hart began to use the time-outs very effectively. At the end of treatment she had achieved the expected level of success and was continuing to use the time-out method.

Methods of problem-solving and decision-making were also discussed in relation to Mrs. Hart's goal to have fewer arguments. In observing the interaction between Mrs. Hart and Judy a cyclical pattern emerged. Judy challenged her mother on almost every statement she made and Mrs. Hart responded by defending, explaining and placating. This cycle was discussed with Mrs. Hart. To break the cycle, problem-solving steps were suggested in which each one stated the problem and how she was feeling without blaming the other one. In developing alternative solutions to problems Mrs. Hart was advised to tell Judy what solutions were appropriate and to limit the number of choices. These steps were discussed in relation to specific arguments that occurred on weekend visits. Education about decision-making in parent-child relationships was provided, as to how much was appropriate for the child at what age, how much was appropriate for the parent and how much was done jointly. During the family sessions and in situations Mrs. Hart described it was observed that she was beginning to limit Judy's choices in decision-making and to discuss problems without blaming.

During the family sessions Judy was contionually interrupting and demanding attentin. Mrs. Hart felt, and I agreed, that little could be accomplished because of the interruptions. In order to address this problem and to provide modelling on setting limits for Judy's behavior, two contracts were set up. In one interview, the goal of the contract was to increase Judy's participation in a way that did not interrupt (see Fig. 10) and the current level of functioning was at the much less than expected level. Judy improved to the more than expected level in that interview and earned the bonus reward.

In a second interview the goal of the contract was to increase the amount of time Judy sat quietly (see Fig. 9). The Follow-Up Guide was completed (see Fig. 10), and the current level of functioning was at the much less than expected level. She improved to the less than expected level. In both of these contracts Judy was given praise for her cooperative behavior and she became less disruptive in the interviews.

Mrs. Hart and Judy also practiced identifying and expressing their feelings. They identified what they would feel and how they would express their feelings in relation to specific situations. When it was Mrs. Hart's turn, Judy kept saying what she would feel and do in that situation. It was explained that they each had separate feelings and that it was important to know how Judy felt in her situ-

Figure 9. Treatment Goals Contract

Goals	Tasks	Rewards
#1		
To increase Judy's participation in the interview in a way that does not interrupt	a) Wait until no one is talking before speaking b) Say "excuse me" and wait until given a chance to speak	1 scratch 'n sniff sticker for each time the task is done
Bonus: 5 stickers - ice cream or soft drink 5+ stickers - ice cream or soft drink and Mrs. Hart will give her a ride to the foster home.		
#2		
To increase the amount of time Judy sits quietly in an interview.	sit quietly without interrupting for 2 minutes	1 sticker for each 2 minutes Judy is quiet

Figure 10. Follow-Up Guide

Scale Attainment Level	(No Interrupting) Scale #1	(Sitting quietly) Scale #2
Most unfavorable outcome	interrupts every time she speaks	sits quietly for less than 3, 2-min. intervals
Less than expected success	speaks without interrputing 1-4 times	3-4, 2 minute intervals
Expected level of success	speaks without interrupting 5 times	5, 2 min. intervals
More than expected success	speaks without interrupting 6-7 times	6, 2 minute intervals
Most favorable Outcome	speaks without interrupting 8 or more times	6+, 2 minute intervals

ations. This was more difficult for Judy. Mrs. Hart was concerned about Judy's feelings toward her father but when this was brought up, Judy became very agitated saying she hated him. Judy did some drawings in the sessions and when difficult topics came up, her drawings became very wild and messy. Mrs. Hart was given, The Boy's and Girl's Book About Divorce (Gardner, 1970) to read and discuss with Judy.

Judy was seen individually to read and talk about "A Child's Guide to Understanding Foster Care". She was a very bright girl who understood and remembered what she read. Judy was particularily interested in the sections, "Why Am I a Foster Child?" "Feelings Foster Children Have". This guide helped to bring out areas Judy was concerned about and she was able to talk about how she felt it was her fault she was in a foster home. She was assured that it was not her fault but that her mother had to make some changes.

Termination.

In the termination session with Mrs. Hart and Judy, the social worker from the Children's Aid Society attended. The goals the family worked toward were reviewed and the progress evaluated. Mrs. Hart was beginning to talk about her feelings rather than exploding angrily, she was limiting the number of decisions Judy made and was more consistent in setting limits for Judy's behavior. Further change was needed in these areas and both Mrs. Hart and Judy needed to

resolve their feelings in relation to the divorce from Mr. Hart and his subsequent remarriage. Mrs. Hart and Judy were referred for further family counselling.

Discussion.

Contracting did not work well initially with the Hart family and I felt this was because of our focus on Judy's behavior. She became very upset and tore up the first contract that specified goals and tasks for her. With more of an emphasis on Mrs. Hart's goals and on increasing desired behavior of Judy, the contracts became more successful. Mrs. Hart felt the contracts gave her direction in setting goals and in steps to take in reaching them. This was particularily true in increasing her child management skills. The contracts also helped Judy to be involved in the sessions in constructive ways.

EVALUATION

Evaluation Instruments

The use of the ecological perspective, the problem-centred systems model and behavioral contracting in working with families whose children were in foster care was evaluated in this practicum. In the use of the ecological perspective and the problem-centred systems model, a subjective assessment of goal attainment was derived from client feedback, social worker observation and supervisor feedback. Goal Attainment Scaling (Kiresuk & Garwick, 1975) was used to measure the achievement of goals for which contracts were developed. A post-intervention questionnaire (see Appendix H), provided client evaluation of the use of contracting.

Evaluation Results

The Ecological Perspective

In my subjective evaluation I found that the use of the ecological perspective provided a broader understanding of the dynamics of child abuse and neglect. Aspects of the parents cultural background and how they were parented were useful in suggesting points of intervention. Assessing the family's interactions with the extended family and community support systems indicated further areas for intervention.

This was useful in changing the focus from individual pathology to an emphasis on the family within the environment. Feedback from the Children's Aid Society supervisor and social workers indicated that they felt the broader focus was helpful to them in suggesting points of intervention within the community.

The Problem-Centred Systems Model

Evaluation of use of the problem-centred systems model was derived from observations and feedback from myself, the Children's Aid Society staff and the supervisor. It was felt that this model provided a systematic structure for assessment and a useful problem-focused approach for working with families whose children were in foster care. The six dimensions of the McMaster Model of Family Functioning allowed me to assess specific areas and aided in determining the focus of the intervention. The social workers and the supervisor at the Children's Aid Society felt the assessment device was thorough and that the structure gave direction to the assessment process. The process of developing a problem list lent itself to the use of contracting. One difficulty with the problem-centred systems model was the distinct separation of the assessment and the intervention phases. I found, in working with the families, that the two occurred simultaneously. It was the supervisor's and my observation that in applying the model too rigidly at times, a great

deal of information was gathered that was not useful to the intervention.

Contracting

The usefulness of contracting was evaluated by the results on the Goal Attainment Follow-Up Guide and by post-intervention questionnaires. The goal attainment results are shown on scales for each of the families with whom contracts were developed (see Fig. 11, 12 & 13). Each scale indicates the level of functioning at the beginning of treatment and at the end of treatment. The results indicate that there was improvement by at least one scale attainment level for all the clients except Vicki Brown (see Fig. 12) who regressed one one level. Note: Her behavior however, was identified at the beginning of treatment as being satisfactory. The most improvement was seen with Mrs. Brown and Bradley (see Fig. 12) and with Judy Hart (see Fig. 13), who improved by three attainment levels in reaching their goals. These measures, however, are not empirically reliable because baseline data was not clearly established. The client reported the number of times the behavior had occurred and this was not necessarily a reliable count. Results may also have been biased by the client or by myself in completing the Follow-Up Guide. We may have indicated more or less progress depending on our own expectations. The results, therefore, are not intended to empirically demonstrate the

client's progress but to serve as a guide in assessing how much and in what direction the client was moving in achieving the goals. The client's perceptions were also important indicators of his/her progress in the assessment.

Post-intervention questionnaires entitled, "Evaluation of Service" (see Appendix H), were mailed to the six families and all members twelve years of age and older were to complete them. Three families completed the questionnaires and returned them to the Children's Aid Society. Eight items on the questionnaire addressed factors related to contracting including how clear the contracts and expectations of the social worker were, how involved the client felt in selecting goals, how helpful the goals, tasks and rewards were and if there was enough time to reach the goals. The remaining three items were for general comments on how helpful the family counselling was and what would have been more helpful.

Two of the families indicated there was not enough time to reach the goals. It was also my evaluation that three months was not enough time to assess the family functioning, select goals for treatment, develop contracts, and assess progress.

The three families felt very involved in selecting treatment goals and found it very helpful to have goals to work toward. They all found the contracts very easy to under-

Figure 11. The Jones Family

Scale Attainment Level	Scale 1: Increase involvement in personal interests
Most unfavorable outcome	
Less than expected success	Beginning of treatment
Expected level of success	End of treatment
More than expected success	
Most favorable outcome	

Figure 12. The Brown Family

Scale Attainment Level	Scale 1: Completing tasks		
	Joan	Bradley	Vicki
Most unfavorable outcome	Beginning of treatment		
Less than expected outcome	End of treatment	Beginning of treatment	
Expected level of success			
More than expected success			End of treatment
Most favorable outcome		End of treatment	Beginning of treatment

Scale Attainment Level	Scale 2: Not Yelling	Scale 3: Social Reinforcements	Scale 4: Time With Children	Scale 5: Weight loss
Most unfavorable outcome	Beginning of treatment			Beginning of treatment
Less than expected outcome		Beginning of treatment	Beginning of treatment	End of treatment
Expected level of success	End of treatment		End of treatment	
More than expected success				
Most favorable outcome		End of treatment		

Figure 13. The Hart Family

Scale Attainment Levels	Scale 1: Organization	Scale 2 Parent Effectiveness	Scale 3: Not interrupting	Scale 4: Sitting quietly
Most unfavorable outcome		Beginning of treatment	Beginning of treatment	Beginning of treatment
Less than expected success	Beginning of treatment (no change)			End of treatment
Expected level of success		End of treatment		
More than expected success			End of treatment	
Most favorable outcome				

stand and two families found the rewards very helpful and the tasks easy enough to do. One family found the rewards somewhat helpful and the tasks somewhat easy to do.

The general comments by the families were very positive and indicated they felt they had received direction and support from the service provided.

Client evaluations, though extremely important, must be considered in terms of their validity. Two factors that may have affected the validity of the evaluations are: 1) the clients may have received as much benefit from the attention as from the particular interventive strategy; and 2) the clients may have been reluctant to convey any negative impressions. I did, however, find the feedback helpful.

Contracting, based on may observations and social worker and supervisor feedback, was found to be a useful tool in working with families whose children were in foster care. It was most successful with two of the single-parent families in child management issues. Behavioral change, however, often led to some affective change. For example, by increasing Mrs. Brown's use of social reinforcements with her children, she began to have more positive feelings toward them. Contracting facilitated the process of specifying and operationalizing problems in terms of behaviors that could be observed and measured. Some families indicated that delineating goals and tasks gave them concrete steps to

take in solving their problems. The emphasis on the use of rewards also increased positive exchanges between family members and between family members and other systems. The contracts facilitated mutuality between the client's and myself. It provided a medium by which to work together to select goals, to write the contracts and to establish measurement criteria. The conract clarified the expectations of the parties involved. It was also seen as useful in structuring the visits between the parents and the children in foster care. Feedback from the supervisor and social workers at the Children's Aid Society indicated they would find contracting a useful tool to employ.

Contracting was not appropriate in every situation. The specific difficulties in setting up the contracts were discussed in the case illustrations. To summarize, contracting was difficult to employ if the family members and I could not reach a consensus on the goals and when the clients were unable to participate because of depression or because they did not see the need or possibility for change. It was particularily difficult to use contracting with the family in which the mother was severely depressed and suffering many medical problems. There were other situations where contracting was not appropriate and other methods were more effective. For example, discussing and practicing problem-solving steps and ways to express feelings was effective in working with Mrs.Jones toward more positive interaction with

Ann. Individual sessions were also useful in helping the children with feelings about being in foster care.

Evaluation of Educational Benefits

This practicum was very useful to me in developing skills and knowledge in working with families whose children were in foster care. Applying the ecological perspectives and the problem-centred systems model gave my approach structure and direction. In using the ecological perspective, I was able to look beyond the individual or the family to the environment in assessing the etiology of the maltreatment of children. The literature research provided a thorough grasp of the theory and a knowledge base on which to further develop my practice skills. Reading about problem-centred systems theory and applying it with the families was a useful process in developing my skills. The use of contracting provided a number of benefits. Assessing problems in behavioral terms helped me to be more specific and concrete in working with families in delineating areas for change. In using contracts I became more conscious of increasing desired behavior through the use of positive feedback and used this more in my approach. Through this awareness my approach became more supportive. For my own practice in child welfare I also learned the importance of not rigidly applying a theoretical model or interventive strategy. A theoretical model, I feel, is best used as a guide or a frame-

work and a specific interventive technique adds to the tools available to the practitioner.

Conclusions and Implications for Practice

The application of ecological theory to understanding child abuse and neglect provided me with a much broader perspective of child welfare problems. This perspective indicates possibilities for intervention beyond the nuclear family and is an area I would like to explore further.

The emphasis of the problem-centred systems model on mutuality between families and social workers in selecting problem areas is useful in its application in child welfare. From my literature review, it does not appear that the usefulness of this model in child welfare practice has been evaluated. Such research is necessary to determine its applicability in this area.

Behavioral contracting with families whose children are in foster care,needs to be evaluated over a longer period of time to further determine its usefulness and circumstances of application. The limited time frame of this practicum afforded enough time for me to develop a beginning knowledge and skill in the use of contracting and to make some observations of its applicability to child welfare practice.

It was my observation that contracting was difficult to apply to relationship, communication and severe emotional

problems. It appeared to be most effective with single-parents in relation to child management issues. Contracts that involved child management goals helped parents to develop their skills. These contracts also helped to engage the children in the therapy sessions by involving them in selecting tasks and rewards. The written contracts given to the families reminded them of their tasks during the week. Involving parents in establishing contracts emphasizes mutuality between the family and the social worker. This emphasis applied in child welfare practice may be helpful in moving families from being involuntary receivers of services to voluntary participants in determining their goals.

The contracts also provided a tool by which the family and the social worker could acknowledge and measure small steps that were taken in reaching long range goals. This is essential in child welfare practice where the social workers and the families are often overwhelmed by the number and magnitude of the problems they face.

Establishing a time frame for reviewing contracts and achieving goals helps define termination. With many families, intervention can, and often does, continue indefinitely because criteria for termination are never established. Contracts could be used in child welfare to delineate goals that need to be achieved before termination of services can occur. These goals are necessarily selected and defined through a mutual process between the family and the social worker and child welfare agency.

There are also implications for the usefulness of contracting with families to prevent the placement of children in foster care. I believe prevention could occur in some circumstances if there was intervention with families to delineate goals and tasks that give concrete direction to the resolution of their problems. Contracting is a tool I will continue to use and develop in my practice in child welfare.

In order to increase the effectiveness of contracting, I believe it is essential to provide more than weekly contact with the family. This contact could involve the use of parent aids, trained volunteers, or telephone checks by the social worker. The contracts could be discussed with the parent aids or volunteers who could observe, monitor and support the family in completing the contract. This would be particularily useful with a single parent in dealing with child management problems. Telephone checks by the social worker would also be useful in supporting families to complete tasks. Constructive use of support staff is essential to providing child welfare services.

"A Child's Guide to Understanding Foster Care" was useful in discussing with children issues related to being in foster care. I hope to further develop its use in my practice in child welfare. In working with children, I also found games and picture drawing useful vehicles to explain abstract concepts and for children to express their thoughts

and feelings. I would like to develop further skills in the use of play with children.

This practicum provided an opportunity to apply a theoretical framework in working with families whose children were in foster care. I developed new skills and increased my knowledge in the application of the ecological perspective, the problem-centred systems model and behavioral contracting. The application of these theories have also helped, I believe, to further define an interventive strategy for work with families whose children are in foster care.

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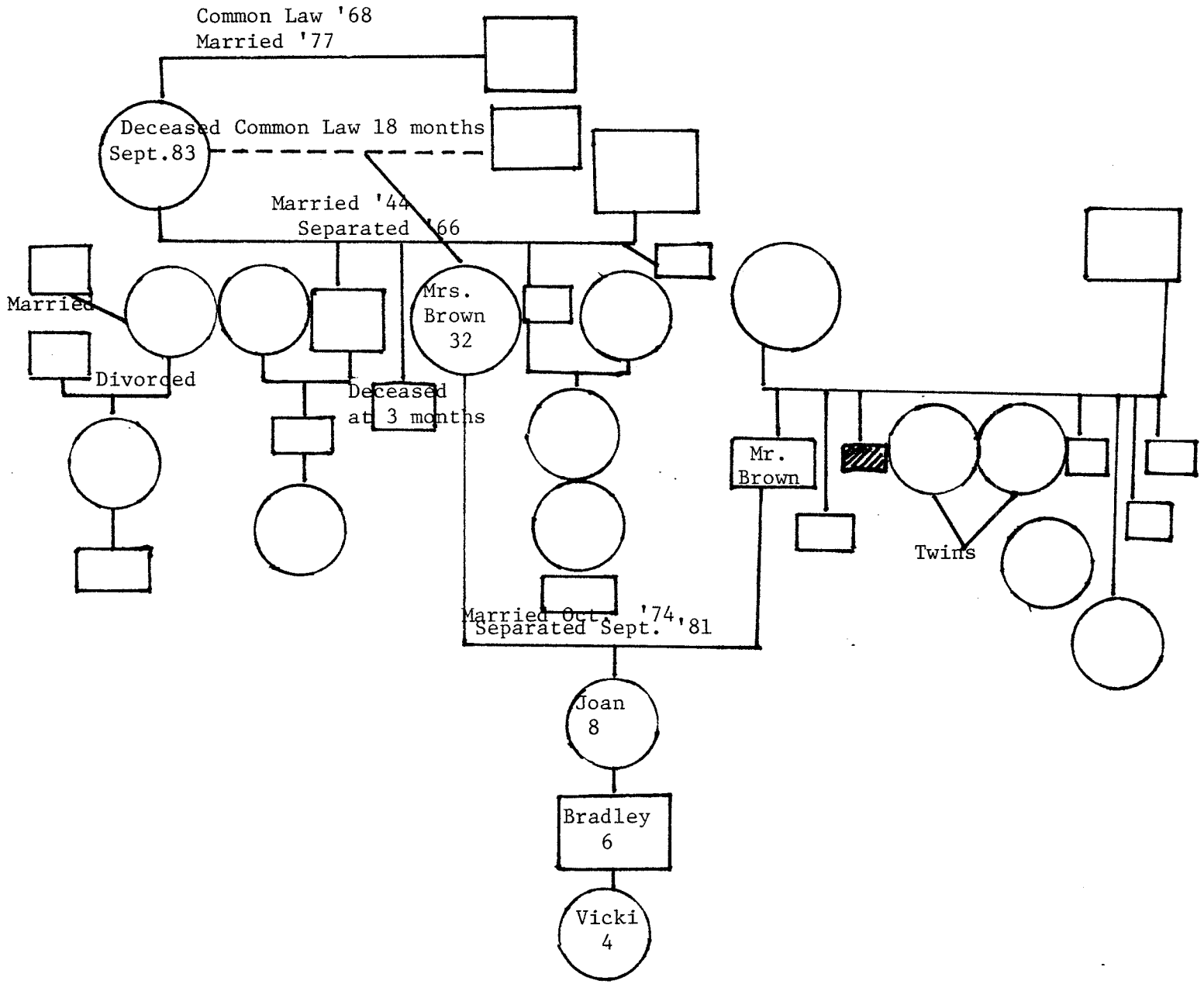
Appendix A

GENOGRAM: BROWN FAMILY

Genogram: Brown Family

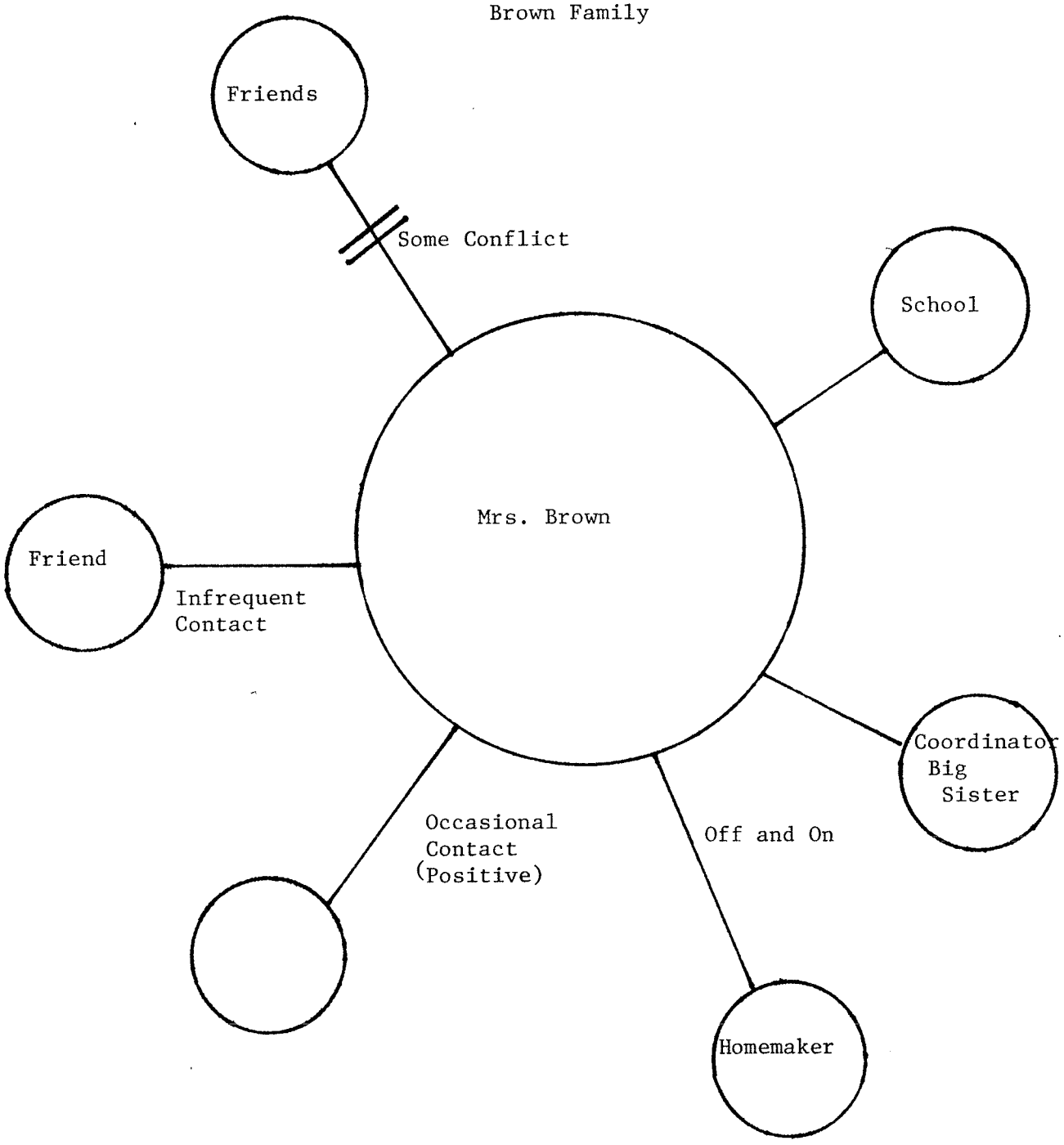


Appendix B

ECOGRAM: BROWN FAMILY

Ecogram

Brown Family



Appendix C

TREATMENT GOALS CONTRACT

TREATMENT GOALS CONTRACT

Parent's Name: _____ CHILD'S NAME: _____ EFFECTIVE DATES: _____ TO

_____ _____ _____(Review)

_____

TREATMENT GOALS	TASKS	REWARDS	RESULTS

Appendix D

AN OVERVIEW OF THE USE OF GOAL ATTAINMENT

Goal Attainment Scaling is a methodology for "developing personalized, multi-variable, scaled descriptions which can be used for either therapy objective-setting or outcome measurement purposes" (Kiresuk & Garwick, 1975). The concept of the G.A.S. was first proposed by Dr. Kiresuk and Dr. Sherman in 1968 and has since been implemented and tested for its feasibility, reliability and validity. It has been used within a broad range of human services in goal setting for both individuals and organizations (Kiresuk & Garwick, 1975). Its most distinct feature is that it can be adapted to the personal peculiarities of client goals rather than measuring changes according to general criteria (Dowd & Kelly, 1975).

A continuum or scale of behaviors is developed for each problem area. Each of these areas is given a title that summarizes the problem, such as employment, self-concept or weight loss goal attainment predictions refer to specific outcomes at a specific target date and are made for each problem area. A variable is selected for each problem that can be a source of outcome measurement. These outcomes are listed to correspond with the levels described on the left

side of the Follow-Up Guide. (See Appendix D). These five descriptions include the "most favorable outcome thought likely", "more than expected success with treatment", "expected level of treatment success", "less than expected success with treatment", and "most favorable treatment outcome thought likely". The "expected" level is to be the most realistic prediction possible of the outcome to be attained by the date the Follow-Up Guide is to be completed. This is the most likely outcome to be expected and the other outcome levels are less likely.

Appendix E

GOAL ATTAINMENT FOLLOW-UP GUIDE:

C.

Goal Attainment Follow-Up Guide:

SCALE ATTAINMENT LEVELS	SCALE 1	SCALE 2	SCALE 3	SCALE 4
Most unfavorable treatment outcome thought likely				
Less than expected success with treatment				
Expected level of treatment success				
More than expected success with treatment				
Most favourable treatment outcome thought likely				

Each vertical scale represents a scale of outcomes related for each treatment goal. At the end of the treatment time the outcome for each treatment goal will be measured.

CLIENT NAME _____ DATE _____

SOCIAL WORKER _____

/ch

Appendix F

GOAL ATTAINMENT SCALE

B.

GOAL ATTAINMENT SCALE

Current Level of Functioning:

Scale 1	Scale 2	Scale 3	Scale 4
much less than expected	much less than expected	much less than expected	much less than expected
less than expected	less than expected	less than expected	less than expected
expected	expected	expected	expected
more than expected	more than expected	more than expected	more than expected
much more than expected	much more than expected	much more than expected	much more than expected
D.N.A.	D.N.A.	D.N.A.	D.N.A.

For each treatment goal indicate the current level of functioning with an asterisk. Mark D.N.A. if the client's level does not appear on the scale.

CLIENT NAME _____ DATE _____

SOCIAL WORKER _____

Appendix G

A CHILD'S GUIDE TO UNDERSTANDING FOSTER CARE

A CHILD'S GUIDE TO UNDERSTANDING FOSTER CARE

Independent Reading Course

Instructor: Dr. Kathryn Saulnier

Carolyn Setterlund

A CHILD'S GUIDE TO UNDERSTANDING FOSTER CARE

TABLE OF CONTENTS

14. THIS IS JUST THE BEGINNING

I. INTRODUCTION TO THE HELPING ADULT

children are often left in the dark as to what is happening to them when they are removed from their homes and placed in foster homes. This adds to the trauma of the event and can have long-lasting effects on their development. If children have an understanding of what is happening it will make their adjustment to a new and frightening situation a little bit easier. We try to protect children by keeping information from them. This only serves to confuse them. It is sometims difficult to know how to explain foster care to children in a way that will help them to understand and accept their situation. This book was written to help social workers, foster parents and teachers discuss children's concerns and fears with them. It is not designed to cover all the issues associated with being in foster care but to serve as a guide and a springboard from which children can bring up other concerns. The children can read the book and discuss it with an adult or the adult can read and discuss certain parts with them. It is written with the hope of helping children feel better about themselves and their plight and to learn to cope with the problems of being in foster care.

ABOUT PLANTS AND FOSTER CHILDREN

There are many different plants,
Some are green and beautiful;
Some grow pretty flowers.
Some have lots of leaves and branches;
Some grow straight and tall.

Did you know that plants get sick?
Some get brown and spotty;
Some lose all their leaves.
Some grow long and skinny branches;
Some don't grow at all.

Some plants need extra help to grow.
They need a bit more care;
Some need more sun and water.
Some need a bigger place to grow;
Some need a bit more soil.

Sometimes to help a plant get well,
So it will grow new leaves,
It's dug up by its roots;
Then put into a different pot
And given lots of care.

Children are alot like plants.
Some do not grow so well;
Some need alot more care.
Some need a different place to grow;
Some need more hugs and smiles.

Some children go to foster homes
Just like the plant that's moved.
It's pretty hard at first;
But with the extra care they're given
They soon grow leaves and flowers.

So children, if you feel misplaced,
Remember this one thing -
You are very special.
Living in a foster home
Gives you a chance to grow.

3. INTRODUCTION TO THE CHILD

Some children have to be moved from the family they were born into and live in another family where they do no know anyone. This can be very upsetting and confusing. This book is to help you understand what has happened to you and why you are now called a "foster child".

4. WHAT IS A FOSTER CHILD?

A foster child is someone who is being looked after by someone other than his/her parent. To foster means to care for and to help to grow. All children need to be cared for and helped to grow in different ways. You can grow in ways that make your body taller or wider and in ways that make you healthy and strong. This is physical growth and you need food, sleep and warm clothes to help you grow physically. Another way to grow is inside you. Things inside you that need to grow are the way you feel (sad, happy, angry), and the way you think about school, your friends, your parents and other things that are important to you. A foster child is someone who is being cared for and helped to grow. Let's look more closely at the ways you can grow.

Growing Outside

When you look in the mirror you see your outside. You might have blue eyes or brown eyes, long hair or short hair, dark skin or light skin. You might be tall and thin or short and fat. Children come in all shapes and sizes (just like adults), but all the things you see in the mirror are what make you - you. Children all have different outsides but all need special care to grow. There are lots of things you need to help you grow. You need different kinds of food (not just candy and chips), you need fresh air and exercise, sleep and warm clothes. When you get these things you will grow strong and healthy. Food, exercise and rest won't change the color of your hair or skin (remember, that is what makes you - you), but I will help so you can be strong and not feel sick.

Growing Inside

When you look in the mirror, you cannot see your inside but that is a very important part of you. Inside of you are your feelings and thoughts. You cannot see your feelings but they can be seen in what you do. For example, when you feel sad, you may cry, or get very quiet or your mouth may turn down at the corners. When you feel happy, you might laugh and get very noisy or just smile alot. When you feel angry you might yell or hit or scowl fiercely. Everyone has feelings but different children show their feelings in different ways. That is part of what makes you - you, just like your body shape or your hair color. Also inside of you are your thoughts. You have ideas in your head that say what you think about other people, things or happenings. You may think your teacher is nice because he/she is kind to you and does not scold you when you come to school late. You may think the boy next door is nice because he lets you use his bicycle. You may think peas taste horrible and that you should have pizza every night for supper. You might think it is more fun to play outside than to read a book. You might not think the same way as another child but what you think is part of what makes you a special person.

Just like your outside, your inside can grow too. It never gets bigger than your body but usually grows along with it. As you get bigger, you also learn more by what you see and are taught. Some children learn faster or more than others but the way you learn is also a part of what makes you special. You learn how to read and write, add and subtract. You learn how to ride a bike or swim. You learn not to cross the street when the light is red or not to play on thin ice. You learn things about people too. Some are kind and you like to be with them and others are not so kind. You learn that some people are your friends and others are not. As you grow older and bigger, your thoughts and feelings grow and change. Being a foster child means you are being helped to grow inside and outside.

5. WHY AM I A FOSTER CHILD?

Some children have to go into a different home to be cared for by people who are not really their parents. There are many reasons why this has to happen and these reasons are different for each child. Sometimes parents are sick and have to go to the hospital. Sometimes parents have so many problems of their own that they cannot do the things they need to to look after their children. We will talk more about these problems later. The most important thing for you to know is that you are not in a foster home because you have done something wrong. Sometimes children think they have to be put in a different home because they have been so bad that their parents do not want them anymore. This is not true. Children do things that are wrong sometimes and need to be corrected but this is part of growing up. It is not the reason you had to be placed in a foster home.

6. FEELINGS FOSTER CHILDREN HAVE

Thoughts and feelings can get pretty mixed up when you are taken from your home. Many children feel that nobody loves them. They think that because they cannot live with their parents they are not wanted or loved. They think they are not lovable.

You are lovable. Sometimes parents do not show love to their children because they never learned how to. Sometimes they need to learn what they should do to show love to their children. Sometimes they are sick or have problems so they cannot do the things they need to so they can show you love. You are still a lovable person. Many parents learn to show their children love by giving hem the care need. Some parents are never able to do this. The most important thing for you to know though is that you are lovable and there are other people such as friends or foster parents who can and will show you love.

Sometimes children are very angry that they cannot live with their parents. It is alright to be angry. It is a normal feeling we have when we cannot get something we want. Children act in different ways to show they are angry. Sometimes they hit people or break things. Sometimes they

yell and scream and make a big fuss. They may hurt other children or adults by what they say or do. Other children get very quiet and will hardly say or do anything because they do not want anyone to know how they are feeling. It can make you feel pretty bad, though, if you cannot tell anyone that you are angry. One way to help you feel better is to tell someone how angry you feel. It helps to get it off your chest. Talk to a friend, your teacher or your foster parents. Being angry, though, does not always help you to get what you want. Being angry will usually not help you to get back with your parents so it is best to do something about those angry feelings. You can decide not to be angry because it will not make things better for you. You can help make things better by making the best of things the way they are. You can change the way you think about being a foster child. You can decide that it is the best thing for you and your parents.

You may feel very sad once you know you cannot go back home -- at least not right away. Most children want to live with their parents and are sad when they cannot. You may want to cry and that is alright. Crying helps to get your feelings out of you and outside where other people can see them and try to help. It takes time to feel better so you may not be happy right away. Even though you cannot live at home, there are other things that can make you happy. You will

find other people who care for you and can help you feel happy. You may find friends that are fun to play with. Or a teacher that you can talk to. You can do things that make you feel better too. Maybe you especially like to draw or color. Maybe you would rather play games with other children or play a musical instrument. Keeping busy can help you so you do not feel so sad.

Getting Help With Bad Feelings

Sometimes children have thoughts and feelings that make them feel so bad inside that they do things that are not good for themselves and other people. There are people who understand how children feel and are able to help them. Some of the people are called social workers, counsellors, psychologists or psychiatrists. They have pretty big names but they are not scarey and will not hurt you. They want you to feel better. They can help by helping you talk about what feelings you have inside you. They can also help you to do things so you can get rid of some of those awful feelings.

7. WHAT ABOUT MY FAMILY

Parents do not always do what they should in caring for their children. Remember what you need to help you grow physically? You need food, sleep, exercise, warm clothes and, of course, a place to live. Some parents are not able to give their children these things. There are many reasons for this. They may be sick and unable to work and can not buy you the things you need. They may not work because they cannot find a job or because they do not want to work. These parents need help to find a job, or get well so they can work. Some parents need help because they have a problem with drinking too much alcohol. Until the parents are able to give their children the things that will help them grow and be healthy, it may be best for the children to be in a different home.

Why Can't I Live At Home?

Sometimes it may be dangerous for a child to stay in his/her home if the parent does not protect him/her or physically hurts him/her. Parents may get so angry or upset that they hit or burn or hurt the child in a way that is dangerous. this is wrong. Parents may have feelings or thoughts inside them that cause them to do things that hurt their children. These parents need help to change those thoughts and feelings so they do not hurt their children. It is not because a child is so bad that the parent hurts them. Sometimes children do things that are wrong and they need to be taught not to do these things. There are ways to teach children without hurting them. Some parents do not know how to do this because their parents yelled at them and hit them. Usually the parents who hurt their children need help themselves and sometimes children need to be taken out of the home for awhile so they do not get hurt anymore.

Many times parents cannot take care of their children because they drink too much whiskey or beer (alcohol). If parents get drunk too often they soon are no able to do the things they should for their children. They cannot get up in the morning to feed the children and make sure they have

good clothes to wear to school. They feel so awful -- inside and outside -- that they have to drink more beer to make them feel better. This really does not make things better. They only feel worse when they stop. Then they drink more. Sometimes they go out at night and do not think about if it is safe for the children to be left alone. sometimes when parents are drunk they do or say things to their children that are not good for them. Parents who are hurting their children or not looking after them because they are drunk, need help. They cannot help themselves. They may feel that they could never stop drinking so there is no use trying. Or, they may think they can stop drinking whenever they want to but just keep drinking. It is sort of like being sick. If you have a bad cold but do not go to a doctor or do things to help you feel better, you may get sicker. Parents who drink alot are like people who are sick. They need to do things to help make them better. They can go to places where people can talk to them and help them feel better inside so they do not keep drinking. This is very hard for parents to do. It takes a long time to get better and some parents never do.

8. SHOWING LOVE

What is Love?

Many children (and adults too), get pretty mixed up about love. Let's look first at what love is. One thing that love is, is a feeling inside you. It makes you feel all warm and happy like how you feel when you are holding a little puppy or kitten. Or when you share something special with a friend. You feel love when your mother or father or another adult gives you a warm hug and a smile. Someone may tell you that they love you and that makes you feel good inside too. Love is also things you do. Helping your little brother tie his shoes shows him that you love him. Saying kind words to people is showing love. You can show love by teaching your friend how to skate instead of making fun of her because she cannot skate as well as you. There are different kinds of love. There is love that parents have for each other, love that parents have for their children and love that children have for their parents. These different kinds of love are not just feelings inside but are shown by things people do.

How Parents Show Love

Let's talk a little bit about how parents show love to their children. Showing love does not mean just giving children anything they want. parents show love by giving children what they need to help them grow inside and outside. This means that you won't get to eat candy all the time because you need meat and vegetables to help you grow. This means you cannot watch late movies every night because you need sleep to help you grow. Parents show love by giving children things they need. They also help you grow inside by making you go to school even when you do not want to. They show love by teaching you to do things so you will be kind and helpful. This means you may have to do the dishes before you can watch T.V.. Or you may have to say you are sorry when you have hurt someone else. Parents also show love by letting you have fun playing outside with your friends. They show love by taking time to listen to you and to have fun with you. Other nice ways parents show love are by giving you hugs and smiles and saying kind things to you. These are some of the ways parents show children that they love them.

Getting Mixed Up About Love

Children can get pretty mixed up about love. This happens when a person says he/she loves you but does not do things to show love. A friend may say she loves you but won't share her candy or says nasty things about you. This can make you feel pretty awful inside. Parents may say they love you but do things that do not seem to show love. They may yell or scream at you or hit you alot. They may not listen to you or take time to do nice things for you. This can be pretty confusing and make you feel awful inside. It is hard to understand that the people you love and you think should show you love, do not seem to love you at all. Parents who do not show love to thier children need help. They may have some awful feelings inside them that they need to talk about with someone. They need to get rid of things inside them that make them do wrong things. They may need to learn how to show their love in ways that can help you grow.

9. WHOSE PROBLEM IS IT?

Your parents have problems but it is important for you to know that you did not cause them. They have to take responsibility for their own problems. This means that they cannot blame someone else. For instance, children do not cause their parents to drink. If they drink too much they choose to keep drinking or choose to get help to stop. You cannot change your parents or make them stop drinking. If they do stop drinking, they can be better parents. Some parents, though, never stop drinking and may never be able to give their children the care they need. This does not mean, though, that these children will not be cared for. We will talk more about that later. Just remember, YOU do not make your parents do the things they do.

10. WHAT ABOUT THE REST OF THE FAMILY?

We should talk a little bit about your brothers and sisters and other relatives. It may be that you and all your brothers and sisters are together in one home. You are very lucky. It is a little less lonely when you are with a brother or a sister. It may be that you fought alot at home but brothers and sisters can be good to talk to when you are feeling bad inside. They may be feeling the same way. Many times brothers and sisters are placed in different homes because there was not room for everyone in the same home. This may make you feel sad and lonely. Often you can talk to them on the phone if they are not too far away. It will help you feel better if you can at last talk to them. Sometimes only one child is moved to a different home and the brothers and sisters are left in the home. This may be because the one child was getting worse treatment than the others. It would no be good for that child to stay there. This happens in alot of families. It is not because one child is worse than the others. Each child in a family is different and behaves in different ways. One child may be treated worse because the parent has thoughts and feelings inside that come out in ways that are hurtful. They need help to change their thoughts and feelings. You do not cause those feelings. It is best for you, though, to be in a different home for awhile so you do not keep being hurt.

There may be other people in your family that you miss too. There may be aunts or uncles or grandparents that you would like to see. You may not see them as often as you like. Sending letters or talking on the phone once in awhile can help you feel less lonely.

11. ABOUT THE FOSTER HOME

What Kind of A Home Am I In?

Now let's talk about the place you are living in. It is called a foster home. Remember, foster means to care for and help to grow. A foster home is where that happens. Foster parents are the ones who do it. There may be other foster children in the home or there may be just the children who were born into that family. There may be both kinds of children. Whether foster children or not, all children need adults to look after them. Some children are lucky enough to be able to live with their parents. This does not make them better than you. It just means they are luckier.

Feeling At Home

It can be pretty scarey going into a home where you don't know anyone and everything is so different from your home. It takes a while to get used to the new rules and the new ways of doing things. Foster parents are there to help you feel at home. You do not love them like you do your own parents. It takes time for you to get to know each other. They may never seem like real parents to you but they are people who will care about you. As you get to know the people in the foster home and get used to the way they do things, you will feel more comfortable.

Changing Foster Homes

Sometimes children have to be moved to a different foster home. There are many reasons why this may happen. It may be that it is not a good place for you to stay. Foster parents, like other parents, do not always do the right things. Unfortunately, some foster parents do not really care about the foster children. They might not treat foster children as well as their own. This can make children very unhappy. If you are really unhappy in the foster home, it is important for you to talk to someone about it. Tell your teacher or the social worker (the person who brought you to the foster home). It may be better for you to be in another foster home. Sometimes foster parents ask for a foster child to be moved from their home. this may be because they have their own problems and feel it would be best for you to be in another home. Sometimes foster parents do not get along with each other or know the best way to help children. This may not be good for the child and it would be best for him/her to be moved. Sometimes you may have to stay in a place you do not like very well. You can be happy though by enjoying other people and activities outside of the home. It is important to know that you can get help if you are not happy there.

What Will It Be Like?

Most foster parents do care about the foster children in their home and do all they can to help them. These foster parents will give you the food and other things you need to help you grow on the outside. They will also give you hugs and smiles you need to help your inside grow. Foster parents will listen to you and try to understand how you are feeling so they can help you. Remember, you may have to do some things you do not like but that also helps you to grow. For example, eating vegetables, sweeping the floor or doing your homework. Foster parents help you to do these things and sometims discipline you when you do not do them. This is a hard part of growing up but it is an important part. Foster homes are usually a very good place to live. Some children even like them better than their real homes.

Most foster children, once they get used to the foster home, do very well and get along fine. Some do not. This may be because of the foster parents' problems that we talked about. Sometimes it is because of the foster child's problems. Remember we talked about what children do when they are feeling angry or sad. It is not wrong to have those feelings. Sometimes, though, the things children do

when they feel this way can hurt other people. Some hit other children or break alot of things. They may hurt other people's feelings by calling them names or yelling at them. Children, like adults, need to look inside at their thoughts and feelings. Some adults, like a foster parent, teacher or social worker, can help you talk about how you are feeling. Sometimes they can change things so you feel better. Sometimes they cannot. This means that you have to accept things the way they are and make the best of it. You will feel better inside when you do this.

How Long Will I Be In The Foster Home?

This is a very hard question to answer. Some children stay in foster homes only a few days. Others stay for many months. Some even stay until they are old enough to be on their own. When you fist move to a foster home it is hard to tell how long you will stay. First of all, it is important that when you go back home things are better for you. This means your parents have to make some changes and get help with their problems. If they do not, it would not be best for you to return. When your parents get help and make things better, it is best for you to return as soon as possible. This may take six months. Usually, though it takes longer and may take as long as a year or a year and a half. It is not a long time for adults. It takes time to make important changes.

Some children are never able to go home to stay. It is best if children can live with their own parents but this is not always possible, for the reasons we talked about before. It is not good for children to keep wondering if they will be going home or not. Sometimes it takes a very long time for parents to make the changes they need to and some never do. The next best thing is to stay in one home until you

can be on your own. Many foster children come to think of the foster home as their own. They become one of the family. Some children are adopted and get the same last name as the people who adopt them. Not all foster children are adopted but are still loved and cared for by their foster parents. Some children keep thinking they would rather live with their own parents. It is natural to feel this way. Often children forget why it is best not to live at home. They imagine it would be alot better than what it really is and forget the bad parts. It is good to remember good things about your parents. It is also important for you to remember why it is best for you not to live with them. If you are always thinking you would rather live with your parents, you will not be happy. Do you know the saying, "The grass is always greener on the other side of the fence?" This is about a cow who is always stretching her neck under the fence because the grass looks better to eat there. If she looked really closely, she would see that there are alot of brown patches in the other field. She would be happier, and not have such a sore neck, if she just noticed that there is green grass in her own field. So, if you look for good things about being in a foster home, you will find them AND you will be alot happier.

12. VISITS WITH PARENTS

While you are in a foster home you can still have visits with your parents and other people in your family. Sometimes these visits are very short and in the social worker's office. This is done if the child is better off not being alone with the parents, at least at first. You may be able to go home for visits and spend a few hours or days there. It is important for you to visit your parents. Sometimes, though, children get mixed up and get very upset by these visits. It is hard for them to see their parents for a little while and then have to go back to the foster home. Visits are usually lots of fun. Parents are very happy to see their children and may give them gifts and let them do anything they want to. This does not mean they are able to look after you the way they need to. It is hard to go back to the foster home and have to listen to rules and be with people you do not really know. But remember, the things that help you grow are not always easy to do. Sometimes parents do not show up for the visits and this is very upsetting for the children. Remember, parents do not always do the things they should because of their own problems. It is not because you are not lovable. Visits may also make you sad if your parents still yell at you, or drink too much. Remember, it takes time for things to get better and YOU cannot change your parents.

13. COURT, JUDGES AND SOCIAL WORKERS

There are alot of people that you do not know that are doing things for you and deciding things about you. There are judges, lawyers, social workers and sometimes doctors or psychologists (the people that help you with your feelings), that are trying to do what is best for you. That makes you a pretty important person. It can be pretty confusing though, when you do not know what is going on. I will try to explain. The social worker is the person who takes you from your home and places you in a foster home. That might sound like a pretty mean thing to do. Social workers, though, need to do some things that will protect children and help them grow. The social worker is also the one who visits you in the foster home, makes sure you are being looked after, arranges visits for you with your parents and tries to help parents to make changes so that you can live with them again. When a social worker places children in foster homes he/she has to follow rules (or laws). Most of these rules are in a book. This book tells about how children should be looked after and what should be done if they are not getting good care. There are many rules that the social worker must follow (See! It is not just children that have to obey rules).

There is a very important person that makes sure the rules in this book are being followed. This person is called a judge. S/he works in the court. There is a special court called Family Court where it is decided if children are to stay in foster homes or go back to live with their parents. The judge sits in a room called a court room. There is a special time set when the parents, the social workers and the lawyers explain to the judge what has happened and what they think is best for the child. The parents may no agree with what the social worker says is best for the child. Parents can get lawyers to help them tell the judge why it is best that their children live with them. When the judge gets everybody's story, s/he decides if it is best for the child to be in a foster home or not. This is called a court order. The court order says how long the child must be in the foster home. Before this time is up, everybody must go back to court and it is again decided if the child should be in a foster home or not.

What Does A Child Have To Say?

By now you are probably wondering where you fit into all of this. If you are old enough (twelve years or older), you can usually go to court. You can talk to the judge about what you would like to do. If you do not feel brave enough to do that, you can tell your social worker what you want to say and he/she will talk for you in court. Other people that can talk for you are lawyers, teachers or another adult that you know well. If you are too young to go to court, it is important that you tell your social worker or foster parent how you are feeling so that can be said in court. The judge may not do what you want but it is important that you have a say just like everyone else.

14. THIS IS JUST THE BEGINNING

This may be the end of the book but it is not the end of your story. Each of you has a special story to tell about yourself. Some stories are very sad. This book was written for you. It was written to help you understand a little better about what it means to be a foster child. It is very important for you to talk to your foster parents or social workers or someone who understands, when you are worried or have questions. Remember, a foster child is being cared for and helped to grow. I can see you are getting new leaves already!

Appendix H

QUESTIONNAIRE EVALUATION OF SERVICE

the children's aid society of winnipeg

114 Garry Street, Winnipeg, Manitoba R3C 1G1 (204) 942-0511

Dear

The attached questionnaire is a valuable part of the evaluation of the counselling provided by the undersigned. Please complete the form as soon as possible and mail it to:

Children's Aid Society of Winnipeg
c/o Elaine Gelmon
114 Garry Street
Winnipeg, Manitoba
R3C 1G1

Thank you for your cooperation. I have enjoyed working with your family.

Sincerely,

Carolyn Setterlund
Master's Student
School of Social Work

CS/ch

QUESTIONNAIRE
EVALUATION OF SERVICE

In helping to evaluate the service provided it is important to have your input. Please have each family member who is twelve years of age or older complete the following questionnaire. For each question place a check mark in one of the columns under VERY MUCH, SOMEWHAT or NOT AT ALL. Any additional comments about the service are welcome.

	Very Much	Some-what	Not At All
1. Were the Social Worker's expectations clear?			
2. Did you feel involved in selecting treatment goals?			
3. Was it helpful to have goals to work toward?			
4. Did you have enough time to reach the goals?			
5. Were the contracts helpful?			
6. Were the contracts easy to understand?			
7. Were the tasks easy enough for you to do?			
8. Did the rewards help you to work toward the goals?			

COMMENTS:
In what way was the family counselling most helpful to you?_____

_____

_____

What could have been done differently to make the counselling more helpful? _____

_____

_____

Additional Comments: _____

_____

_____

_____

_____

Appendix I

QUESTIONNAIRE EVALUATION OF SERVICE

QUESTIONNAIRE
EVALUATION OF SERVICE

In helping to evaluate the service provided it is important to have your input. Please have each family member who is twelve years of age or older complete the following questionnaire. For each question place a check mark in one of the columns under VERY MUCH, SOMEWHAT or NOT AT ALL. Any additional comments about the service are welcome.

	Very Much	Some-what	Not At All
1. Were the Social Worker's expectations clear?	✓		
2. Did you feel involved in selecting treatment goals?	✓		
3. Was it helpful to have goals to work toward?	✓		
4. Did you have enough time to reach the goals?		✓	
5. Were the contracts helpful?	✓		
6. Were the contracts easy to understand?	✓		
7. Were the tasks easy enough for you to do?	✓		
8. Did the rewards help you to work toward the goals?	✓		

COMMENTS:

In what way was the family counselling most helpful to you? It gave me new ideas and much needed support as I worked toward the goals with my kids.

What could have been done differently to make the counselling more helpful? The only thing that could have been improved would have been more time than we had.

Additional Comments: I found the help to be very beneficial and am most grateful.

Appendix J

QUESTIONNAIRE EVALUATION OF SERVICE

QUESTIONNAIRE
EVALUATION OF SERVICE

In helping to evaluate the service provided it is important to have your input. Please have each family member who is twelve years of age or older complete the following questionnaire. For each question place a check mark in one of the columns under VERY MUCH, SOMEWHAT or NOT AT ALL. Any additional comments about the service are welcome.

	Very Much	Some-what	Not At All
1. Were the Social Worker's expectations clear?	✓		
2. Did you feel involved in selecting treatment goals?	✓ ✓		
3. Was it helpful to have goals to work toward?	✓ ✓		
4. Did you have enough time to reach the goals?	✓		
5. Were the contracts helpful?	✓		
6. Were the contracts easy to understand?	✓		
7. Were the tasks easy enough for you to do?	✓ ✓		
8. Did the rewards help you to work toward the goals?	✓ ✓		

COMMENTS:
In what way was the family counselling most helpful to you? Been able to talk openly about our feelings. And most of all some one that is willing to hear each of the things that bought us most.
What could have been done differently to make the counselling more helpful? I dont think there is anything Id have changed to make the counselling more helpful. I looked forward to each each Counselling
Additional Comments: Going to family Counselling really made me do alot of thinking. In what way I can help myself to be more understanding. That I really can't expect my daughter to be a perfect child. That I should let her live her childhood just because I never had one. I should let her grow up in love +

Appendix K

QUESTIONNAIRE EVALUATION OF SERVICE

QUESTIONNAIRE
EVALUATION OF SERVICE

In helping to evaluate the service provided it is important to have your input. Please have each family member who is twelve years of age or older complete the following questionnaire. For each question place a check mark in one of the columns under VERY MUCH, SOMEWHAT or NOT AT ALL. Any additional comments about the service are welcome.

	Very Much	Some-what	Not At All
1. Were the Social Worker's expectations clear?	yes		
2. Did you feel involved in selecting treatment goals?	yes		
3. Was it helpful to have goals to work toward?	yes		
4. Did you have enough time to reach the goals?		✓	
5. Were the contracts helpful?		✓	
6. Were the contracts easy to understand?	✓		
7. Were the tasks easy enough for you to do?		✓	
8. Did the rewards help you to work toward the goals?		✓	

COMMENTS:
In what way was the family counselling most helpful to you? In helping setting goals & finding ways in which to achieve them.

What could have been done differently to make the counselling more helpful? more time - not enough seemed to get done in one session

Additional Comments: Carolyn was just great and has shown me how to get back on the right track.