A MODEL FOR WORKING WITH

DYSFUNCTIONAL BLUE COLLAR FAMILIES

by

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Abstract

The central purpose of this thesis was the development of a model of intervention with the dysfunctional blue collar family. The overall discussion focused on two issues. The first involved the delineation of a method of treatment for the blue collar family. A specific approach was determined through an examination of some of the characteristics of the blue collar family. The second major area of discussion centered on the combination or pairing of two divergent psychological approaches to compliment the proposed treatment style. The Rogerian approach and a behavior modification approach were examined and the advantages of each as an overall treatment method were utilized in the proposed model.

The sources of information for the study came from personal clinical experience in working with blue collar families and from a review of current relevant literature. The literature reviewed covered four main subject areas: a) a social learning or behavior modification approach, b) the use of parents as change agents for their children, c) the Rogerian therapeutic relationship, and d) some characteristics of the blue collar family.

The review of the literature and personal clinical experience resulted in a proposed treatment model for therapeutic intervention with the blue collar family. The model contains six components which come under three main headings. They are:

A. Assessment

    A1. Role-Induction Interview

    A2. Intake Interview

    A3. Baseline

B. Treatment

    B1. Parent Training Sessions

    B2. Assessment of Change

C. Evaluation

    C1. Consultative Follow-Up

Some Implications for further research regarding the model presented include a comparison of the proposed model with other models of family intervention. Investigation of the dynamics of the relationship between the therapist and the parent and/or the parent and the child might also result in contributions to the field of family therapy.

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To my family with love.

Chapter 1

Introduction to Study

Introduction

Effective approaches in the treatment of children with be-
havior problems have interested professional clinicians for
decades. The methods of treatment tend to be as varied as the
clinicians employing them. Intervention strategies range from
the Freudian psychoanalytic approach to the Reality Therapy of
William Glasser (1965), and from the non-directive, client-
centered approach of Carl Rogers (1951) to the behavioral
therapy or social learning approach first researched by B.F.
Skinner (1953) and most recently made popular by Patterson
(1975) and Tharp and Wetzel (1969).

The environments chosen for the treatment of the problem
child are almost as diverse as the theories of treatments them-
selves. Locations have ranged from the more traditional setting
of the therapist's office, to a classroom or school
setting, to the home of the child. This latter setting for
treatment has only recently been popularized (Patterson, 1975;
Tharp and Wetzel, 1969; Fullmer and Bernard, 1968; Werry and
Wollersheim, 1977; Fleischman and Conger, 1977).

In fact, within the last five to ten years an increasing
amount of research has centered on the issue of treatment
locale. That is to say, researchers have turned to investigate
conditions which afford the therapist his or her best chance of
successfully intervening in the behavior of the problem child.

More specifically, comparisons have been made between the effectiveness of the therapist's office compared with the environment where the problem originated.

According to much of the research that is currently being published, the best possible place for positive intervention with a child is the social environment in which the child spends the majority of his time and in the presence of those who are most influential upon him (Faust, 1968; Tharp and Wetzel, 1969).

> ...given the adequate training, supervision, and reinforcing feedback, parents can effectively eliminate the injurious conduct of their children (Bandura, 1973, p. 247).

The social environment being referred to is the home. Although the school deeply affects the life of the child and is a powerful source of influence in the development of the child, Fullmer and Bernard (1968) feel that the family is still the primary influential environment for the child. Clausen (1966) says there is no doubt that in all societies a child's mother, father and siblings - the nuclear family - constitutes the very core of his or her early personality development. Wagner (1973) states:

> If we are to use our manpower in the mental health field with maximum effectiveness, it is necessary for us to put the therapy where the problem is - in the home (p. 295).

That a child's family environment exerts a primary amount of influence on his behavior, both at home, in the school and in the community, represents a fundamental assumption upon which this thesis is based.

<u>Statement of the Problem</u>

The problem to be investigated required the logical assembly of many different areas of already proven research and tested intervention strategies into a new form or model. Heavy emphasis was given to; a) the educational approach to training parents in better child management techniques (Patterson, 1975; Fleischman and Conger, 1977), b) the use of the child's natural environment as the arena for the intervention (Tharp and Wetzel, 1969), and c) the appropriate use of the Rogerian (1951) or Carkhuffian (1967) communication skills combined with social learning theory in effecting behavior and perception change. The model developed was applied to the blue collar family. It is often experienced that the children of the blue collar family exhibit more behavior problems than other classes of the population and therefore seem appropriate for this study (Lewis, 1968). Finally, throughout the study I draw from my own case study experiences by offering examples from these families to highlight specific techniques of the past, present and the future.

<u>Objectives</u>

The overall objective of this study is to construct, through a review of the literature and from clinical experience, a new model of treatment intervention with the blue collar family.

Sub-Goals

a) To show by a review of the literature containing
existing models of intervention that training parents as inter-
ventionists with their own children is an effective technique.

b) To define by a review of the literature the unique
characteristics of the blue collar family.

c) To develop by a review of the literature and to illus-
trate using excerpts from clinical cases a model of interven-
tion with blue collar families.

d) To illustrate the difference between more traditional
family therapy and the model of family intervention proposed
by this study.

Contributions of the Study

This study should contribute to the generation of a theore-
tical structure that will enhance the professional clinician's
practice. More specifically, there are four areas where it is
felt this study contributes.

First of all, it should be apparent that the proposed
approach with a problem child is an economical treatment method.
That is, the time commitment of the therapist is small in com-
parison to the results achieved and therefore the program is
inexpensive. The treatment is ongoing, 24 hours a day, in the
home of the child and carried out by the parents of the child.

Secondly, there is the educational aspect to a behavioral approach that makes the overall treatment preventative. Parents are trained in more proficient child-management skills that deal with not only their present problem, but also any future problems. It can be said that the treatment this study investigates has universal applicability.

Thirdly, a detailed treatment or intervention strategy for the blue collar family is outlined and an argument for its combination with a behavior modification approach is presented.

Finally, what makes this study unique from Tharp and Wetzel (1969), Patterson (1975) and Fleischman and Conger (1978) is its emphasis on the specialized communication skills the therapist brings to a consultative-social learning approach. These skills are singled out in this study and given a new emphasis within the context of a behavioral approach.

Definition of Terms

The broad nature of this study dictates the definition of several terms. The definition of these terms should facilitate a better understanding of the nature of the study.

Social learning approach. The social learning approach as defined in this study indicates a learning theory approach that has operant conditioning (Skinner, 1953) as its core. The basic assumption underlying the approach is that the organism performs in a certain manner according to the consequences or

reinforcement which followed the same act on previous occasions. This means that there are a range of environmental events which are likely to produce a learned response (Werry and Wollersheim, 1967). For young children, their family is the primary dispenser of reinforcing and aversive consequences. Synonomous terms for social learning approach will include behavior therapy (Ross, 1974; Wolpe, 1973), behavior modification (Skinner, 1953; Gambrill, 1977) and reinforcement theory (Tharp and Wetzel, 1969).

Behavior problem child. The behavior problem child is defined as the child in the family who exhibits such socially aggressive behavior that he or she, a) is of such a concern to the family that professional help is sought, and/or b) cannot function in the public school system because of his/her socially aggressive behavior. For a list of specific behaviors refer to Appendix E in Patterson. (1975) The emphasis lies upon overt problem behaviors the child exhibits that when performed repeatedly become socially unacceptable. In this study the term used most often to describe a child exhibiting the latter behaviors will be the target child or problem child.

Problem child's family. The family of the targeted child will mean to include all those who are naturally related to him and those who are related to him by law (ie. divorce and re-marriage, step-sisters/brothers). Therefore the family of the problem child will include the parent(s), siblings, grandparents, aunts and uncles. Emphasis will lie with the members

of the family with whom the target child lives.

Blue collar family. The blue collar family is defined
family whose income is classified as lower than average and
where the parents are either semi-skilled or unskilled workers.
Distinct characteristics of the working class individual in-
clude, among others, action-orientation rather than verbal;
orientation toward problem and symptom removal rather than
personality change; extrospection rather than introspection;
below average education, and in a doctor-patient relationship
the blue collar parents are expectant of more immediate, direct
results (Gould, 1967). Further descriptive traits of the blue
collar family are given in Chapter II.

Communication skills. The definition of appropriate and effec-
tive communication skills involves what Rogers (1957) called
empathy, unconditional positive regard, and congruence. Cark-
huff and Truax (1967) operationalized these three tools of
the therapist as accurate empathy, nonpossessive warmth, and
genuineness. Other synonomous terms include empathic communi-
cation, respect and authenticity (Hammond, Hepworth, and
Smith, 1977).

Limitations of the Study

1. The population that is emphasized in this study is the blue
collar family and therefore generalization to other populations
with markedly different characteristics would require further

investigation.

2. No carefully controlled statistical study was undertaken comparing the proposed model with other family intervention models. Although examples from actual case studies are described in the study, the emphasis lies in the analysis of the ideal circumstances under which this type of intervention can occur.

Overview of the Study

The study just outlined will progress in the following manner. Chapter II will constitute a review of the literature regarding the behavior modification approach, the use of parents as change agents for their children, and the characteristics of the blue collar family. Following Chapter II will be a step-by-step look at the proposed model. The final chapter will present some important guidelines for the application of the model. Furthermore, I will address the difference between the present model and other models of family intervention and will conclude with some implications for further investigations.

Chapter II

Review of the Literature

Overview

The purpose of this chapter is to present a theoretical foundation for the development of a model for the treatment of blue collar families. Concepts and research articles will be reviewed which address themselves to the theoretical issues underlying this study. The major position presented in this study is that the principles and techniques of behavior modification have considerable validity in the training of blue collar parents to carry out their responsibilities with respect to their children.

In developing the above proposition, it is the intent of this chapter to review the literature in three distinct areas: a) the social learning approach, b) the use of parents as change agents for their children, and c) the characteristics of the blue collar family. In the latter sections the three areas will be woven together into an integrated structure. To review all of the literature in these three widely researched areas of investigation would be a practical impossibility since volumes have been written in each area. Consequently it is my intent to review the literature which has immediate relevance to the area of inquiry. The criteria used in the selecting of the literature are:

1) Only very contemporary articles are reviewed for this chap-
ter.

2) The review of the literature was selected from research con-
ducted with blue collar caucasian parents from Canada and the
United States.

3) Articles reviewed in the area of parenting were based on a
behavior modification approach using blue collar parents and
their children.

As a means of developing the theoretical foundation for
this study, the social learning approach was introduced in
a general manner and was compared with other psychothera-
peutic models, the advantages and disadvantages of the social
learning approach were ennunciated, and the concepts and
terms of social learning theory defined. Secondly, the litera-
ture was reviewed which demonstrated the efficacy of the
use of parents as psychotherapeutic agents in the training of
their children, and thirdly, the research relating to the
characteristics of the blue collar family will be reviewed.
Fourthly, from my personal experience as well as researchers'
experience with the structure and the culture of the blue
collar family, a treatment strategy evolved. Finally, the
method of treatment that has crystallized from the blue collar
structure and culture was compared with the advantages of
using a behavior modification approach over other approaches.

Introduction to Social Learning Theory

Social learning theory grew out of the overall framework of the carefully controlled laboratory experiments of classical and operant conditioning (Pavlov, 1927; Skinner, 1938). With its emphasis on overt behavior, operant conditioning experiments first attempted to control the behavior of animals by manipulating the contingencies of their environment. Relating behavioral principles to humans, behavior therapists, who talk about maladaptive behaviors rather than psychopathology, believe that abnormal as well as normal behaviors are acquired according to the same behavioral principles.

In a social learning approach the appropriate arena for changing a person's behavior is the environment in which that person lives. The family controls much of the environment which can affect the response of a behavior problem child (Tharp and Wetzel, 1969). A social learning theorist who wanted to help a child resolve some specific problem behaviors would therefore want to work in the home with the people who control the reinforcers for the targeted child.

Bandura (1973) sees the guidelines for this intervention in the following manner:

> By treating the actual problems in the contexts within which they arise, with influential members in those settings, social learning procedures are ideally suited for achieving enduring changes in psychological functioning. The further one departs from these optimal conditions the weaker the results are likely to be (p. 247).

Ross (1974) notes that the focus of behavior therapy is on the current presenting behavior and its accompanying current circumstances. The child's past history is considered only to the extent that it will aid in resolving the present behavior problems. Other current psychological theories regard behavior as having its roots in a person's past. For example, a psychoanalyst uses various analytic techniques to help his patient become aware of certain past experiences that are blocking him or her from a healthy lifestyle. At other times patients are said to be stagnated at an earlier psychosexual stage of life. Other psychotherapies place an emphasis on the history of their client and believe that it holds the key to their illness. Therefore, if we assume that the causes of behavior reside in the present and not in the past then most other theories of treatment are not useful.

Reinforcement Theory

Predominant in the theoretical orientation of behavior modification is reinforcement theory. Reinforcement theory embodies the principles dealing with behavior and its consequent events. Basic to reinforcement theory is Skinner's (1953) assertion that if a behavior is rewarded the probability that same behavior will be repeated in the future is increased. This is the core principle of operant conditioning. Through application of reinforcement theory, behavior patterns can be established, maintained or extinguished.

Though reinforcement theory has been scientifically and professionally generated it is highly related to common human

experiences and can be useful in providing effective consulta-
tion with persons from many non-professional walks of life.
(Tharp and Wetzel, 1969). Krasner (1971) emphasizes this point
when he notes that the key difference between dynamic-based
theories of change and operant-based approaches is one of the
changing role of the healer. Whether they are a teacher, a
nurse, a parent or a sibling, the healing role has been natur-
ally adopted by a member of the immediate environment in which
the maladjusted individual lives.

Comparison of Social Learning Theory with Other Psychotherapies

There are many other psychotherapies that offer distinctive
interpretations of human behavior (Corsini, 1973). Three of
the more widely used psychotherapies are psychoanalysis (Freud,
1936), Adlerian psychotherapy (Ansbacher and Ansbacher, 1953)
and client-centered psychotherapy (Rogers, 1957).

Psychoanalysis. Psychoanalytic therapists view man's be-
havior as being driven by unconscious, instinctually derived
forces. It is the therapist's job to help bring these forces
to the patient's consciousness by having the patient re-live
certain stages of analytic development and by a process called
transference. Transference refers to the process whereby the
patient re-lives some 'unfinished business' of his/her past
in the present by reexperiencing certain feelings of rejection
or hostility. The patient transfers these feelings onto the
analyst (Corey, 1977). Maladaptive behavior in the patient
is partly a result of poor psychosexual development and an un-
resolved Oedipus complex. The Oedipus complex is a period

where the child wishes to replace a parent of the same sex and to have sex or bodily contact with the parent of the opposite sex (Corsini, 1973, p. 13-14).

Considering the focus of the present investigation psychoanalysis would seem like a difficult technique to employ. Reisinger, Ora and Frangia (1976), in discussing psychoanalytic procedures and the use of parents, notes:

> that an active role for the parent has not been characteristic of this treatment model. Instead, when the parent has been involved in therapy, it has frequently been for treatment of their own problems which were thought to be affecting their child (p. 113).

To teach the parents anything about psychoanalytic procedures would probably be a long and strenuous task and therefore this theory usually requires the therapist to work directly with the patient. Finally, even on a one-to-one basis, the majority of times psychoanalists treat adult patients rather than children.

Adlerian psychology. Adlerian psychology was formulated by Alfred Adler (1927). Like psychoanalysis, it is a psychotherapy whose operating principles seem so complex that they can only be understood and explained by someone specially trained in its theory. An Adlerian views motivation in early childhood in terms of the child's perceptions of his or her family constellation and his struggle to find a place of importance within it. Adlerians are very much like behaviorists working with a family in that they believe that man cannot be understood in isolation; that man is a social being.

Client-centered therapy. Rogerians see man as being in a constant state of moving towards 'self-actualization'. The

therapist, trained in Rogerian philosophy, tries to create for
the child an atmosphere or certain therapeutic conditions
appropriate for this growth to take place. Like Adlerian
therapy and psychoanalysis, client-centered therapy is a tech-
nique that is used mostly by professionals in a one-to-one
approach with their client. The use of non-professionals
trained in the approach is common but requires intensive and
expert training. The therapeutic conditions of accurate em-
pathic understanding, unconditional positive regard, and
genuiness or congruence would take many hours of learning
(Hammond, Hepworth, and Smith, 1977). Axline (1964) notes how
few studies have detailed a Rogerian approach which utilized
the parent as a change agent. Instead the literature has
focused on only the professional and the client. About the
only Rogerian approach which does employ parents in the treat-
ment of their children is filial therapy (Guerney, 1969).
Filial therapy trains parents to conduct standardized play
sessions with their children.

Rogers believes that 'the forces of self-actualization
in the infant and child bump up against conditions which signif-
icant others in his life impose upon him' (1953, p. 126). Be-
havior therapy tries to educate the significant others regard-
ing their control of these conditions and what effect these
conditions have on their child.

Overall, it would appear that behaviorists and Rogerians
have only concentrated on the positive aspects of parental
inclusion in treatment while the psychodynamic therapists have

feuded about its pitfalls and wondered how parents could be properly included at all. It would appear that in most cases, across most therapy models, the use or exclusion of the parents as agents of change for their children depends on the profes- sional's affiliation with a particular treatment model or theory (Reisinger, Ora, Frangia, 1976).

Evaluation of the Social Learning Approach

Disadvantages. The disadvantages of using a social learn- ing approach are well documented by many authors (Corey, 1977; Carkhuff and Berenson, 1967; Patterson, 1973; O'Dell, 1974). A collection of the more popular criticisms appears below.

1. Behavior therapy usually ignores the past history of a client when formulating possible avenues of action concerning a present problem.

2. Behavior therapy often does not provide the client with the insight into why he/she behaves in a particular manner.

3. Behavior therapy mostly ignores the relational factors in creating a conducive therapeutic atmosphere for the client and the therapist; there is a mechanical and nonhumanistic level of interchange.

4. Behavior therapy usually focuses only on behaviors and does not focus upon the client's feelings.

5. Behavior therapy deals only with overtly specific problems and does not appear to be able to address itself to broader problems of personal and social adjustments more often tackled in traditional psychotherapy.

6. For clients who appear to be functioning at relatively high coping levels, behavior therapy does not, in most cases, appear applicable. Corey (1977) states, 'It does appear that behavior therapy does not have much to offer for the client who does not have specific maladaptive problems' (p. 136).

7. Behavior therapy more often deals with symptom removal rather than addressing itself to the cause of the disorder.

8. With such a mechanical orientation some critics wonder whether clients can generalize their problem solving skills to other areas in which they are experiencing problems.

9. It is argued that a person equiped in behavioral techniques can use these skills to manipulate, either consciously or unconsciously, the behavior of others for their own benefits.

Advantages. The advantages of using a social learning approach in training parents appear to outweigh the disadvantages of using such an approach. O'Dell (1974), in an article on parent training, summarized the many advantages of a social learning approach.

1. The use of nonprofessionals who can learn the principles and techniques of behavior modification and carry out intervention programs is common to behavior therapy.

2. The theory underlying behavior modification is laboratory derived and tested.

3. The techniques of behavior modification can be taught to large groups.

4. The actual training time in behavior therapy is short.

5. The overall impact of a social learning approach on overt problem behaviors is usually greater than one-to-one treatment models.

6. The social learning model is not based on the medical model which sees maladaptive behaviors as 'sick'. Rather, behavior problems are learned and therefore productive, facilitative behavior is simply a matter of proper learning and reinforcement.

7. Most childhood problems consist of well-defined, easily observable problem behaviors which lend themselves perfectly to a behavior modification approach.

8. As an intervention strategy behavior modification is ideal in dealing with problems in the child's natural environment.

Bandura (1973) says that what most people need is, 'not the insight that they are behaving inadequately but the means to learn more successful ways of behaving' (p. 253). This would appear to be even more the case with children who need to learn better ways of behaving around others rather than the deep insight into why they behave the way they do. One of the best comparative studies on behavioral and reflective parent counselling techniques appears to be Tavormina's (1975). Tavormina concludes that behavioral parent counselling is more effective than the other approaches. It would appear on the basis of the studies cited that a social learning approach is viable in working with behavior problem children, in their home, using the parents as the primary therapists.

Definition of Behavioral Terms

Definition of terms often used in counselling employing social learning techniques should prove helpful to the understanding of the present investigation.

Contingency management. Contingency management is the rearrangement of the environmental rewards and punishments which either strengthen or weaken subsequent behaviors (Tharp and Wetzel, 1969).

Contingency manager. The contingency manager is a person whose knowledge qualifies him to specify the correct patterns of reorganized control via consulting with the parents. He modifies the behavior of the parents so that they will corectly organize the environment of the targeted child (Tharp and Wetzel, 1969).

Extinction. The gradual reduction in the frequency and subsequent removal of a behavior following the withdrawal of maintaining reinforcers is known as extinction.

Fading. Fading is the gradual lessening of treatment contacts from perhaps daily contact down to approximately once a week prior to termination. The therapist eventually turns the whole program over to the parents and their targeted child to run on their own with perhaps the odd 'booster shot' by the therapist (See Fleischman and Conger, 1977).

Mediator. The mediator is usually, but not always, the parents of the targeted child. He or she occupies an intermediary position between the target child and the therapist.

Tharp and Wetzel (1969) believe that when using a social learn-
ing approach in the natural environment that the overall effec-
tiveness of the intervention rests with the behavior of the
mediators or the parents.

Positive reinforcers. Positive reinforcers are those
things or events that when presented tend to increase the like-
lihood that a certain behavior will occur again. Some examples
of positive reinforcers are money, smiles, attention by a sig-
nificant other (parent) and food.

Time-out. Time-out is the immediate separation of the
targeted child from a situation that in some way reinforces
his inappropriate behavior. The separation is only for very
short periods of time, usually no more than ten minutes, into
an environment that is as non-socially reinforcing as possible.

Use of Parents as Psychotherapeutic Agents

> The hyperprofessionalization of the mental health
> professionals militates against the use of society's
> greatest resources: the client's natural relation-
> ships, with their extraordinary potential power for
> generating behavior change (Tharp and Wetzel, 1969,
> p. 2).

Guerney (1969) notes that in the area of mental health
problems the use of nonprofessionals has steadily increased
over the past decade. Of the research in this area, the major-
ity of it has investigated parent training approaches (O'Dell,
1974). The focus of current research efforts involving parents
tends to focus on programs using a social learning approach
(O'Dell, 1974).

There are three distinct lines of reasoning that would
seem to suggest that parents are of primary importance in deal-
ing with mental health problems of children. First, by train-
ing parents in more effective child management techniques the
mental health professional is directly addressing the important
issue of prevention. Changes in behavior of the significant
adults in a child's life are usually more important than
direct services to that child (Christensen, 1972). It is during
the formative preschool years that the parents have primary in-
fluence over their children and therefore it is the parents
who are positioned best to provide preventative services
(Hawkins, 1972). Some researchers see the prevention of child-
hood mental health problems as having the highest priority in
community mental health (Glidewell, 1971).

A second argument which addresses the issue of parent in-
volvement is that the number of children in need of some sort
of mental health service far outnumbers the number of pro-
fessionals available (Lindsley, 1966). One researcher believes
that the number of children with behavior problems is so large
that only by instituting a compulsory parent training program
in the schools can the problem be brought under some degree of
control (Hawkins, 1972).

Finally, and perhaps most importantly, there is the issue
of whether behavior change can truly be effective if the treat-
ment does not lend itself to the environment in which the pro-
blem manifests itself. Tharp and Wetzel (1969) note;

> No field of treatment or rehabilitation, no organized
> attempt to alter human behavior, is without continual

confrontation by evidence that the environment in which the individual is embedded is principally responsible for the organization or disorganization, the maintenance or change, the appearance or disappearance of any behavior (p. 7).

The therapy, then, must be easily adaptable for use in the child's natural environment and working in this environment inevitably leads to parental involvement. The parents control the majority of the environmental contingencies for their children. Therefore, the parent's involvement as dispensers of reinforcement is crucial to the success or failure of this approach. (Tharp and Wetzel, 1969.)

Training Parents in Operant Techniques - Background

One of the first times that parents were cited as change agents for their children was in 1909 when Sigmund Freud used a child's father as a psychoanalytic agent in the case of 'Little Hans' (Freud, 1959). One of the first experiments demonstrating that a person unskilled in behavior modification could be taught to control certain behaviors in others by manipulating reinforcement contingencies was done by Ayllon and Michael (1959). In behavior therapy the use of parents in the treatment of their children goes back as far as the early 1930's (Weber, 1936). O'Dell (1974) credits Pumroy (1965) with one of the first studies at teaching parents the principles and techniques of behavior modification.

Behavior modification training with parents is a new field with almost two thirds of the research done since 1968 (Goodall, 1972). Patterson (1971) sees a current trend to develop more powerful procedures for training parents than

just the interview. Berkowitz (1972) echoes Patterson's con-
cern when he notes that many different procedures for training
parents are being tried. Among some that are listed are group
and individual approaches, direct coaching, modelling, parent
group discussions, assigned readings and programmed materials.
It would appear that a good approach to training parents to be
effective with their children would include some combination
of all of the above methods.

Today, however, researchers predict that within the next
decade counselling will shift its focus away from individual
and group approaches towards methods which will affect the
social environment of individuals and thereby reach larger
populations of people. Hutchinson and Stadler (1975) in their
book Social Change Counselling: A Radical Approach are advo-
cates of an approach to counselling which acknowledges the
sometimes detrimental effects of accepted socialization and
social institutions of the western culture. For example,
where a traditional family therapist might diagnose a child's
problem as being the result of poor interrelationships within
the family, a therapist with a social change orientation would
argue that it is the overall institution of the family which
causes the problem and not necessarily the interactions of
the parents and siblings.

A child's early social environment is influenced mostly
by his parents (Hawkins, 1972). The therapist, using a social
learning approach, sees the use of these parents as mediators
and co-workers as being of primary importance. For the thera-

pist to achieve maximum efficiency the parent of the child will have to be brought into the milieu of treatment (Lucky, 1967).

Blue Collar Family

Many researchers have defined groups or populations of parents that they would not collaborate with but few, if any, have defined the parameters for predicting high and low success parents for using a parent training approach (Graziano, 1977). Wiltz (1969) and Patterson (1965) excluded parents who appeared psychotic. Others, such as Bernal (1973), screened out families in which there was sharp marital discord. Stricter parental types who would not be accepted for parent training were parents who were described as conflictual and had excessive rigidity (Tharp and Wetzel, 1969).

There are researchers on both sides of the issue pertaining to the advisability of involvement of parents from different socioeconomic levels as change agents for their child. Hirsch and Walden (1969) and Mira (1970) believe that there is no relationship between a parent's socioeconomic level and his/her subsequent success in a parent training program. On the other hand, Reisinger et al (1976) see a definite relation between the two. Patterson et al (1972) believes that lower socioeconomic parents should not be trained in parenting techniques because they are deficient in even the most basic child management skills.

Addressing the topic of lower-class families and their suitability or non-suitability for parent training programs,

Reisinger et al (1976) states;

> Many behavioral studies have concentrated upon the
> middle-class family, while few studies have explored
> the lower-class family response to intervention train-
> ing. The available evidence suggests that the latter
> families react less enthusiastically and efficiently
> to intervention programming than do middle-class famil-
> ies (p. 107).

However, what appears to be more important is an investi-

gation of what style of intervention or type of treatment is

specially suitable for this type of client. I have also noted

and concur with Goldstein (1973) when he states:

> Perhaps the most significant failure in contemporary
> psychotherapy has been the marked absence of treat-
> ment approaches of demonstrated or even apparent
> usefulness for lower-and working-class
> patients. The wide array of attempts to employ
> traditional outpatient psychotherapists with such
> patients has yielded an overwhelmingly dismal pat-
> tern of treatment outcomes. (p. xi).

That professionals tend to involve parents as change

agents for children to a degree determined by theory, in de-

fiance of fact, is an assertion that I feel is disputable

(Reisinger, Ora, and Frangia, 1976). It is hoped that certain

advantages to working with this population will become apparent

by looking at important specifics about the blue collar family

and a certain style of treatment delivery. Furthermore, an

outline of the combination of the social learning approach and

the treatment method for the blue collar family is proposed.

Characteristics of the Blue Collar Family

Blue Collar Characteristics (Riessman, 1962; Skynner, 1976;

Trotter, 1977; Minuchin, 1967, 1964).

That the therapist and his client are congruent in their
goals and how they are to be achieved is an important thera-
peutic rule. By working with a population whose characteris-
tics suit the therapist's intervention style we can achieve
this therapeutic rule. The blue collar family possesses many
unique characteristics which suggest style of therapy or inter-
vention. These characteristics were originally divided into
two broad and overlapping categories of family structure and
family culture. They have been combined below into one list
with an abstraction of the more important points.

a) There is an overall atmosphere of impermanence, un-
reliability and inconsistency, little or no clear rules to
internalize exist, and there is a minimum of enduring struc-
ture. However, the blue collar family prefers structure and
organization to a relaxed and ambiguous situation.

b) Because of the lack of structure and rules the child-
ren are forced to react to fluctuating parental moods.

c) Their vocabulary and their capacity for abstract
thinking is meager. There is more of a work and action orien-
tation rather than a verbal orientation.

d) Because blue collar parents are dysfunctional in the
way they react to their children's behavior a deficity is
created regarding the child's awareness of his impingement on
others. This has broader implications for it exposes a limited
awareness of these families in regard to their own functioning,
their strengths, their weaknesses, and how they relate to
other people.

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e) The emphasis of these families is on control, authority, and inhibition rather than on teaching or guidance.

f) Blue collar families are usually self-perpetuating families in that the parents function poorly in child management skills because they also had backgrounds where their parental examples or role models were dysfunctional.

g) The blue collar family focuses on the present more than the past or the future.

h) Culturally, the blue collar family is very family and group orientated but prefer less intense relationships outside of the family.

Blue Collar Family - Method of Treatment

Investigators have studied the problem of the high dropout rate among lower-class patients (Overall and Aronson, 1963). Generally, they have found that problems exist in the different types of treatment not being tailored to the characteristics of the client. Mayer and Timms (1969) note:

> Clearly treatment effectiveness will increase when case-work practioners, researchers, and mental health personnel in general give more thought and attention to the outlook of clients (p. 32).

Underlying the suitability of the social learning approach to the blue collar family is the concept that this population is most amenable to a prescriptive type of intervention (McMahan, 1962). That is, they are more responsive to a therapy whose emphasis lies in practical action rather than insight. As Gould (1967) notes, the therapist's first duty is to address the problem presented by the family. The blue collar family looks to the therapist as a professional who is either

going to address directly their immediate concern or is going
to prescribe for them a way that they themselves can eliminate
the problem (Overall and Aronson, 1963).

Overall and Aronson (1963) list three areas they discovered
to be important factors related to blue collar dropout.

a) Lower-class clients generally expect a specific pat-
tern or style of interview from the therapist. An ambiguous,
non-directive, verbal format is usually not best when treating
a blue collar client.

b) Early in the treatment or in the initial interview
it is usually a good idea to re-educate the blue collar client
as to both his role and the therapist's role in the future
treatment.

c) The therapist should encourage the direct expression
of the expectancies of the blue collar client.

Skynner (1976) echoes the research findings of others
when he says that abstract Rogerian, conceptual techniques are
relatively ineffective in working with a blue collar popula-
tion. He believes that the structure of the family must be
adjusted by concrete means. For example, Skynner says that
children of blue collar families should respond positively
to behavior contracting because of the lack of consistent
structure or coherent rules to internalize. Furthermore,
behavioral techniques such as contracting naturally lend
themselves to the external focus of such families. Minuchin
(1966) states:

> This is our most serious problem in acting-out families. They are unskilled in introspection - in observing and evaluating their own actions - and require a therapy that centers on ways of making this process more available to them (p. 613).

A Specific Treatment Approach

The characteristics of the blue collar family can suggest specific therapeutic treatment approaches which are especially suited for this population. Two such approaches to treatment are those proposed by Gould (1967) and Skynner (1976). The two approaches have been combined and appear below as one.

a) There is a crisis orientation or a focus clearly on the presenting problem. The therapist directs his energy towards the specific area of concern that the family brings to him.

b) An interviewing atmosphere of informality is created wherein the client is made to feel as comfortable and relaxed as possible. The appropriate use of simple communication void of fancy professional jargon is of trememdous importance.

c) Establishing contact with the client on a nonverbal level, being more physical in descriptions and conducting therapy where it is most appropriate and comfortable for the client are all important. This leads to an (atmosphere) emphasis upon 'reaching out' through home visits, school visits and phone calls.

d) Intervention with a blue collar population is usually more effective when it is short term, 6-12 weeks.

e) The extensive use of the techniques of role-playing,
modelling and behavioral rehearsal are important.

f) An education orientation is usually more effective than
an intellectual, analytic, explanatory or verbal approach.
This type of format is also appropriate because sometimes the
client simply does not know what appropriate behaviors are
necessary.

g) The approach is based on a directive or authoritarian
delivery in the early stages. Most families expect direction
and put themselves trustingly in the therapist's hands. The
therapist must learn to take constructive advantage of this
dependence.

h) The approach should be based on the values, needs and
desires of the client, rather than those of the therapist.

i) It is supportive intervention due to some low self-
esteem of the client. Encouragement and positively phrased
language are used unsparingly.

The Blue Collar Family and the Behavior
Modification Approach

By looking at the blue collar family structure, their
culture, and O'Dell's (1974) conclusions about training parents
in behavior therapy techniques, specific treatment approaches
to the blue collar family naturally emerge. Approaches, such
as Gould's and Skynner's, are tailored to the blue collar
population. The almost perfect fit of these treatment approach-
es and the behavior modification or social learning approach
is really where the advantages of using the proposed approach

outweigh the disadvantages. It is proposed that if one uses these treatment approaches which are derived from the family structure and culture of the blue collar family, then the best theory or technique of therapy to be used in treatment appears to be the behavior modification approach.

The behavior modification approach for the treatment of the dysfunctional blue collar family is probably the best approach because:

a) The behavioral approach is very prescriptive, direct and unambiguous in its approach. There are specific steps and guidelines to follow.

b) The behavioral approach is a short term approach involving usually no more than 6 weeks of treatment. (Note: the proposed model involves no more than approximately 6 weeks of treatment.)

c) The behavioral approach emphasizes practical action with concrete and easily understandable intervention steps; non-insight orientated, non-verbal emphasis.

d) The therapist is symptom orientated and addresses the presenting problem of the family first rather than, perhaps, avoiding this and going on to more of what he sees as the problem (eg. marital problems).

e) The roles of the parent(s), the problem child and the therapist are made explicit from the very beginning of intervention.

f) The behavioral approach addresses directly the lack of structure in an unstructured home environment. The behavioral approach can better organize the blue collar household.

g) The behavioral approach uses home visits, school visits, and phone calls in practically all stages of intervention. Such a style of reaching-out reduces the formality of the therapist/client relationship and consequently reduces 'role distance' and facilitates the open and honest expression of expectancies in treatment by the parent(s).

h) Role-playing and contingency contracting are basic to a behavioral therapy approach and are most appropriate with a blue collar family (Gould, 1967; Skynner, 1976).

i) For the most part, the format of a behavioral approach in the home is educational.

j) The focus of behavior modification is on the here-and-now and primarily addresses itself to overt problem behaviors that are happening now and can be defined in clear operational terms.

k) The therapist communicates to the family at a level which can be understood with a minimum of professional jargon.

l) Encouragement and reinforcement of the parents by the therapist during all phases of treatment is of primary importance to this treatment approach (Tharp and Wetzel, 1969).

Chapter III

The Model

Introduction

Chapter II concluded with a review of research proposing
a behavior modification approach to working with blue collar
families. This was the result of a series of investigations
covering three main areas; a) behavior modification approach,
b) use of parents as change agents for their children, and
c) characteristics of the blue collar family.

Chapter III will examine how the behavioral approach can
be strengthened by combining it with another important thera-
peutic orientation, that of Rogers (1951) or Carkhuff (1967).
A psycho-behavioral (Woody, 1971) intervention style will also
be examined and a treatment model, combining the theoretical
foundation of Chapter II, will be outlined.

It is becoming increasingly clear from both theoretical
and research perspectives that one therapeutic approach cannot
be successfully applied to any type of client exhibiting any
type of problem. One approach the logic of Chapter II has
taken is that what the therapist does in his or her interven-
tion style must make sense to the client. Woody (1971) states:

> ...counselor-therapists should be prepared, for the
> good of their clients, to escape the confines of a
> single theoretical approach or set of techniques,
> and to tailor their professional actions to the needs
> and characteristics of the client being treated (p. 8).

The behavior modification approach has been proposed as an especially suitable intervention style for the blue collar family in dealing with family problems centering around their children. However, it appears from my clinical experience and the research of others that one skill which the behavior therapist should efficiently incorporate into his or her repertoire of skills is the effective use of the therapeutic relationship. Behavior therapists, such as Tharp and Wetzel (1969), state:

> The ability to form open, trusting and accurate relationships is of a value as great in contingency management as in psychotherapy; rapport and empathy will serve the contingency manager well in his efforts to understand the complex articulation of a social environment (p. 24).

The Therapeutic Relationship

As presented in Chapter II the behavior modification approach contains important disadvantages. Among these are two that address themselves to a critical difference between behavior therapy and Rogerian therapy:

a) Behavior therapy for the most part ignores the relational factors in creating a conducive therapeutic atmosphere for the client and the therapist; there is a mechanical and nonhumanistic level of interchange.

b) Behavior therapy usually focuses only on behavior and does not focus upon the client's feelings.

That most behavior therapists have, in the past, ignored the relationship factors between themselves and their clients and have not focused upon their client's feelings has been

well documented (Patterson, 1973; Wilson and Evans, 1977).

The importance or unimportance of the client-therapist
relationship in the intervention style of a therapist trained
in behavior modification has been a point of long standing
controversy. Wolpe (1958) conceded that as much as 60 percent
of the effectiveness of behavior modification may be due to
'non-specific relationship factors'. Research today, for the
most part, supports Wolpe's early position. However, the re-
lationship factors that Wolpe spoke of are today quite identi-
fiable and specific (Carkhuff and Berenson, 1967). The defined
dimensions should be present in the therapeutic relationship
if the therapy is to be as effective as possible. Much of the
evidence seems indisputable. Woody (1971) takes the issue one
step further when he notes:

> Of special importance is the possibility that these
> particular dimensions could, at least in part, depend
> on personal characteristics as much or more than on
> professional characteristics (p. 7).

That the therapeutic relationship is of great importance
in the overall therapeutic encounter is a point that appears
to be no longer debatable (Goldstein, 1962). Indeed, serious
consideration is now being given by many behavior therapists
to the importance of the therapist-client relationship in
their work (Woody, 1971; Patterson, 1973; Sloane, Staples et
al, 1975). There appears today to be a camp of behaviorists
forming what is somewhat analogous to the first Neo-Freudians;
Adler, Jung, and Rank. That is, these behaviorists are dis-
agreeing with the 'pure' Skinnarian behaviorists and their
strict learning theory approach and they are incorporating

into their therapeutic repertoire the facilitative conditions
of the therapeutic relationship; namely those conditions of
accurate empathy, unconditional positive regard, and genuiness
(Rogers, 1951; Carkhuff and Berenson, 1967). Mickelson and
Stevic (1971) agree with Carkhuff's (1967) conclusion that
maximum benefits from any behavior modification program must
have as a pre-requisite high levels of interpersonal function-
ing exhibited by the therapist. Other researchers, such as
Patterson (1973) and Hammond, Hepworth and Smith (1977) also
point to the evidence that certain attributes of the therapist
have a reinforcing effect on the client. Patterson calls them
respect, interest, concern, and attention. Lazarus (1968),
perhaps, best sums up the relevance of the position of the
therapeutic relationship in behavior therapy when he notes
that nothing in learning theory precludes the behavior thera-
pist from offering, 'human understanding, empathy, support,
and other factors that foster hope and mobolize an expectation
of help'.

In a large research study by Sloane, Staples, Cristol,
Yorkston and Whipple (1975) entitled Psychotherapy Versus
Behavior Therapy the authors undertook the task of experiment-
ally comparing behavior therapy and psychotherapy. Three
groups of clients, one a control group, were treated by be-
havior therapists or psychotherapists.

Of the authors' six general conclusions from the study,
two directly address themselves to the issue of the therapeu-
tic relationship. First, it was noted that the styles of the two

types of therapists differed dramatically. The behavior thera-
pists were more active than the psychotherapists and more
frequently gave explicit instructions and advice. They pre-
sented their own value judgements, provided information, domin-
ated the conversation verbally and controlled the content of
the conversation. Furthermore, they achieved a deeper level
of inter-personal contact and empathy than did the more passive
psychotherapists. Behavior therapists, besides being seen by
their clients as more genuine persons, were also pictured as
encouraging less independence than the psychotherapists
(Sloane et al, 1975). Secondly, the research indicated that
the crucial indicator for successful psychotherapy, as well
as behavior therapy, was the therapist-client relationship.
The clients from both behavior therapy and psychotherapy saw
the single most important factor of their treatment as being
their personal interaction with the therapist.

Combining Behavior Therapy and Aspects of the
Therapeutic Relationship

Patterson (1973) believes Thorne's (1973) eclecticism
has one major weakness. Patterson feels Thorne fails to
successfully integrate the two major schools of therapy, client-
centered therapy and behavior therapy. Woody (1971), on the
other hand, in his book Psychobehavioral Counselling and
Therapy - Integrating Behavioral and Insight Techniques, has
tried to do what Patterson says Thorne has failed to do.
Woody describes psychobehavioral counselling and therapy as a
"technical eclecticism' that effectively combines Rogerian and
conditioning techniques and relegates the role of the person

chiefly responsible for the therapeutic action to the therapist and not to the client as some psychotherapists might.

The therapist provides what Goldstein (1973) refers to as social class-relevant techniques or prescriptive psychotherapy and not 'therapeutic shotguns'. This appears to address the issue of the blue collar family and the effective combination of behavioral and insight techniques. It is proposed that probably one of the most effective styles of intervention for the blue collar population is a combination of the two.

Overall, the therapists would exhibit empathy, genuiness and positive regard for his or her clients. On the other hand, they would also recognize that insight was not the basic goal of the therapy but that certain pre-agreed upon behavioral goals were. Addressing the topic of client insight in therapy, Hammon, Hepworth and Smith (1975) note:

> ...insight should be pursued only as far as it is essential to removing the barriers to change. The counsellors ethical responsibility is to assist clients as rapidly as possible, and in some instances, little insight is required before the client can undertake corrective actions (p. 50).

Improvement in the proposed style of therapeutic intervention would not be reflected in the amount of self-understanding that the client achieved. This, in most cases, would be a strict Rogerian or insight view of client improvement. Behaviorists see the beneficial cognitive and emotional changes that can occur from therapy as byproducts of behavior change (Glasser, 1965; Hammond, Hepworth, and Smith, 1975).

It is hoped that by making the blue collar client some-
what aware of the barriers that impede his change, using a
Rogerian style of interaction or effective use of the thera-
peutic relationship, the therapist can assist the client to hurdle
the barriers to change by concrete behavioral intervention
techniques.   This is the combination of the two types of thera-
pies that I envision.

Underlying the behaviorist position on insight is what
Hammond, Hepworth, and Smith (1975) see as the 'Spread of
Effect' phenomenon.   The spread of effect phenomenon refers
to a client who after making considerable progress with his
original presenting problem gains the skill and confidence to
deal with other home problems on his or her own.   The valuable
preventive overtones of this are obvious.

The overall intervention style for the blue collar family
would be based on the following guidelines: 1) behav-
ioral emphasis, 2) short-term intervention, 3) authoritative
administration 4) early, continuing, and frequent reinforcement
and encouragement (Goldstein, 1973), and 5) empathy, uncondi-
tional positive regard and genuiness exhibited towards the
client at all times.

A Proposed Alternative Treatment Model

Introduction

The proposed treatment model for working with a blue
collar family involves a collage of therapeutic techniques.

The model is designed not only to educate the blue collar parent in principles and techniques of behavior modification but to also integrate related aspects of humanistically oriented approaches, specifically the effective use of the therapeutic relationship. Sadler and Seyden (1975) see the combination of the best of both the behavior modification and the humanistic approaches as offering an ideal combination in a well-organized parent training course.

The following model is an outline of what I consider to be an effective style of intervention with the blue collar family. The model is the result of my clinical experience and a review of the related research and literature. Furthermore, apparent gaps in previous models have been examined. There are six distinct components to the model with various subsections to each. The six components are;

A. Assessment

    1). Role-Induction Interview

    2). Intake Interview

    3). Baseline

B. Treatment

    4). Parent Training Sessions

    5). Assessment of Change

C. Evaluation

    6). Consultative Follow-up

This model should not be followed or interpreted as if it were a step-by-step 'program' but rather as an outline for intervention with the blue collar family exhibiting difficulties

in dealing with children of pre-school or elementary school age.

Finally, the following model attempts to address Carkhuff's (1971) criteria for a comprehensive program for parent training. In Carkhuff's criteria, which appear below, the integration of the behavioral and insight approaches is evident again.

1). Training in the interpersonal and other skills necessary to function effectively.

2). Training in the methods of discerning and developing effective courses of action.

3). Training in the means and modalities necessary to implement the resultant programs.   (Carkhuff, 1971, p. 12).

A.   Assessment

A.1.   Role-Induction Interview

The role-induction interview (Hoehn-Saric et al, 1964) is the first interview the therapist has with the parents. This interview is critical for two reasons. First, in this inter-view the therapist should try to discern the overall motivation or readiness of the parents for the counselling program and he should also come to some conclusions as to the commitment of the parents towards the program. Some researchers see the client's motivational level as being the single most crucial factor relating to successful therapy outcomes (Ripple, 1964). Kuchenmuller (1975), in his research, recently concluded that the importance of an evaluation of the parent's and the child-ren's readiness and commitment to enter a concentrated behavior

modification program cannot be underestimated. Hammond, Hep-
worth, and Smith (1977) state:

> Efforts to continue counselling with an inadequately
> motivated client are generally doomed to failure
> (p. 41).

Hammond, et al, (1977) go on to say that almost any client's
motivation to carry on in therapy centers around his or her ex-
perience in looking the therapist over during the very first
interview. By the therapist being sensitive to the importance
of the role-induction interview he or she will be rewarded with
clients who stay longer in therapy and do not prematurely ter-
minate (Hoehn-Saric et al, 1964).

The second major importance of the role-induction interview
concerns itself with how this first interview got its name.
That is. The second important function of this interview is that
it should be used by the therapist to discuss any existing thera-
pist-client role ambiguities. With the blue collar client there
is usually a large degree of covert disagreement as to how the
therapy will proceed (Mayer and Timms, 1969). In most instances
Mayer and Timms (1969) discovered that the blue collar client
was almost totally unaware that the therapist's approach
to therapy differed dramatically from his own.

> ...two persons ostensibly playing the same game but
> actually adhering to rules that are private (Mayer
> and Timms, 1969, p. 37).

Role-induction is what Goldstein (1973) would refer to as
a technique for ambiguity reduction. The therapist should take
time to clarify for the blue collar parent what his or her
style of therapy is like and why it is like that. Furthermore,

an atmosphere where the client feels he can offer some genuine feedback of his or her own expectations from the therapist should always be created by the therapist using his humanistic skills.

Role expectations in therapy also involve prognostic expectancies. With the blue collar client this is especially important for usually the lower-class client enters therapy expecting a great deal of change or help while, on the other hand, the therapist holds low prognostic hopes for this type of client (Goldstein, 1973).

Finally, the role-induction interview is a good time to prepare the client for the many different emotional paths that therapy can take. The therapist should avoid frightening the client, but at the same time be prepared to be honest with him about the possible periods of sorrow and pain as well as the times of joy and progress.

A.2. Intake Interview

The intake interview is, in most cases, the first interview the therapist has with the client. Normally, the role-induction interview would be subsumed under the heading of the intake interview. The separation of the two underlines the importance of the role-induction interview when it comes to dealing with the blue collar parents who may lack in understanding and motivation. However, if the therapist can easily see that the parents are ready and motivated to begin the program and that they understand the direction that the therapy will take, then the therapist could combine the role-induction interview with the intake interview.

The intake interview comes under the broad heading of what some therapists might refer to as Assessment (Patterson, 1975). In the present model the Role-Induction Interview, Intake Interview, and Baseline all come under the heading of Assessment. Patterson (1975) and others see the intake interview as a time for the therapist, the parents, and the child to familiarize themselves with each other as well as having the parents and the child fill out various assessment forms. These assessment forms include background or historical data for the clinic and the therapist as well as tests for the parents and the child designed to assess their suitability or non-suitability for certain types of programs.

Whether the parents and the child are interviewed together or separately the therapist in his or her opening statements should try to convey to them a sense that they are entering a program that will provide for them all a time for positive change (Patterson, 1975). Furthermore, the therapist should be careful in making sure that his opening remarks address and include the whole family. That is, after the intake interview the family should go away with the feeling that they all will contribute to this change process and that the child is not being brought to the therapist's office to be 'fixed' and then given back to the family.

Breakage Fee

If it appears that the family is suitable for the proposed style of intervention then the collection of a 'breakage fee' should be discussed next (Patterson, 1975). A breakage fee is

a small amount of money that is collected by the therapist before the treatment has begun. The approach to the collection of the breakage fee is more of a firm suggestion by the therapist that needs the understanding cooperation of the parents. The amount varies with the socio-economic level of the client. In the case of the blue collar family it might be $10.00. The breakage fee is used as a means of 'motivating' the family to keep appointments, do their homework and, in general, cooperate as fully as possible with the therapist.

Other means or methods of inducing cooperation from lower-class parents have included china (Risley, 1968), money (Patterson, McNeal, Hawkins, Philps, 1967), and hair dressing appointments (Patterson, Reid, 1970).

For example, when appointments are missed, without a good excuse or prior notification, the therapist could deduct $2.00 from the parent's breakage fee. Similar deductions would occur for other serious types of un-cooperative family behavior. If, on the other hand, the parents and the child are relatively consistent in their respective responsibilities in the treatment program the full amount of their breakage fee is returned to them at the end of the treatment.

The breakage fee serves two purposes. One, it helps to ensure that the parents will cooperate with the therapist in being responsible for the tasks assigned to them. Secondly, it conveys early in the program an introduction to a social learning type of approach by making certain behaviors of the parent's contingent upon their breakage fee being returned.

Initial Behavioral Organization

Once the breakage fee has been worked out with the parents it is time to begin pinpointing some specific behaviors of the problem child that have brought the parents in seeking help. Each parent is instructed to make a list of both negative and positive behaviors that the child exhibits. It cannot be emphasized enough that each parent's list should contain specific behaviors; actions that can be defined or described in terms of the child's actual behavior. Along with these behaviors the parents should be asked to describe approximately how often they occur, where they occur, under what circumstances they occur, and finally, the consequences of these behaviors. After this has been completed the parents are asked to put their lists together and try to arrive at what they feel are the two most negative behaviors their child exhibits as well as the two most positive behaviors he or she exhibits.

This last part of the intake interview gives the therapist important insights into how the parents communicate together and how each of them 'pictures' their child. The therapist should be somewhat passive and act like a moderator for the early part when the parents are comparing their lists. For example, the therapist might find that only one parent sees the child as having any problems while the other is very protective of the child. This exercise, besides providing very valuable information, will also give the therapist some idea as to how well the parents can cooperate together on a task. The therapist, if needed, should eventually promote this co-

operation between the two parents and have them at the end of this interview experiencing what it is like to work together in helping to solve their child's problems rather than fighting with each other.

Finally, and just as importantly, this exercise has the parents take the first steps in the organization of what had probably previously been a very disorganized household. For example, the parents are starting to think about some of the good things that their child does and not only the bad things. The parents are being drawn into the treatment of the child by themselves with the therapist's help and guidance.

During the intake interview the therapist uses Rogerian skills in helping the parents explain their difficulties with this child. The therapist is empathic towards the parents for the trouble they say they have had to put up with and reinforces through his or her therapeutic skills the parents commitment towards helping the child and is as positive and upbeat as possible during the entire interview. When the parents leave the intake interview they should feel positive about themselves and optimistic about their problem. They will have taken an active part in the very initial steps to help their particular child. They should leave the therapist's office feeling like responsible parents.

It should be noted that the intake interview may stretch out over more than one interview. There should be no strict time limit in terms of one or two interviews to accomplish the tasks listed above. The therapist may find the parents have

raised certain issues that are of a good deal of concern to them and that his timetable may have to be more flexible.

A.3. Baseline

Baseline is the last component to come under the broad heading of Assessment. The term baseline refers to the accurate documentation by either the parents or the therapist of the current specified behaviors of the targeted child. The collected baseline data will serve as a record of the child's behavior before any form of treatment is implemented. With the collection of accurate baseline data the therapist and the parents can actually see whether there has been any positive and concrete behavioral change in the problem behaviors of the child. Therefore, the baseline component of the proposed model is intergrally tied to the fifth component called Assessment of Change.

There are essentially two valid methods of collecting baseline information; a) home observations by the therapist, and b) home observations by the parents. This investigation will only cover the latter method. For information concerning home observations by a therapist the reader should refer to Reid (1978).

Baseline Data Collection by the Parents

The collection of the baseline data by the parents can sometimes indicate to the therapist just how devoted the parents are to the treatment program. During the baseline period the parents are asked to collect data on the four behaviors they specified in the intake interview. Gelfand and Hartman (1968)

suggest that observation of problem behavior frequency should also be accompanied by baseline observation of prosocial behaviors. This is not an easy task for the parents to do. The parents have many other things to do in their day-to-day lives and have brought the child to the therapist for help. As I pointed out earlier, the blue collar parent often expects direction and authority from the therapist. However, the therapist must be especially sensitive to the unexpected work load he is putting on the parents in the very early stages of the treatment. The parents, usually, would like to cooperate as much as possible but it is the therapist who is in charge and it is he or she who should do most of the work. The therapist, therefore, must be aware of the seemingly large amount of work that he expects the parents to tackle that has no apparent immediate pay-offs for them.

With the above cautions in mind it is now appropriate for the therapist's second, or perhaps third, interview with the parents. The first thing that he or she must teach the parents is how to observe or attend to the targeted child's behaviors (Patterson, 1971). One approach to this task is for the therapist to role-play one of the four targeted behaviors and instruct the parents just how to record their baseline data. The therapist's role-play should be tried by each parent for each behavior so as to make quite certain to them just what behaviors they will be looking for. The active involvement of the parents during this interview further helps them to feel a part of the therapy.

Once the therapist is satisfied that the parents will be able to record the baseline data for the targeted behaviors he arranges, in cooperation with the parents, a schedule of observation and phone calls is developed. The schedule of observation usually involves both parents having to observe the targeted child for one hour each day during which the two negative behaviors are most likely to occur. For example, the father, due to his work, may be able to observe only in the morning or afternoon. With blue collar parents there is more than a good chance that both parents will be working shift work.

A careful record is kept by both parents of the number of times each targeted behavior has occurred. The following day one of the parents phones the clinic or the therapist's office with the information which they have collected. The therapist then records this information on a master tally sheet for future reference. The phone calls are made at a flexible but pre-arranged time. For example, the mother might phone the therapist every morning for one week at 10:A.M.

The effective use of the therapeutic techniques of empathy, genuiness and unconditional positive regard play a major role in relation to the parent's phone calls to the therapist. 'Baseline' is a time when the parents are involved in a process that is relatively new to them where they are collecting data and possibly do not really understand its place in the treatment of their child's problem. The therapist must be very sensitive in the manner in which he talks to the mother or father when they call with their collected information.

For example, the therapist might find himself or herself having to deal with a complaining parent who will only complain about the terrible behavior of their child and not get to the observation information that they have or have not collected. The rule is data first. The parent upon phoning must first of all give the therapist their observations from the day before. After the information has been recorded then the therapist should use his therapeutic skills to empathize and comfort the frustrated and confused parent. The therapist should contin-uously reinforce and encourage the parent for his or her efforts at home and assure them that this baseline period is an impor-tant part of the overall treatment plan. An example of part of such a conversation might be;

> Therapist: Mrs. Smith, you are really doing such a good job of phoning me regularly with your information about Tom. I know it must be terribly hard for you to manage him as well as take care of your house and do all those household chores. I know I would sure have a hard time and find it very frustrating. There are only a few more days left where you will have to do this and then we can really sit down and come up with some ways of really getting rid of Tom's bad behaviors. Thank-you for calling. I'll talk to you again tomorrow.

During the collection of baseline data by the parents the parents are usually spending an unusually large amount of time observing the targeted child. Remember, if the parents are following the therapist's instructions they are each closely, but not too obviously, observing the child for one hour each day for one week. For blue collar parents, who are usually both working full eight-hour shifts and then fulfilling other obliga-tions, this is an extraordinary amount of time for observation. One effect this can have on the child is an overall behavior

improvement during the baseline period, even before official treatment intervention. As Tharp and Wetzel (1969) note, 'One of the most powerful developing reinforcers is attention from both adults and peers' (p. 20).

Improvement will most likely be noted in the child's over-all attitude and behavior and not necessarily the behaviors the parents targeted. Many children misbehave as an only means of attracting their parent's attention. With the parents making special note of their positive as well as negative be-haviors the children may act out less frequently. The thera-pist has instructed them only to observe and note the behavior in its frequency and description and take minimal action in stopping it. This is, of course, extremely hard for the parents to do especially if the child is screaming at the top of his or her voice. Here again, the therapist must be especially sensi-tive to the parent when he or she is talking to them on the phone. In the next section the above description of parental attention or non-attention is very close to an actual inter-vention strategy and will be discussed later in the treatment model.

B. Treatment

B.1. Parent Training Sessions

With an accurate record of the targeted child's behavior over a one week period it is time for the therapist and the parents to move onto the next phase - treatment. Here, the therapist involves the parents in educational sessions on how

to effectively cope with their child. The sessions usually in-
volve other parents that the therapist is working with. By
involving different parents in these meetings the therapist
provides his or her clients with an ongoing support group. That
is, the parents come to realize that they are not alone with
their problems in dealing with their children and that other
parents also have similar or even very different problems from
their own.

The next section will look at two behavioral avenues of
training parents to become better at dealing with their child-
ren's behavior. They are; a) Social Praise Contingency Train-
ing, and b) Point or Token-Incentive Contracting. However, be-
fore discussing the details of these two techniques The Triadic
Model (Tharp and Wetzel, 1969) will be introduced and explained.

The Triadic Model

The triadic model evolves quite naturally from the approach
of some of today's behavior therapists. Increasingly, behavior
therapists have discovered that there is little need for direct
contact with the client. Reinforcement theory has shown them
that direct contact with the child should naturally go to the
person(s) who; a) possess the child's reinforcers, and b) are
able to place them on contingency (Tharp and Wetzel, 1969).
In most cases the therapist is not that person. Therefore,
what develops is not the traditional therapeutic dyad of the
medical model, with just the doctor and the patient but rather
a triad. The triad consists of:

1) The therapist, who acts as a consultant to the mediator.

2) A mediator, who could be for example, a parent or a teacher.

3) A target, who is the client or in the present example is

    child identified as the problem by the parent.

Tharp and Wetzel (1969) sees the consultant as being anyone who

possesses knowledge specific to the problem, the mediator as

anyone who possesses the required reinforcers and who can

dispense them contingently, and the target as any person with a

problem.
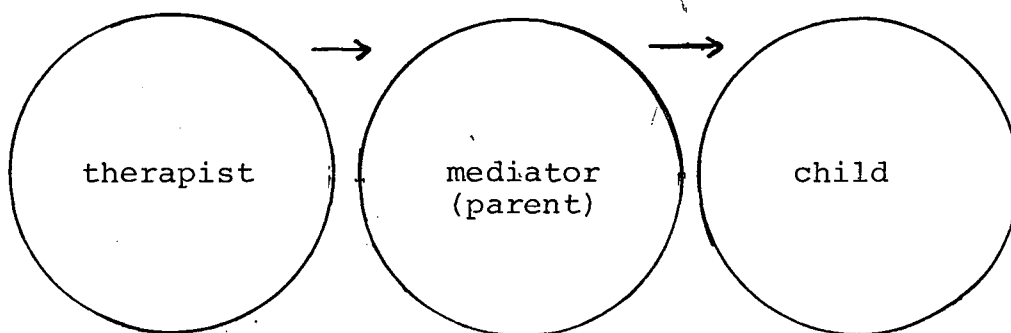
Fig. 1.   The Triadic Model

    Like the hub of a two-pronged wheel, the mediator functions

in a position that is crucial to the success of the overall

intervention strategy.   The mediator is in contact with the

consultant-therapist who instructs and guides his or her actions

with respect to the target.   The mediator is the intermediary of

the consultant.   For the purposes of the present investigatiga-

tion it will be assumed that the parent(s) is the mediator and po-

ssesses the two criteria necessary to function as a mediator

in the triadic model.

The importance of the parent in the triadic model cannot be overstated.   Because the contingency management technique acts as the foundation for the therapist's intervention strategy the role of the parent is crucial.   In order to rearrange certain contingencies so that favorable behavior is rewarded and unfavorable behavior is not rewarded the therapist must be sure that the parents can act contingently upon the child's behavior.

With the parent playing such a critical role in the triadic treatment strategy it becomes apparent that the quality and consistency of his or her behavior is of the utmost importance. Tharp and Wetzel (1969) note:

> ...it becomes apparent that the central issue must become the maintenance of the mediator's desired behavior.   Since the key agent for control is the mediator, the target's behavior is a near-strict function of the effectiveness of the mediator. Therefore, behavior modification in the natural environment stands or falls on the effectiveness of the behavior of the mediator (p. 51).

The effectiveness of the parent's behavior depends upon the reinforcement he or she receives for their performance with the child.   The reinforcement for the parent can come from as many as three different sources at once.   The reinforcement can come from; a) the therapist, b) the target (child), and/or c) from others in the child's environment.

Reinforcement from the therapist is the most important source of encouragement and support for the parent (Tharp and Wetzel, 1969).   Since the child's behavior modification is correlated with effectiveness of the parents, the therapist is constantly reinforcing the parent's work whether it be by phone

calls, home visits, or moral support. The therapist uses the same principles of learning theory with the parents as the parents are with their child. Furthermore, the therapist's use of his or her humanistic skills when talking with the parents cannot be emphasized enough.

A second source of reinforcement for the parents is the child. As the parent's attempts at behavior modification improve they will be reinforced by the improvements in their child's behavior. From my experience, I have noted that even the very smallest improvements in the child's behavior, improvements that cannot be noticed by the therapist or others, are usually noticed immediately by the parents and have accompanying reinforcing consequences.

The third source of reinforcement for the parents is the reinforcement from 'others' (Tharp and Wetzel, 1969). Others can refer to anyone in the child's natural environment with whom the child has contact. With the gradual improvements in the child's behavior these other people, who can be school personnel, peers or other parents who know the child, naturally comment to the parent on how much their child has improved and what a good job they, the parents, have been doing.

Social Praise Contingency Training

In recent research, Gordon (1971) reported that as many as nine out of ten parents communicate with their children in a manner that is 'destructive to both the kids and the relationship' (p. 1). From a reinforcement theory perspective the communication that Gordon refers to has no consistency to it

and follows few, if any, of the rules of learning theory.
Parents will sometimes verbally reinforce a child's behavior
while at other times punish that same behavior. Even worse,
parents will rarely reinforce or praise positive behavior of
the child and only punish or verbally abuse the child's nega-
tive behavior. Furthermore, not only must some parents be
made to realize that their social reinforcement in the form
of verbal communication is important, but they also should
realize the important position their behavior occupies as far
as it being a model for their children. Friesen and Csapo
(1975) note:

> Familiarity with the application of the basic rules
> of learning, effects of social interaction might
> prevent the acquisition and maintenance of a great
> variety of maladaptive child behaviors (p. 80).

It is the basic rules of learning and the understanding of these
by the parents that the present section will investigate.

A basic principle of operant learning theory is that be-
haviors, when they are reinforced, will increase and behaviors
when they are ignored or punished will decrease. It is this one
basic principle that the therapist must teach the parents in
order for them to take their first few steps towards becoming
more effective parents. Some therapists, such as Patterson
(1975), assign the parents a book to read. The book contains
information on reinforcement theory with illustrations and a
fill-in-the-blank format. The book is very short and simply
worded so that as little difficulty as possible is encountered
by the parents in reading it. The parents are told they will
be given a short quiz when they are finished the book and that

treatment will not begin until they have both finished the book. Delays or difficulties here can sometimes be handled by use of the parent's breakage fee. The books assigned are usually Families, Applications of Social Learning to Family Life by Patterson (1971) or Living with Children by Patterson and Gullion (1968). The latter book is recommended for families with a limited vocabulary or reading level such as the blue collar family.

Some researchers (O'Dell, Flynn, and Benlolo, 1977) have recently discovered that lengthly training of parents in the general principles and theory of behavior modification did not better prepare them to deal with a problem more adequately than groups of parents with very little general knowledge of behavior modification. However, the differences that did occur between the various groups indicated that some general knowledge of the principles of behavior modification were helpful for parents who applied this knowledge directly in the home. Overall, the findings tended to indicate a briefer training period for the parents.

Another approach to educating the parents on the contingent use of social praise is by using the group meetings of the parents. The therapist can role-play certain procedures and there is also a short film on social reinforcement available for the parents to watch and discuss after it is over. The author prefers the discussion, role-play, and film approach to a reading assignment for the blue collar parent. By this point in the treatment, which can be three weeks following initial therapist

contact, the parents usually want to see some results and want
some concrete suggestions as to what they can do to be better
able to cope with the targeted child. Furthermore, an educa-
tional approach in such an environment using role-playing,
modelling, and behavioral rehearsal utilizes some of the earlier
suggestions for a style of treatment for the blue collar family.

What form these group sessions take depends upon the indi-
vidual group composition. However, in general a parent group
session takes on certain qualities and has a basic structure to
it. The therapist must keep in mind throughout these early
meetings with the parents that he or she is teaching or training
the parents to take a positive approach towards handling this
child. For years the parents have possibly had only a negative
and punitive approach towards this child and now they must learn
to behave differently. Furthermore, the therapist must be sen-
sitive to the possibility that the child's bad behaviors have
allienated the parents from him or her.

The therapist's first job is to instruct the parents in a
few of the more basic rules of reinforcement theory. As the
architect of change, the therapist must supply his builders with
the necessary materials and tools with which they can work.
Perhaps one of the best approaches to this didactic beginning
is for the therapist to employ as much demonstration and self-
disclosure as possible. Humor is a good tool with which these
latter two techniques can be reinforced to effectively communi-
cate to the blue collar parents the framework of operant learn-
ing theory. Finally, once the therapist thinks that most of the

parents have a grasp of the material, he involves the whole group in lively games or role-playing situations in which they can use what they have learned. Reinforcement consistency is stressed throughout. The parents reinforcement vocabulary can be added to by the therapist modelling many different phrases and words and non-verbal gestures. Sometimes parents simply do not know what words to use. The therapist must be careful in his suggestions so that they are words and phrases that would naturally come from the same value and belief system as the mediator's.

Reinforcement of the child in terms of social praise and recognition for his or her positive behaviors will not guarantee the elimination of any or all of his negative or targeted behaviors. The reinforcement strengthens the consistency and quality of the positive behaviors of the child. The child learns that he can get parental attention by doing positive things. When the child behaves in a negative fashion the parent is instructed to ignore the behavior. However, there are two instances when just simply ignoring a child's negative is not enough and a form of punishment from the parents is necessary. They are: a) disobeying a direct command or instruction from the parent, and b) damaging or hurting other people or property (Fleischman and Conger, 1978). The form that this punishment takes is explained to the child at the very beginning of treatment by the parents. It is explained to the child under what circumstances it will occur and what the child is expected to do. Therefore, any misbehavior or disobedience by the child is met with a consequence that is familiar to the child.

Time-Out. Fleischman and Conger (1978) describe time-out
in the following manner;

> The purpose of time-out is to separate the child
> immediately from a situation that in some way
> reinforces his inappropriate behavior. It is the
> immediacy and separation that makes time-out effec-
> tive. Time-out does not need to be done in a hostile,
> angry or punitive manner. The best procedure is a
> matter-of-fact and calm attitude (p. 184).

Time-out follows a routine-like procedure. First, the child is
asked to stop his or her misbehavior. If the child continues
the parent instructs the child that they have disobeyed and
are to go to time-out. No threats are to be used, the child
is not to be argued with or listened to. The child then immedi-
ately goes to a pre-determined area of the house where he or
she will be socially isolated from those around him. For exam-
ple, a small room with any toys and books removed could be set-
up. The child is to stay in time-out for anywhere from five
minutes to thirty minutes. At the end of the 'time-out' the parent
simply instructs the child that 'time-out' is over and returns to
whatever they were doing. Further disobedience by the child
puts him or her back into 'time-out' with extra time added on.

Point or Token-Incentive Contracting

The parent group sessions can take from three to four weeks
with a group meeting once a week and an individual meeting with
the therapist once a week. At the private meeting with the
therapist the parents can share their more private complaints
or failures with the therapist. Sometimes the therapist will
find that social praise contingency training is not enough
and that one or both of the parents need a stronger method for

them to begin to deal effectively with their children. At this

point the therapist may, after only one or two group meetings,

decide to introduce Point or Token-Incentive Contracting.

Contracting is based on earlier work done by Patterson

(1971), (1975), and Stuart (1971). The use of a 'Contract' to

deal with the child's two original presenting problems is what

point or token contracting is about. Contracting is not done in

a group with other parents and for contracting to begin the

therapist alone meets with the two parents and their targeted

child.

First, it must be understood what a contract is. A contract

is a document drawn up by the parents, the child and the thera-

pist. An example of a contract can be found in Patterson (1975),

Appendix I or Fleischman and Conger (1978).

> A 'contract' is a written document detailing the
> specific behaviors and reinforcing arrangements to
> which two or more family members have agreed.
> Because they are written, there is less chance for
> confusion. A contract requires daily attention
> and repeated entries, it functions as a kind of
> consistent prosthetic device supporting the program
> (Patterson, 1975, pps. 63-64).

With the contract the child learns that by doing certain behav-

iors he will gain points which can earn him or her certain pri-

veleges.

The therapist's next move is to help the parents and the

child behaviorally define the two positive and two negative

behaviors which will appear on the contract. These can be

written down on the back of the contract or on a separate sheet

of paper and attached to the contract. Next, the therapist sets

a limit of IO points or tokens that can be earned per day for

each specified behavior cumulatively (Patterson, 1975). The

behaviors have points assigned to them which the child can

accumulate during the course of the day for a maximum score

of 10 points. The points or tokens must be awarded immediately

upon doing or not doing one of the behaviors. At the end of

the day the child may 'cash' in his points or tokens for an

agreed upon privilege. An example of such a contract appears

below;

1)   Behaviors

    a)   talking quietly to my sister in the morning; no yelling,

        - 4 points

    b)   putting away my clothes and making my bed, - 3 points

    c)   helping mom do the dishes, - 2 points

    d)   doing 1/2 hour of homework a night, Sun. - Mon., - 2

        points

2)   Privileges (Patterson, 1975, p. 64)

    10 points - stay up until 9:00 P.M. and watch television

     8 points - go to bed 8:30, get special dessert

     6 points - go to bed 8:30

     4 points - go to bed 7:30

     2 points - go to bed 7:00

    Minus or 0 points - wash dishes (alone) and go to bed 7:00

The contract's activities and point system operate on a

daily basis. The child receives three types of pay-offs with

this contract. First, the parent, upon seeing that the child

has fulfilled one of the 4 behaviors, immediately praises the

child socially. Some examples might include:

1)   "Sean, that was really great the way you didn't yell at
     your sister all morning. You must feel good about your-
     self."

2)   "Thanks Sean for helping me with the dishes. It sure is
     much easier for me to get through the day when you help me
     with the dishes."

Secondly, at the same time as the parent is praising the child

for his or her positive behavior the child is awarded points or

given the appropriate number of tokens. The points are added

to a tally sheet which is placed somewhere where everybody in

the family can see it. If plastic tokens are preferred over

points then a tally sheet is still used and the child can store

his or her tokens in, for example, a small box in his/her room.

Thirdly, when the day is over the child 'cashes' in the points

or tokens according to the agreed upon privileges.

When the contract has been agreed upon by the parents, the

child, and the therapist, it is signed by all three parties and

posted somewhere where all can see it, for example the refriger-

ator. This public posting of the contract and the tally sheet

is a good way to get everyone in the house involved in the tar-

geted child's treatment. Other siblings are asked to comment

daily on their brother's or sister's progress as noted by the

ongoing record of the contract's tally sheet. Father, when

he arrives home from work, or for that matter mother, can immedi-

ately see how Sean has behaved that day and can praise him for

behaviors completed. It is important here for the therapist to

make the family realize that only the child's progress is

commented upon and the child is not to be bullied, taunted, or teased about the lack of points or behaviors he or she has not done. The accent is always on the positive. Secondly, the targeted child is to be commended for his behaviors on the contract and not the number of points or tokens earned.

Any contract can be re-negotiated at any time by the concerned parties. The child's first few contracts should not be too demanding on him or her. Some simple behaviors that the child can already do with some regularity might have to be added on with low point value assigned to them so that the child can start succeeding and moving in a positive direction immediately. The child should feel what it is like to succeed and achieve some points as soon as the contract takes effect. Glasser (1965) is one therapist who firmly believes that a greater focus on success is needed for children rather than a constant atmosphere of failure, especially in the educational system. As the child begins achieving his full load of points quite regularly the contract is adjusted. For example, the child can work on another kind of a contract where he or she accumulates points or tokens over the course of a week. At the end of the week the child can turn those points into certain other agreed upon privileges. These privileges might include a movie, a small toy of his/her choice, or a special request on the weekend dinner menu.

Behavior therapists call this type of bargaining or contracting with a child the effective use of the Premack Principle (Premack, 1965). The Premack Principle is based on the premise

that activities the child enjoys may be used as effective rein-
forcers for less pleasurable behaviors. Therefore, in the case
of 'Sean', the parents might have observed the enjoyment that
Sean gets by staying up late and watching television or eating
sweet desserts. On the other hand, Sean is inconsistent in
doing his homework, does not like doing his chores or making
his room tidy, and often yells at his sister in the morning when
they are getting ready for school. The parents, who control
the use of the television and what is for dinner, contingently
use these to accelerate behaviors that Sean does not like and
reduce negative behaviors.

During the contracting period, the therapist is consulting
with the parents as to how things are progressing. Consulta-
tion by the therapist with the parents is by this point in
treatment probably the major form of contact between the two
parties. Consultation itself is becoming more and more impor-
tant as a tool of the therapist and some researchers say it is
even becoming a trend in counselling (Cottingham, 1965; Gazda,
1965). Mayer (1972) sees the therapist's overall objective in
the consultation process as helping the parents to implement
behavioral procedures. Friesen (Note 1.) sees consultation as,
'...an educational endeavour... to enhance the parent's know-
ledge of behavior dynamics, leadership, and to provide support
for learning and applying parenting skills'. It is my experi-
ence that it is the support and encouragement by the consultant
or the therapist that is crucial just as the reinforcement for
the parent is critical. Hammond, Hepworth and Smith (1977)

note: 'Encouragement is vital in maintaining the client's hope, an indispensible prerequisite to change' (p. 54).

The therapist is in daily contact, usually by phone, with the parents and reinforces the parent's efforts at this new style of learning to cope with their child. Tharp and Wetzel (1969) describe this daily contact of the therapist's or contingency manager in the following manner:

> The task of the contingency manager in the complex
> social environment is thus to specify the correct
> pattern of reorganized control, and to modify the
> behavior of the controlling people so that they
> will correctly reorganize for the ultimate benefit
> of the deviant individual (p. 3).

Indidivual meetings can still be held with the parents if crisis situations warrant it but generally the parents are allowed to operate here quite independently of the therapist. The parents are usually by this stage receiving reinforcement for their efforts from the targeted child in improved behavior and from others in the child's environment who have contact with the child. Improved relations at home often result in better school performance. Teachers and administration note improvement in the child's behavior and usually pass it on to the parents at home. Furthermore, improvements in the child's behavior make for a friendlier and more relaxed atmosphere around the house. The family can begin to do more things together, often with less friction.

Fading Out the Therapist's Involvement

By now the intervention strategy is often into its 9th or 10th week. As the parents become more familiar with the use of social contingencies and contracting they are better able to cope with their child. The therapist's contact, which began with home visits, private and group meetings, and phone calls is now possibly only a phone call once or twice a week. Now the use of intermittent reinforcement by the parents to gradually separate the child from token or point incentive contracting system is employed.

It may now be time for the therapist to meet with the parents and the child for a brief review of the past, a look at the present situation, and maybe a prognosis for the future. Overall, the therapist's emphasis should be on the progress the parents and the child have made. The therapist then asks if it would be all right if a colleague of his came into their home in about a week just to check on the original presenting problems. It is explained that this data, when compared to the baseline data the parents collected, will help the therapist and the clinic tremendously and give them a clear picture of whether or not the original presenting problem behaviors have been reduced in frequency.

B.2. Assessment of Change

In almost any kind of therapy one objective or goal is to demonstrate positive change in the client. The change in the client can come in many forms. For example, depending upon

one's theoretical orientation, client change can come in the
form of insight (Rogers, 1951), or analytic transference (Freud,
1954). For most behavior therapists change concerns itself with
a change in behavior. Although behavior therapists also hope
for client awareness in their identification of particular
themes or patterns of thoughts, feelings and behavior, this is
not their primary goal. Whereas more humanistic or analytic
therapists see as a goal the translation of awareness into be-
havioral action and planning, most behavior therapists see it
as quite the opposite process. It is behavior, and its increase
or decrease, that is the scale for measurement and is used for
determining change.

If the present model is to be effective at all it must
demonstrate to the parents and the therapist that the original
problem behaviors of the child have decreased in frequency and
prosocial behaviors have increased in frequency. The best
means of determining the degree to which this has been achieved
is by comparing a weeks observation of the child's behavior now,
in the post-treatment period, to the data collected during the
baseline period. For the best possible reliability in the
observations the conditions under which the first observations
were made should be duplicated as closely as possible during
the post-treatment observations. This would seem to imply
that the parents should again collect the data rather than a
visiting colleague of the therapist. However, my clinical
experience appears to indicate that the differences in who
does the actual observing are not as important as other varia-

bles such as the time of day or what went on at school that day (ie. birthdays, holidays, Monday versus Friday).

The demonstration of positive change in the identified child is really where a method of intervention proves itself. To further properly evaluate whether change has occurred in the child Graziano (1977) has the following criteria:

1)   The child's distressing behaviors have changed in the desired direction.

2)   New problem behaviors or 'symptom substitution' have not occurred.

3)   The improved behaviors have somewhat generalized and become stable outside the treatment setting.

4)   The improved behaviors are being maintained over a substantial period of time, of, for example, 6-18 months.

Graziano's (1977) criteria cover four important areas for assessing whether change has occurred in a behavioral program. First, Graziano addresses the most obvious yardstick for change. Have the identified problem behaviors, identified during the intake interview, decreased in frequency? Secondly, the phenomenon of 'symptom substitution', so often encountered in behavior modification programs, usually results from the parent's ineffectiveness in specifying and reinforcing a positive alternative behavior. That is, through proper and consistent reinforcement of the child, positive behaviors will grow stronger and anti-social behaviors will fall in frequency.

Thirdly, whether the child's improved behaviors generalize to other environments and stabilize appears to be more a

question of time and the overall effectiveness of the parents
as interventionists, rather than assessment. To facilitate a
generalization of the child's new behaviors the therapist might,
for example, want to call a group meeting with the child's
teachers at which time a synopsis of the past intervention
strategy with the child is given and the school's cooperation
solicited. At times, such a move between the school and the
home can be made at the very beginning of treatment. In fact,
such a cooperative move on behalf of the parents and the thera-
pist is recommended. Fullmer (1968) notes: 'The whole concept
of family consultation and family group consultation is based
on the premise that the work of the home and the school are
inseparable' (p. 20). Therefore, with time, cooperation
from others, and effective and consistent mediation by the
parents, generalization and stability will come to the targeted
behaviors of the child.

Finally, Graziano's fourth criteria represents a goal most
types of therapies strive for. For any kind of intervention
to be effective its immediate positive results should endure
over long periods of time (3 months - 24 months) with little
relapse or reentry into treatment. The present model deals
with this last point by suggesting efficient consultative
follow-up and 'Booster Shots' (Fleischman and Conger, 1978)
which will be examined in the final section called Consultative
follow-up.

C.   Evaluation

C.1.   Consultative Follow-Up

Consultative follow-up really describes two processes in
one.   This component could read Consultation and Follow-Up.
Here, the therapist is involved in following the family's
progress over a varying length of time.   Fleischman and Conger
(1978) divide their period of monitoring the family and follow-
ing their progress into three home observation sessions at
the 4th, 8th and 12th months plus an assistant calling the home
once a week for a year.   The emphasis here is on behavioral data
that will assist the clinicians in improving their intervention
strategies.   On the other hand, the parents are also made aware
of further assistance that is available to them.

'Booster shots" are involved in what Fleischman and Conger
(1978) call the crisis that the therapist enters after formal
treatment with the family has ended.   They note that approximately
1/4 of their families needed such assistance at some period short-
ly after termination.   However, with a thorough follow-up by a
concerned therapist or team of clinicians these crises can
sometimes be avoided.

With regard to the present model, follow-up may not
have to be as extensive as the approach taken by Fleischman and
Conger.   The blue collar family would most likely resent such
weekly intrusions into their home life and with their original
problems somewhat alleviated they would probably just as soon
go on with their onw lives.   Follow-up would have a timetable
of two home visits in the first month after termination and

then one home visit a month for the next 2 months. The parents

would understand that their questions and/or problems are wel-

come at any time during the 3 month follow-up by the clinic

and therapist at no obligation to them.

Chapter IV

Summary and Conclusions

Overview

The overall objective of the present investigation was to develop a model which provides a strategy for intervention with the blue collar family. In Chapter II, the framework for the model was established by examining relevant literature and research in the areas of; a) the use of parents as change agents for their children, b) the characteristics of the blue collar family, and c) a behavior modification approach. Furthermore, my clinical experience provided support in establishing the basic framework for the model as well as deciding upon the final components for the model.

Chapter III began with the development of a rationale for the addition of a humanistic Rogerian (1951) approach to the behavioral orientation already outlined. It was proposed that the combination of these two divergent approaches is important to a successful method of intervening effectively with the blue collar family. Following this the components for the model of intervention with blue collar families were introduced under the three main headings of A. Assessment, B. Treatment and C. Evaluation. The model, including its sub-sections, is as follows:

Proposed Alternative Model

A. Assessment

    1). Role-Induction Interview

    2). Intake Interview

3). Baseline

B.   Treatment

4).   Parent Training Sessions

5).   Assessment of Change

C.   Evaluation

6).   Consultative Follow-Up

The model in Chapter III presents the blue collar family
with a structure that is tailored to certain definable charac-
teristics of their population.   Researchers, such as Wilson and
Evans (1977) and Goldstein et al (1966), advocate that to ensure
a productive degree of expectancy and to avoid client overcon-
fidence, the best solution is to structure the therapy for the
client.   Many of Goldstein's proposed steps in structuring a
treatment are included in the model presented in this paper.
They include; a) an overall persuasive rationale for the speci-
fic treatment methods that are employed, b) an explanation of
the development, maintenance, and modification of the family's
problems, and c) a description of the procedural steps involved
and the parent's own responsibilities in actively participating
in the treatment.

Some Guidelines Regarding The Application of the Model

It has been pointed out that this intervention strategy
is a model and not a program to be followed in a step-by-step
fashion.   A program of intervention would be more detailed in
covering each step so the reader would hopefully have fewer
questions as to its application.   I believe this model provides
important points in providing a framework of effective inter-

vention with the dysfunctional blue collar family. All com-
ponents and subsections of the present model are important and
should be applied in the order in which they are presented.
However, there are certain important guidelines that should
be considered when examining and applying the model presented
in Chapter III. These guidelines are listed and explained
below.

1.) Age of the Child. Perhaps the most important aspect
to consider in applying the model to the blue collar family is
the age of the identified client or target child. Through
personal experience and consultation with others in the field
of family counselling using a behavioral approach, I believe
that the approach described in this paper is most effective with
pre-adolescent children. It appears from my clinical experi-
ence that the elementary school aged child presents a much
better opportunity for success, using a behavioral approach, than an
adolescent child. The reviewed research for this paper, how-
ever, documents no clear evidence to back-up this claim.

The reasons for the relative lack of positive effects using
a behavioral approach with adolescents are probably many. Per-
haps one important reason for the poor success rate in applying
a behavior modification approach with adolescents has to do
with the many difficult issues faced by adolescents. Adolescence
finds the child in a state of transition from childhood to adult-
hood. Laufer (1975) breaks adolescence into 3 stages. The ages
of 12-15 years, 15-18 years of age and 18-21 years of age. At
each stage Laufer notes the child's resistance to his or her

parents. For example, in the years from 15-18 the child's, '...main stresses revolve around the adolescent's efforts to become emotionally independent of the parents. He begins to feel that thoughts, wishes and actions are no longer determined by the expectations of his parents. Contemporaries now become more important in deciding what is acceptable or unacceptable (p. 21).' The first and the last stages mark the beginnings and the end of this independence from the parents.

The Triadic Model stresses the importance of the parent as the mediator. Adolescence would appear to be a time when this important link is severely tested. It appears the parents now hold far fewer of the reinforcers they possessed before the child was a teenager. Many of the things that were once very important to the child are now not so important in adolescence and the spotlight has shifted from the parents and the home to the child's peers and his or her environment outside of the home.

My point regarding the adolescent stage is not that the parents have less control over their child. I simply wish to guard against expecting the same kind of results in applying the model with adolescents as with applying the model with elementary school aged children. The person(s) who can now take on the role of the mediator has probably shifted to someone outside of the home and only through careful investigation by the therapist can these people be located and properly utilized. I believe that during adolescence the child's natural developmental focus is to break some of the bonds with the

parents so as to enable himself or herself the autonomy to begin to grow as a young adult.

2). <u>The Importance of the Parent Mediator</u>. The parents hold the key to success in the intervention strategy suggested in this research. The motivation of the parents to carry out the many tasks they are asked to do is a point of constant concern to the therapist and therefore the parents are the focus of the therapist's attention and encouragement. Bandura (1971) notes that the use of the parents as effective mediators in the therapy ensures, '...more genuine and enduring relationship experiences than thos derived from a purchased relationship provided by a busy professional therapist at brief weekly intervals (p. 697).' Furthermore, any progress, no matter how small or seemingly insignificant, is attributed to the dedication and work of the parents and not to the therapist or any theory or model that may have been used (Patterson, 1975).

3). <u>Some Characteristics of The Therapist</u>. A very important quality of the therapist in the present model is his or her degree of expertise in the practice of family therapy or counselling. The therapist should be professionally trained in the use of empathy, unconditional positive regard and genuiness. Furthermore, Wilson and Evans (1977) point out that the behavior therapist is more of a consultant than a controller of passive respondents to external forces. The therapist advises and encourages the parents in active, problem-solving strategies involving themselves and their children.

> The best solution, then, is for the therapist to have
> a certain facility in relating to a number of differ-
> ent types of person. These interpersonal skills have
> the consequence of increasing attractiveness and thus
> ability to influence: it is in this way that such
> therapist characteristics as empathy, warmth, and so
> forth, are considered important in behavior therapy
> (Wilson and Evans, 1977, p. 553).

One other characteristic of the therapist that could prove

of some importance in the treatment of the family is his or her

marital status. A married status of the therapist

may prove to be advantageous when practising any kind of family

therapy just as it can sometimes be beneficial to be married

to practice marital therapy. One reason for this is that the

clients are sometimes, but not always, more personally assured

that the therapist understands their situation because he or

she is also married and has children. In fact, from a thera-

pist's viewpoint there can be instances where being married

can prove to be a real asset in family therapy because it

allows for more self-disclosure (Egan, 1975) by the therapist.

4.) The Model and What Types of Problems? The proposed

model advocates a specific approach, for a special type of

problem, for a certain type of client. The approach concerns

itself with the combination of a behavior modification style

and a Rogerian orientation. The model should find its broadest

application with a blue collar family. The type of problem

the therapist should consider workable under the present model

would involve a pre-adolescent child who exhibits observable

and definable behaviors which are causing problems to the

parents and are happening at a rate which would not be considered

normal for a child of that age, sex and background. Werry and Wollersheim (1967) describe four criteria for using a behavior modification approach:

1.) where there are discrete, easily recognizable symptoms or problem behaviors.

2.) where, because of clinical conditions or mental age, the client is not suitable for a more verbalized approach such as a psychoanalytic or client-centered approach.

4.) where professional therapists are scarce and, because of its systematic and concrete nature, behavior therapy can be readily executed by relatively unskilled parents with some degree of supervision and consultation.

With a blue collar style of intervention the parents find themselves enjoying particular benefits from a therapy employing behavior modification techniques and principles. Five advantages of this approach listed by Carkhuff (1971) are

1.) They provide the parent with a system of well-defined and well-organized procedures.

2.) They outline for the parent a definite role for them to play in the treatment.

3.) They provide the parents with a high and extremely useful level of confidence in what they are doing and where they are going.

4.) They begin to provide order to a previously disorganized household.

5.) They provide the parents with a specific behavioral base from which to begin to understand their child's behavior.

5.) Assessment Before Intervention. At the very beginn-
ing of therapy, at the moment of referral, one of the thera-
pist's first concerns should be to make an accurate assessment
of whether or not the identified client really is the problem
in this family. Simply because a child is referred to the
therapist it cannot be assumed that the child really is the
problem. The therapist should first of all carefully examine
what the beliefs and attitudes of the referring parents are
in regard to their child and what expectancies they hold
regarding both his/her behavior as well as their own. Abidin
(1975) notes;

> Successful consulting demands that the consultant be
> sensitive to the values and behavioral expectancies
> of the consultee and be cognizant of the limitations
> placed on the consultee by the values and behavioral
> contingencies of the social system in which he works
> (p. 363).

How This Model is Unique From Other
Models of Family Intervention

Much of the very basic framework for the model was arrived
at by eclectically borrowing ideas from research by others such
as Patterson (1975), Tharp and Wetzel (1969), Carkhuff (1967)
and Goldstein (1966). However, the six components in the model
are new in their particular arrangement. The model
also took shape from a review of related research in consulta-
tion and one-to-one counselling. At one point I thought I had
a unique idea of combining behavior therapy with Rogerian
therapy only to discover through further investigation that
Sadler and Seyden (1975) had three years earlier advocated a

similar combination. However, the combination, investigated in the present model has much more of a behavioral orientation than the program proposed by Sadler and Seyden. Furthermore, neither Patterson's (1975) nor Fleischman and Conger's (1978) proposed models include exactly the same component arrangements as the model presented.

What does make the present model unique in its scope and direction is the population for which it is intended. Literature related to the blue collar family was examined closely to determine what style of therapy would prove most effective. In Chapter II the recommended treatment approach for this population is clearly outlined and then combined with the behavior modification orientation. I believe the result of this union suggests a viable approach to intervening with the blue collar family.

Implications for Further Research

The model of intervention presented in this paper has many implications for further research. First, a comparison of the present model applied in a clinical setting to other models of intervention would seem appropriate. This would involve testing the relative effectiveness of this model against other styles of family therapy with blue collar families. For example, a comparison of the present model with a humanistic or verbal approach model or a behavior modification model, might produce valuable results for the field of family therapy.

A second suggestion for further research is noted by Tharp and Wetzel (1969) regarding the importance of the mediators. Tharp and Wetzel suggest a study involving the functional relationship between aspects of the parent's behavior and certain aspects of the consultant's behavior; an investigation into the interaction or dynamics between the therapist and the parents. What makes for a successful alliance or working relationship and what does not? This concept could also be applied to the relationship between the parent and the child. An intensive study directed at what actually happens when the child and the parent interact and what in the interaction causes the parent and the child to behave in a certain fashion could also prove to be extremely informative.

Two other implications for further research regarding the proposed model would include an investigation regarding the model's components. Research centering around whether or not certain components were absolutely essential to the model or whether certain parts of the model could be left out would appear important as far as shortening the overall time of intervention.

Another interesting avenue of investigation would focus on the issue of the age of the child and/or the socioeconomic level of the family. An investigation comparing different ages of the target child and the application of the model to middle-class and upper-class families may reveal that the model has a broader application than I presently envision.

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LIST OF NOTES

Note 1. - Friesen, J. Personal communication. February, 1977.