Behavioural casework —

A Social Work Method for Family Settings.

by
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Introduction

Contemporary behaviour modification (or therapy) seems to offer what is both a useful theoretical and practical approach to the treatment of a very wide range of childhood and adolescent disorders (Gelfand and Hartmann, 1975; Herbert, 1975). We intend in this paper to describe this relatively new method of assessment and treatment of problem behaviour as it applies in family settings, and examine its relevance to social work practice. In doing this we shall consider briefly the nature of the social work task. After a discussion of the theoretical basis of behaviour therapy we shall attempt to demonstrate how the methods themselves can be applied in the social work setting giving examples from our casework in the Child Treatment Research Unit (C.T.R.U.) at the School of Social Work, Leicester University. Some of the traditional objections to a behavioural approach will be discussed and the ethical considerations examined. We conclude, on the basis of evidence accumulated on 117 families (Herbert, 1978) in a Unit staffed mainly by social workers that an adaptation of behaviour modification (which we call behavioural casework) can be used by trained social workers to alleviate many of the problems of childhood and adolescence. Although this is a casework method it is firmly grounded, as we hope to demonstraten in sound community work principles.

Definitions

Definitions of the social work task have been debated extensively over the years but the central theme running through most ideas, no matter which school of thought, involves a genuine, humanely motivated attempt to assist people to cope with the troubles and crises of everyday life in a way which does not diminish their worth or dignity as human beings.

Value Base

The value base of social work existed long before there was any systematic attempt to introduce borrowed knowledge from the social sciences to implement these values, however as knowledge in the fields of social science increases it is important that social workers are aware of new technologies in order that they may evaluate them in terms of their usefulness in furthering these values. The case-worker requires a knowledge of a range of perspectives so that in individual situations she may choose the most helpful and appropriate method — the 'informed eclecticism' to which so many social work theorists aspire. Doubtless many social workers have been put off from even a preliminary exploration of behaviour modification because they find the laboratory-based language of behaviourists alien and because the methods (especially when described out of context) evoke images of 'clockwork orange' machinations such as aversive conditioning, psycho-surgery and brainwashing. The very words 'behaviour modification' sound sinister and dehumanizing.

Back handed

It is perhaps a back-handed compliment to the effectiveness of behaviour modification, that its many critics pay particular attention to its ethical implications. It may be that some critics become anxious about this kind of intervention because they suspect that it really works. Others are contemptuous of the changes brought about by behaviour modification because of their alleged superficiality. Behaviourism is said to be sterile because it fails to get at the real' person, assuming him to be a passive bundle of stimulus-response connections; the behavioural analysis is unfeeling, deterministic, and futile. Other commentators warn that behaviour modification is downright dangerous because its practitioners are out to 'control'

human behaviour. Therapies are not always quite how they are seen by the uninitiated. Cariacatures of theoretical models and practical procedures are set up as 'straw men' for the critics (often poorly briefed) to knock over. Psychoanalysis has suffered the same fate, often at the hands of behavioural zealots, so it is rough justice that the latter should now be on the receiving end. There is, in any event, a case to answer (see: Stolz *et al*, 1975).

First point

The first point that has to be made is that social learning theory which informs so much modern behavioural practice is not the crude fundamentalist behaviourism of history and popular steretype (see: Bandura, 1969; Herbert, 1974). The second point is that whereas the medical model provides a reasonably unambiguous ethical rationale for treatment by a criterion of 'health' and 'pathology', behaviour modifiers construe abnormality as being on a continuum (i.e. not essentially different) from normal behaviour. This means that they face ethical decisions with which the medical model has not been confronted. As Leung (1975) explains, if problem behaviour is considered to be learned, the therapists are involved in making, or at least concurring with, a value or social judgement of what is abnormal and of what other behaviour would be preferable. This inevitably leads to the question: 'to whom is the behaviour undesirable and is it really in need of change?'

Produce change

Of course, all caseworkers are in the business of trying to produce change, no matter what their orientation. But one of the dimensions along which therapies differ is that of direction/indirection. Behaviour modification is highly directive — although that statement requires a good deal of qualifying as we shall see from our description of behavioural casework.

The possibilities of client-choice, a democratic negotiation of treatment objectives and the opportunity for introspective discussion (especially in self-management work) are increasingly allowed for in current practice. Tharp and Wetzel, (1969) note that far from assuming an authoritative posture and considering the art of therapy as a secret cult, behaviour modification is more willing to rally the support of non-professionals like parents, housewives, siblings and peers, than most others.

UNFEELING AND MECHANISTIC?

What of the accusations of behaviour modification being unfeeling and mechanistic? Whatever their failings, behavioural theorists have a great respect for empirical research. And research studies have frequently shown that certain core qualities of sympathy, friendliness and sensitivity on the part of the therapist enhance the effect of any sort of treatment, although alone they have no significant effect (Truax, 1966). Shapiro's review (1975) of the literature of psychotherapy research suggests that the findings do not justify, and may indeed make untenable, the view that social relationships have no place in the modification of psychological disturbances. He states that the client-centred therapeutic conditions of empathy, warmth and genuineness (Truax and Carkhuff, 1967) may serve as a useful adjunct to behaviour modification. Two studies have found that the level of the Truax conditions offered by interviewers does effect their efficacy as behaviour modifiers (Vitalo, 1970; Mickelson and Stevic, 1971). An interesting use of relationship to foster behavioural change is also reported by Persons (1966).

Article of faith

Bandura (1969) notes that it is an article of faith for many that 'relationship' factors are the primary agents of behavioural change, and consequently that the specific methods employed are of secondary importance. As he puts it, "this view — which is somewhat analagous to relying on 'bedside manner' rather than on specific therapeutic interventions in the alleviation of physical disorders — can be seriously questioned".

Behavioural approach

In using a behavioural approach as a casework method we accept the importance of a caring and accepting relationship with the client. We also accept Younghusband's injunction (Younghusband, 1967) that in order to demonstrate one's caring effectively one should be skilled and knowledgeable enough to select the method of treatment most relevant to the client's needs. When using a behavioural approach we find we can work effectively on the basis of a friendly but business-like relationship with the client. A highly charged relationship is not a desideratum for therapy and in any event would exclude the majority of social work clients from treatment. Relationship, when elevated to a mystique, seems to assume, with some degree of arrogance, that the social worker should be one of the most significant figures in her client's life. In behavioural casework no such intense relationship is required. It is only necessary for the client to have enough trust and confidence in the social worker to accept treatment in the first place. A closer relationship may then develop as treatment progresses and the client hopefully sees evidence that the social worker is offering a genuinely helpful way of dealing with his problems.

Role of insight

The role of insight in therapeutic outcomes is anothr point of contention between behaviour modifiers and their critics. Bandura (1969) reanalyses the psychodynamic interpretive insight-giving process as an

instance of social influence or brainwashing rather than genuine self-understanding and revelation. He contends that patients in the emotive ethos of this kind of therapeutic relationship are highly amenable to (sometimes unwitting) persuasion and conditioning. As he sees it, suggestive probing and selective reinforcement of client's verbal reports lead to a self-validating interview in which the patient imperceptibly but increasingly replaces his own opinions and ideas about himself with the therapist's views and interpretations. Truax (1966) has shown that Carl Rogers selectively but subtly reinforced certain classes of desirable behaviours and that the 'unconditional positive regard' which should be accorded to the client was **by no means unconditional.** There are many instances of successful therapies without insight being invoked and examples where insight having apparently been obtained has had little effect on behaviour. It can be argued that insight is a consequence rather than an agent of beneficial change. Cautela (1965) has suggested that changes in verbalizations during psychotherapy, commonly called 'insight' frequently **follow** rather than precede behavioural changes. As relief of tension and difficulties proceed, insight as to their causation may develop.

Fair comment

Yelloly (1972) makes what seems a fair comment on this vexed question, and one which provides a guideline in CTRU practice:

> . . . awareness may operate in a number of ways. The sheer provision of accurate information may correct a false and erroneous belief and bring about considerable change in behaviour; prejudice, for instance, may be diminished by new information which challenges the prejudiced belief. And in human beings (pre-eminently capable of rational and purposive action) comprehension of a situation, knowledge of cause and effect sequences, and of one's own behaviour and its consequences, may have a dramatic effect on manifest behaviour. Thus to ignore the role of insight is just as mistaken as to restrict attention wholly to it. It would seem that the relative neglect of insight by behaviour therapists until recently has occurred partly in reaction to the over-emphasis on it in traditional psychotherapy, and partly because of their pre-occupation with directly observable behaviour, particularly in laboratory studies of animals. As Bandura notes, the potential of symbolic factors for therapeutic change has not been fully exploited.

Over recent years methods such as family therapy, crisis intervention, task centred casework, contract work and systems theory have all been incorporated into casework practice.

These are all ways of approaching particular problems and can be adapted for use with whichever theoretical model one adheres to, whether it be sociological, psychodynamic or behavioural. Behavioural psychologists have 'rediscovered' in the last two decades, some ideas, discussed in the 1920s, which suggest that many forms of childhood psychopathology can be conceptualized as maladaptive or inappropriate responses that have been acquired through learning (Jones, 1924).

Genetic disposition

The importance of genetic predispositions and biological differences is recognised but the focus is on learned behaviour. It is based on the concept of a functional relationship with the environment in which changes in individual behaviour produce changes in the environment and vice versa.

The behaviour of any child tends to be highly specific to the persons, places and situations in which he finds himself involved (Mischel, 1968). Assessment techniques designed to identify and gauge generalized attributes (e.g. deep-seated personality traits) in children have poor predictive value.

Assumption

Likewise, with treatment based on the assumption of generalized effects, the evidence (see: Herbert, 1978) suggests that successful treatment of a child's problems in the home does not necessarily resolve his problems at school, or vice versa. Prediction (for assessment) is best from observation of behaviour in one situation to behaviour in similar situations. In order to get a good intellectual grasp of what a child is doing and why, it is necessary to have highly detailed and specific information (based on specially designed 'sharp focus' interviews and direct observation) about the child's behaviour in his various life situations. The so-called behavioural assessment method and the ecological interview (Herbert, 1978) are aids in obtaining the kind of evidence on which rigorous assessment (and thereby sound casework) is based. The prerequisite of any successful treatment is careful and accurate assessment of the 'problem' to be treated. This is especially vital when the essence of treatment will be in some way to change the relationship of the client with his environment. It is achieved by the careful collection and recording of data by the client or in the case of a young child those in direct contact with him and direct observation by the social worker of the actual behaviours in the client's natural environment. From this information a behavioural analysis of the antecedent and consequent events surrounding behaviour is made. One of the clearest accounts of the assessment of problem behaviour and planning for its treatment is provided by Derek Jehu (Jehu *et al,* 1972). He describes in detail the various stages before treatment is attempted: the identification and specification of the patient's problems and the condi-

tions controlling them; the ascertainment of the available resources; the selection and specification of therapeutic goals, and finally, the planning of the treatment programme. Stress is laid on monitoring the assessment and treatment process throughout the contact with the client.

Many of the processes of change that take place in the various psychotherapies are somewhat mysterious and invisible to the patient or client. (And one might add that **all** therapies are like this for very young children). At the CTRU it is policy to explain to the children (and allow them to be privy to) all the proceedings in working out a treatment programme. The social worker acts as an advocate for the child, in the sense of representing his point of view.

Focus on overt problems

Behavioural casework tends to focus on the child's overt problems, attempting to remedy them by direct intervention. The social worker attends, particularly, to contemporary events — the here and now — rather than delving far back (as a major preoccupation) into the history of the child. This strategy of concentrating on specific and observable behaviours arises not from the naive belief that no aspect of a child's problem behaviour is determined by unobserved or unobservable factors (past or present), but from a conviction that a significant part of it is controlled by events — antecedent and consequent — that can be observed, measured and modified. As a tactic it also has a particular appeal to parents who are struggling with current events and who cannot see the relevance of an obsession with historicism. They know as well as any behaviour theorist that the social environment has a crucial role in shaping and maintaining human behaviour. What they often misunderstand is the precise working of the contingencies, their timing, their paradoxical effects and their potency. When their contingencies of reward and punishment — so often inconsistent or ill-timed — don't work, they tend to show a certain inflexibility. Behaviourists, by recognising at last, interior cognitive events (see: Kanfer and Karoly, 1972) are losing some of **their** rigidity. Thus contemporary behaviour modification belatedly makes room for such concepts as self-control, self-observation, observational learning, and cognitive mediation.

The behavioural casework approach (Herbert, 1978) takes as its framework for therapeutic change, the available literature on learning and normal development. Much of our casework with parents involves what would be more appropriately called 'counselling'. The transmission of information about 'normal' child development is often as important as suggestions about ways of dealing with difficult behaviour. It is assumed that parent education is one of our primary aims and it is hypothesised that the rearing of children is itself a skill. Other casework methods — clarification of problems, support-giving, sympathetic listening and acceptance — are utilized as appropriate. The central proposition is that many behaviour problems of childhood are essentially developmental problems which are exacerbated in faulty social learning interactions.

Techniques

The behavioural casework techniques developed at the CTRU appear to offer particular advantages for social work practice in areas where the traditional approaches have been found deficient. For example, it can be used with the less educated and non-verbal clients and those displaying anti-social behaviour who may lack the social skills necessary for achieving more appropriate behaviour. Also by emphasizing or focusing on observable behaviour and limiting itself to the reduction of maladaptive behaviour and the encouragement of adaptive choices it respects the integrity of the client; because its principles can be clearly and simply explained it minimizes any mystification about treatment methods and objectives to the client's advantage. It is during the initial interview with both parents and child that an account is given (with down-to-earth examples) of the theoretical rationale and practical policies of the CTRU, pointing out how problem behaviour, like normal behaviour, can be acquired through failures or anomalies of learning and how individual differences (e.g. temperament) in children can affect and be affected by the environment. Such problems, it is suggested, can be alleviated by specific methods based on theories of learning.

Stressed

The 'commonsense' and familiar aspects of child management are stressed. It is emphasized that if a behavioural treatment is felt to be appropriate then this is likely to involve altering the consequences of the child's problem behaviour. Parents are asked whether they would be prepared to change **their** present responses to such behaviours, and, indeed to initiate actions — provided that they are not required to do anything contrary to their values as parents. They are warned that a good deal of time and effort could be required from them. The point is stressed that we are not there as 'experts' to take over the burden of the child's problem from the parents but that it will be a co-operative venture with a major part of the 'therapeutic' responsibilities rightfully in their hands.

Permeated

The traditional view of 'psychopathology' is so permeated by the medical or disease model that it places sole emphasis on the therapeutic role of the professional 'expert'. This is associated with the belief that therapeutic activities must only be engaged in by very highly trained professionals (from

one or two favoured disciplines), to the exclusion of other people in the patient's immediate environment, whose involvement in the helping enterprise is viewed as only peripheral. The so-called dyadic model obtains: the expert 'treats the patient' usually in the clinic setting. This is a situation far removed from the child's experience of life and occupying a miniscule proportion of it. Frequently, the therapist is unable to see parent-child (or teacher-child) interactions in their natural settings, and indeed, he may not even observe directly, in the artificiality of his consulting room, the problem behaviours for which the child was referred. Much of his information is hearsay and there can be a startling discrepancy between what parents say the child (and they themselves) are doing and what actually happens.

Anchored

By contrast the behavioural casework approach is anchored in the natural environment; it seeks to utilize the powerful influence of those people in the community closest to the client; it uses to the full the good-will and therapeutic potential of those involved in close everyday contact. The triadic model, as it is called, is crucial to our work. Indeed, there is growing evidence that effective assessment and treatment of many childhood disorders (particularly 'acting-out' problems) requires observation and intervention in the natural environment of the child (Tharp and Wetzel, 1969). Furthermore, the systematic and successful involvement of parents, and particularly mothers, in the psychological treatment of children has increased considerably (O'Dell, 1974; Patterson, *et al*, 1975).

Sharing with parents

We believe it is important to share our thinking and information with the parents. In doing this we indicate to them, at an early stage, that there could be disagreement over treatment objectives (reservations on their part or the part of the CTRU about behaviours to be changed (the so-called 'target behaviours' of children and parents). Parents are invited to the case-conference which occurs after some two weeks of assessment (the baseline period) so as to debate and finalise the plan of treatment, and to draw up a contract. Once the case-conference has arrived at a formulation of the problem (a set of hypotheses about the controlling factors in the situation) a plan is made with the parents for the intervention, which **they** initiate with a good deal of practical and moral support from the social worker.

No set formula

There is no set formula; there is a wide choice of methods but their implementation and back-up require sensitivity, ingenuity and creative casework skills. The tendency at many diagnostic conferences is to 'distance' the problems, leaving them relatively undefined or in the 'soft focus' of global terminology (Herbert, 1978). This leads directly to **premature** 'free-associations' about cause and effect. To discuss causal factors before the 'to-be-explained' phenomenon is carefully specified and precisely described and measured is to reverse scientific method, a perfectly human tendency. After all, it is much more interesting to try to solve fascinating 'why' and 'how' riddles in connection with behaviour problems, than to wrestle with the more mundane 'what' questions. Traditionally, the 'case history' has taken a vertical form, an attempt to relate present troubles to past experience so as to see how they have evolved. Such a retrospective look at past events is often of interest but there is nothing that can be done to change history.

Tends to distance

It also tends to distance the problems. Social learning theorists attempt to conceptualize the 'why' or 'how' question and its answers in a more horizontal way, viewing the client as part of a complex network of interacting social systems any aspect of which may have bearing on his present troubles. Thus in attempting to reach some kind of assessment and plan a programme of treatment the unit of attention is far more broadly conceived; the focus of help is on a family unit rather than an individual child.

Extensively researched

Perhaps the most extensively researched of the behavioural techniques is systematic desensitization developed by Wolpe (1973) and based on positive counter conditioning. In its classic form this method of treatment involves teaching the client relaxation and then gradually taking him through a hierarchy of anxiety-provoking images gradually approaching the full phobic situation. At each stage in the hierarchy the client is encouraged to use relaxation to compete with any fear reaction until eventually the phobia is overcome. In some cases the hierarchy is experienced "in vivo" rather than in imagination. Although systematic desensitization has been used mainly in the treatment of phobias the underlying principles are very relevant to good social work interviewing technique. Fischer and Gochros (1975) suggest that if social workers are warm, sympathetic and concerned about clients' problems and optimistic about their solution and give an impression of reliability and competence then their clients are likely to react with feelings of confidence and increased self-esteem which will help counter anxiety, guilt or self-devaluation.

Treatment processes

The following case* illustrates an adaption of systematic desensitization. Mark N. was referred to the CTRU suffering from severe encopresis. He was seven years old and had been soiling from birth. Assessment revealed that Mark had a history of severe constipation which had caused him considerable pain on defaecation and had required hospitalisation and the administra-

tion of enemas when he was three years old. These experiences had left Mark with a fear of defaecation and he soiled because he tried to ignore the signals which told him he needed to use the toilet, a process which he associated with fear and pain. Mark's fears were allayed by discussion and reassurance and by using an operant programme to reward Mark for successive approximations of the desired behaviour e.g. first changing his own clothes, standing near the toilet and eventually sitting on it. In a matter of weeks his anxieties gradually diminished to the point that he could use the toilet fearlessly and appropriately thus solving the soiling problem.

Modelling

Modeling, a treatment developed from discoveries about observational learning (Bandura and Walters, 1963) is a procedure social workers often use without associating it with behaviour modification. Clients are frequently paired with a social worker who, it is felt, may provide a suitable model of masculine or feminine behaviour especially when no such appropriate models exist in the client's own environment. This informal use of modeling can be effective but more systematic use of such procedures as role-playing could be very valuable in teaching clients social skills in such areas as assertive training (Wolpe, 1973).

Difficult to cope

Jenny was a quiet, shy woman in her late twenties who found it difficult to cope with her bright, forceful four-year-old daughter and was also experiencing feelings of frustration and anger about her unsatisfactory marital relationship, feelings which she had not dared to communicate openly to her husband. Assessment revealed that Jenny had almost no self-confidence and a very poor self-image mainly due to past negative life experiences. Jenny was well aware of the reasons for her self-deprecation and self-doubts but this insight did not seem to affect her behaviour. We began an informal programme involving role-playing situations in which she felt unable to assert herself. By modeling appropriate reactions and using relaxation to allay her anxiety we were able to teach her to be more assertive — behaviour which reduced her feelings of helplessness and frustration and gave her confidence to make a realistic appraisal of her marriage and exert more control over her life.

Assertive training

Assertive training has also been successfully used in the treatment of impulsive and self-defeating aggressive behaviour — commonly the defensive reaction of a person who does not have sufficient skill or confidence to assert himself in a more appropriate way, (Herbert, 1975). The use of groups in assertive training and social skills training has also been found to be successful in dealing with timid and withdrawn clients, (Fischer and Gochros, 1975).

Operant conditioning

Treatment methods based on operant conditioning are those which attempt to control the outcome of certain behaviours through the use of positive or negative reinforcers. A social worker using operant methods can analyse a family system and find out how the various members reinforce undesired behaviour in some members and intentionally or unintentionally ignore or punish desired behaviour. It is then possible to make alterations in such dysfunctional systems by planning with the family to systematically rearrange the consequences of behaviour so that all members of the family receive social reinforcement for desired behaviours.

Conduct disorders

Conduct disorders in children can also be effectively dealt with by using these methods. Gary was six and a half years old at referral and was described as a very unloveable child. He constantly screamed and shouted abuse at his parents and had violent temper tantrums when he would indulge in physical aggression, hitting and punching people and furniture and screaming at the top of his voice until he got his own way. He was also persistently defiant and disobedient and seemed to enjoy provoking confrontations with his parents. Observation and assessment confirmed that Gary was indeed showing all these behaviours but also revealed that they were being heavily reinforced by attention from his parents and by the fact that the shouting and temper tantrums usually resulted in Gary getting his own way and were therefore highly functional for him.

Not surprising

Not surprisingly, against this background, family relationships were very strained and Gary was so unpopular that on the rare occasions when he did behave appropriately it went unnoticed and unattended to, which meant he was only getting attention for anti-social behaviour. By instituting an extinction programme to deal with the shouting and temper tantrums which involved removing Gary from the room as soon as he started to shout, a procedure known as "Time Out from Positive Reinforcement" and designed to eliminate the possibility of him receiving reinforcing attention for anti-social behaviour and also insisting that he complied with the original request on his return, we were able to eliminate these outbursts almost entirely. At the same time great emphasis was placed on rewarding Gary for pro-social behaviour with tokens which he could then exchange for a privilege (such as staying up late) or a treat (such as a favourite play activity with his parents).

This programme was designed to improve their relationship with Gary by providing opportunities for mutually reinforcing activities. By the end of the programme Gary was much happier, showing much more pro-social behaviour and getting on a good deal better with his parents.

This case illustrates how by changing behaviour one can also affect attitudes, and our experiences in the CTRU is that by modifying children's more difficult behaviour they become more rewarding to their parents, and mothers who have been at the stage of rejecting and even abusing their difficult children find they can see more positive sides to the child and start to enjoy the experience of being a parent.

Use of extinction

The use of extinction procedures which has just been illustrated involved the removal of all reinforcers. Simply ignoring problem behaviour can also have this effect and is a very straightforward procedure for the social worker to institute. An example of this, coupled with contingency management, is illustrated in the next case. Suzy was a nine-year-old spastic girl, the only child of rather anxious and overprotective parents. They were very concerned at her difficult behaviour during meal times when, although perfectly able to feed herself, she would refuse to eat unless fed, would throw food and utensils on the floor and often refuse food entirely. Assessment revealed that at school lunches the child showed none of these bahaviours. Nor were they displayed at home when she ate informally in front of the television in the evening. Her problem behaviour was specific to family lunch at weekends and holidays, the only occasions when the whole family sat down together at the table. It appeared that this setting was providing Suzy with an audience to which she gladly reacted. In order to combat this her parents were instructed to ignore any "naughty" behaviour and only to speak to Suzy when she was eating properly. They were not to feed her or coax her and any food refused was to be removed without comment. Between meals snacks were forbidden and the dining room table was rearranged so that Suzy's parents were not directly looking at her. In order to help them ignore her, which they found very difficult at first, they were told to talk to each other, in order to take their minds off Suzy. Within three weekends Suzy was eating normally and has continued to do so. Her parents also used behavioural principles in encouraging self help skills and have themselves become less over-protective.

The use of response-cost procedures is another method of treatment used in behaviour modification. With this, a penalty is invoked for failure to complete a desired response. This may involve the forfeiture of rewards currently available — as for example, when failure to complete homework results in the loss of television privileges.

Hyperactive boy

A hyperactive boy, Darren, was extremely disruptive and noisy. He made life miserable for his older brothers and sisters, whilst they read or watched television, by constantly interrupting them — making loud humming and wailing noises and also banging things. An extension of the range of rewards for therapeutic interventions is enshrined in the Premack principle or "Granny's Rule" — where a preferred behaviour is made contingent on correctly performing a non-preferred behaviour. This principle worked well with Darren. A bottle of marbles representing his pocket money plus a bonus was placed on the mantelpiece. Each transgression "cost" a marble (or penny). As always, sanctions were balanced by rewards. Punishment alone tells a child what he cannot do, not what he is expected to do. He was required to play quietly for set periods — timed with a kitchen timer, and if he did this successfully he was rewarded by tokens. These tokens could then be exchanged for treats — for example, he could loudly blow his sister's trombone for five minutes: something he had always wanted to do and something he found a great incentive.

Two other treatment methods developed from operant conditioning theory are aversive conditioning and the use of token economies. Both of these methods present ethical problems for the social worker and other therapists. It is difficult to justify the use of aversive conditioning in any but the most extreme cases, as for example, with self mutilating children and adults where the damage or pain inflicted by the treatment is considerably less than the situation it is designed to cure.

Grave reservations

The authors do have grave reservations about the use of token economies and behavioural methods involving sanctions in closed institutions and with 'captive' clients such as psychiatric and delinquent cases. The most sensitive and worrying moral dilemma is the use of behavioural methods to deal with the rebellious and nonconformist behaviour of youths in penal institutions. Stolz *et al* (1975). rightly observe that the probation officer/social worker with behaviour modification skills is often placed in the invidious position of assisting in the management of inmates whose rebelliousness and antagonism to authority are catalysts for conflict within the institution. Because of this, distinctions among many possible functions — as caseworker, manager, and rehabilitator — can become blurred and her allegiance confused. Although the professional may quite accurately perceive her role as benefiting the individual, she may at the same time appear to have the institution, rather than the youthful offender, as her primary client. The authors comment that often the goal of effective behaviour modification in penal institutions is the preservation of the institution's authoritarian control. Although some institutional behaviour modification programmes are designed to educate the inmates and benefit them in other ways, other

programmes are directed towards making the offenders less troublesome and easier to manage, thus adjusting the inamtes to the needs of the institution. The effectiveness of behavioural techniques as applied to non-voluntary individuals is in any event doubtful as the kinds of behaviours necessary for survival in a closed institution are very different from those necessary in the outside world. And if behaviour is not functional (useful and rewarding) to the individual in the natural environment (when the artificial reinforcers are removed) the behaviour will extinguish as it is not receiving natural social reinforcement. This is the old problem of poor generalization of rehabilitation carried out in closed institutions (Herbert, 1978). Behaviour modification in such settings could be much more usefully employed in the teaching of social skills. Social skills training is an area where social workers could be very important as therapists and models in shaping behaviour.

Recent developments

Some of the most interesting recent developments in behaviour modification have been in the area of self control procedures. These are designed to give the subject a more effective means of manipulating the eliciting, reinforcing and discriminative stimuli which affect his behaviour. The caseworker's role is first to carefully examine the antecedents and consequences of a piece of behaviour over which the subject wishes to have more control and to then suggest ways in which these events may be altered. They may be altered by either physical or cognitive changes in order that the subject may achieve a greater degree of control over his behaviour. Sue (to give one example) was heavily overweight and was anxious to control her eating behaviour. She was asked to carefully record everything she ate or drank and the time at which it was consumed over a two week period. From this data it became evident that her overeating was restricted to certain types of food and occurred only during the latter part of the day. Further investigation revealed that the sorts of food Sue ate to excess were packets of sweets, cakes and biscuits which she usually bought at a local shop on her way home from work. She admitted that she felt very guilty about overeating and bought these sorts of foods because they were easy to conceal from her flat mates. Sue never overate in company, only when she was alone.

Self control

A self control programme was designed in order to help Sue resist the temptation to overeat. She was instructed to take a different route home so as to avoid the shop she usually called at; and if she was to be alone in the flat, was told to change immediately from ehr day clothes into a housecoat to help discourage her from popping out to the shops later in the evening. Her flat-mates agreed to help by not bringing any forbidden cakes or sweets into the flat when Sue was around and they also made an effort to ensure that she was not left alone in the evenings. Sue was allowed to reward herself for sticking to her diet by having a favourite cake or sweet at the end of each 'successful' evening. When tempted to cheat she was told to visualise an unpleasant and humiliating scene where a group of boys made rude and teasing remarks about her size — a hazard which she would do anything to avoid.

Fast procedure

This last procedure, known as covert sensitization was developed by Cautela (1967) and involves teaching a subject to obtain a clear visual image of an aversive situation or experience and to conjure up this image when trying to avoid temptation. This method has been used successfully with alcoholics who have been trained to imagine a scene where, when they reached for a glass of beer or wine the alcohol changed into a revolting liquid which caused them to vomit violently and resulted in public humiliation. This image helps them to resist temptation.

Main aim

The main aim of the social worker using behavioural methods is to give her client the necessary skills and understanding so that in the future he will be able to apply the principles himself. In the CTRU we have found that an excellent way of achieving this is to let those parents who have successfully modified their own and their children's behaviour meet with and teach other families who are starting treatment. This is done through a weekly self-help parents group (Herbert and Iwaniec, 1977; Iwaniec and Herbert, 1977) at which value issues are debated and new techniques and ideas discussed.

Inappropriate

There are, of course, occasions when behavioural casework is deemed inappropriate. Henry, aged 10 years was referred to the CTRU by his housemother with the following complaints: he taunted other children; was abusive to residential staff; and ate noisily. In addition, he was so uncontrolled when out of the Home that the guide who escorted him to the school bus had been obliged to use a restrainer to stop Henry running off and across busy roads. Henry was also reported to have severe temper tantrums about three times a week and he was said to be highly disruptive, often upsetting the whole household by banging on the floor and by shouting obscenities at some members of staff.

A comprehensive assessment of this child helped to identify several possible factors that seemed to in-

dicate real obstacles to any possible approaches to treatment. As regards biological deficits, it was clear that Henry was very considerably handicapped by intellectual retardation; bearing this in mind and the related poor social development, it seemed that some of the specific complaints suggested that perhaps staff were setting too high expectations for Henry's capacity (e.g. his unpredictability in traffic). He was also found to have a genetically determined clinical syndrome which made more understandable his reported clumsiness, hyperactivity, as well as deficient social and intellectual development. As regards the antisocial behaviour problems, the initial assessment identified several factors which were of relevance. It was clear that such problems occurred only with some staff members. His houseparents were able to control Henry. It seemed that three members of staff had real difficulties in dealing with him, and it appeared that they helped to reinforce the bad behaviour by the very considerable attention they paid to it. His housemother noted that by ignoring his swearing and so on, she very rarely found that it caused her any problem.

Hyeractive behaviour

It was also apparent that any hyperactive behaviour and difficulties arising out of the child's poor social skills were exacerbated by the rather restrictive regime. For example, when the Unit therapist had tea at the Home as part of assessment, it emerged that the children were not usually allowed to talk at the table. Secondly, all the children were ready, washed and in night-clothes by 6 p.m. each evening, and as the tables were set for the next day's breakfast, the children had little space in which to play. Finally, it was apparent from the comments of staff that no one was able to think of positive characteristics in the child; the emphasis was almost wholly on his bad points.

Rather than attempt to set up any specific treatment plan, the caseworker emphasised the child's very real handicaps, arising out of his intellectual, physical and social retardation. Secondly, a considerable correspondence ensued which stressed the advantages of planned social casework designed to facilitate the child's rehabilitation with relatives who lived some considerable distance away from the Midlands.

Psychodynamic

Many theorists and practitioners of a psychodynamic persuasion question the appropriateness of a behavioural approach because they believe that therapy for a particular problem must direct itself to the "root cause" of the problem. According to this view, disorders of psychological origin should be treated by some form of psychotherapy. They regard as symptoms (the outward and visible signs of underlying disorder) what the behaviourally orientated therapists might take as the focus of treatment. It is often argued that a failure to deal with the underlying problems (e.g. intrapsychic conflicts) leads to 'symptom substitution'. Just how one defines operationally such a construct is never made clear. Without measurable indices of 'substitution' — a clearcut way of specifying the links, symbolic or otherwise, between symptoms — the criticism is impossible to prove **or** disprove. Studies (e.g. Baker, 1969) designed (inter alia) to investigate whether **other** problems appear when behavioural programmes have successfully removed symptoms (such as enuresis — a problem which is amenable to treatment by bell and pad administered by social workers) do not indicate that such an eventuality occurs. The belief in sympton substitution ignores the fact that physicians from time immemorial have applied themselves diligently to sympton relief and removal in both functional and organic ailments. In the absence of empirical evidence to support the idea of sympton substitution but with plentiful evidence for the successful treatment of "symptoms" or (as the behaviourists would prefer) alleviation of problems, we suggest that symptom relief is a legitimate goal in any therapeutic intervention. After all, in most cases it is exactly this for which the client is asking. Indeed, Baker (1969) found, as we have at the CTRU (Herbert 1978) that children treated behaviourally, often show improvements in areas that had not been specific targets of the behaviour therapy. It may be that serious problem behaviour blocks the child from engaging in behaviour that might be a source for him of positive reinforcement from his parents and peers, the absence of which hinder his socialization and development of a repertoire of prosocial behaviours. The answer to fears about symptom-substitution is to avoid metaphors such as 'underlying' and 'deep-seated' causes, and rather to carry out rigorous and comprehensive assessment into **all** the contributory causal factors which have a bearing on the planning of successful casework interventions. The 'safety net' is to engage in thorough and systematic follow-ups after the intervention is terminated.

Micawber syndrome

In the authors' opinion, a reliance on 'psychotherapy' (especially if it is the vaguely conceived relationship therapy indulged in by some inexperienced caseworkers) rather than carefully planned specific measures, gives rise to the "Micawber syndrome". "If I develop a good relationship with a child and keep seeing him, some benign change is bound to turn up." It seldom does in the conduct disorders so commonly a matter of concern to social workers, not even "spontaneous remission" is on the side of the serious conduct disorders.

Hollis (1964) has criticised behaviour therapy on the grounds that "it means the abandonment of our present highly valued principle of giving priority to enhancing the client's control over his own treatment". This seems to us to be a very naive argument which fails to take into account the fact that the use of any intervention strategy is an attempt to control someone else's behaviour and we suggest that behaviour therapy's openness about this goal is an advantage to the client. He then at least has the choice to refuse to become involved if he does not wish to change — a choice which is likely to be more obscured if the therapy is based on the worker's interpretation of hidden motives and desires of which the client himself is unaware.

Morality of behaviour control

The idea that controlling behaviour is in itself somehow immoral ignores the reality that

> All behaviour is inevitably controlled and the operation of psychological laws cannot be suspended by romantic conceptions of human behaviour anymore than an indignant rejection of the laws of gravity can stop people falling
>
> (Bandura, 1969)

From the social worker's point of view the issue to be decided with any kind of treatment is not whether behaviour is to be controlled but where the controlling forces lie and to what extent she should intervene or encourage others to intervene in their operation. The moral issues of whether to intervene and if so what the aim of intervention should be can only be answered with reference to the individual worker's value base and that of her profession. In proposing that behaviour therapy be used as one of the social work methods we would emphasize that its usefulness in a particular situation must be carefully evaluated with reference to the cultural, social and economic factors which may also be contributing to the

'problem'. Behaviour modification **does** have a 'human face'; and it might be argued (to take but one example) that the approach described in this paper returns dignity to demoralized parents and provides increased choices for restricted and unhappy children.

Another genuine and understandable concern about behaviour modification is the one of bribery. Contingency contracting, for example, has been said to foster a manipulative, exchange orientation to social interaction, and token economies, an emphasis on materialistic evaluation of human efforts. The most comprehensive answers to these criticisms are provided by O'Leary, Paulos and Devine (1972) and, as with other value issues which pervade these criticisms and counter-arguments, the reader must form his own conclusions.

Ethical

From the ethical point of view we feel that some of the values implicit in the use of behaviour therapy are a safeguard rather than a threat to clients' integrity. Its insistence on monitoring of methods and results for evaluation, and its requirement that a knowledge base, empirically substantiated, be used as a reference point from which any treatment method starts, gives clients an opportunity to question and check a worker's competence and reliability which the more interpretive approaches to therapy do not.

The resistance of behaviour therapy to labels such as "mentally ill" or "abnormal behaviour" removes the possibility that such labels will become self-fulfilling prophecies setting up a chain of responses that reinforce expected patterns of dysfunctional behaviour.

Classical example

A classic example of this last situation can be seen in the case of Robert a ten-year-old boy labelled "autistic". His parents were told that to expect anything other than bizarre and aggressive behaviour from an "autistic" child was being unrealistic and as a result for years they made no attempt to check or prevent his more anti-social behaviour.

Successfully treated

This child was successfully treated using a behavioural programme which assessed his "autistic" behaviour in the same way as any other behaviour would be assessed. By changing certain antecedent and consequent events the social worker was able to reduce his "irrational aggression" (which in behavioural terms could be quite rationally explained by looking at the reinforcement it was receiving) and similar anti-social behaviours so that he was able to start mixing socially and begin to develop the potential he did have without the label getting in the way.

Behaviour therapy

The emphasis in behaviour therapy of an open and honest relationship with the client with no hidden agendas or secret labels and the way in which the value of an intervention is judged in terms of whether stated objectives are achieved means that clients avoid the possibility of being labelled inadequate or manupulative if they fail to share the worker's 'insight' into their 'real' problem.

Relationship

In behavioural casework the casework relationship consists of one person with a problem working with another person who has both special skills and an interest in helping people and although this relationship should be warm and friendly it should not be a replacement for relationships in the client's or social worker's environment.

In conclusion we would suggest that the behavioural methods outlined in this paper are a potentially valuable tool which social workers seeking to increase their practice skills should study and select in appropriate cases. They offer a very effective and relatively quick way of changing certain maladaptive behaviours and of teaching adaptive ones and can only improve the range of help social workers already seek to offer to their clients.

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Single Parents as "Placements of Choice"

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In the last decade, many adoption agencies have begun to "consider" single persons as potential adopters. Most will only use single adopters for children who cannot be placed with two-parent families. (The translation: only for those children so handicapped by age, circumstances, or disabilities that most prospective families are not interested in them.) The reality is that in most agencies and courts, single parents are viewed as second-best alternatives to two-parent families.

Given that perspective, is it possible that for many children categorized as "hard-to-place", a single parent is the better alternative, the "placement of choice" because of the particular problems of the child with a traumatic history and the special capabilities of the single parent? Some experienced placement workers believe so!

The **particular problems** of the child with a traumatic history bear close examination. Many older children available for adoption are confused by their history and unpredictable in their behavior. Familiar functional descriptions include: ". . . distractible . . . complex . . . scattered . . . having poor impulse control . . . untrusting . . . unable to use judgment". Though some of these children are successfully adopted by two-parent families, single parents demonstrate some advantages in placement. The **special capabilities** offered by single parents include:

— a high calibre of parenting potential (The screening process for single parents usually amounts to a rigorous testing of the applicant's interest and ingenuity. Only the most persistent survive the challenging course.)

— a simplified environment (Without a spouse or other primary family members the number of complex relationships is reduced to an absolute minimum. Demands are fewer in number and directions are less apt to be conflicting.)

— focused nurturing (In the absence of other distractions, the single parent usually concentrates extraordinary effort on analyzing and responding to the problems inherent in the parent-child relationship.)

Other than "considering" single parents, we need to examine the possibility that they represent the better alternative for some children awaiting adoption. One parent families are a growing part of the American scene. In 1976, more than 15 per cent of the children in this nation were living within one-parent families. To ignore this entire segment of our society as a viable population of potential adopters, to dismiss the special capabilities they offer children, is to deny significant numbers of children the opportunity for secure family ties.