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Clinicians' attitudes toward biological parents of children in foster care : the relationship between psychological theory orientation and attitudes.

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CLINICIANS' ATTITUDES TOWARD BIOLOGICAL PARENTS OF CHILDREN IN FOSTER CARE: THE RELATIONSHIP BETWEEN PSYCHOLOGICAL THEORY ORIENTATION AND ATTITUDES

A Dissertation Presented

by

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DEDICATION

To all the lesbians and gay men who have made enormous contributions to humanity through their lifelong work in social programs and human services. It is to them, who have given an immeasurable amount to the lives of children, families, and our communities, that I dedicate this work on foster care.

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ABSTRACT

CLINICIANS' ATTITUDES TOWARD BIOLOGICAL PARENTS OF CHILDREN IN FOSTER CARE: THE RELATIONSHIP BETWEEN PSYCHOLOGICAL THEORY ORIENTATION AND ATTITUDES

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The purpose of this research was to investigate, with a graduate level clinical population, the relationship between clinical orientation and clinicians' attitudes toward: (1) biological parents of children in foster care, (2) biological parent involvement in foster care decision making, (3) parent-child visitation, and (4) family reunification. The four attitude variables were tested by means of a survey questionnaire designed by this researcher. One hundred and forty eight master's or doctoral degree clinicians working in 31 community-based agency sites throughout Massachusetts participated.

In order to test the overarching hypothesis that clinicians with a systemic theory orientation would report more positive attitudes toward biological parents and their inclusion in services than clinicians with an intrapsychic orientation, respondents' clinical orientation was broken down into five measures which were used in chi-square analyses with the attitude items. Significance was set at the .05 level.

As predicted, systemic respondents reported more frequent positive attitudes than did intrapsychic respondents across all four attitude variables, with the greatest number of significant differences found in the area of family reunification. Contrary to prediction, the attitude variation between these two groups was considerably smaller than had been anticipated in the areas of (a) general attitudes toward parents, where primarily negative attitudes were reported by both groups; and (b) parental involvement in decision making, where principally positive attitudes were reported.

Contrary to prior research in which negative general attitudes toward parents had been associated with lack of parental decision making, visitation and reunification, this study found no relationship between systemic respondents' reported negative general attitudes and their reported positivity toward these three aforementioned areas.

In terms of reported attitudes, findings from this study suggest that systemic respondents are more focused on working on the primary goal of foster care, family reunification, than their intrapsychic counterparts. Thus, the use of systemic theory concepts seem more likely to result in service outcomes that reflect the goals and principles of foster care.

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CHAPTER I

INTRODUCTION

A major problem in the field of foster care is that foster care services fail to address, include or emphasize biological parents and families. This neglect has been heavily documented by researchers during the last three decades who have discussed: (a) agencies' poor record of parent-worker contact or collaboration; (b) the lack of, or the limited frequency of parent-child visitation while a child is in care; (c) the failure of services to reunify biological families; and (d) the negative perceptions of biological parents held by foster care practitioners (Fanshel and Shinn, 1978; Gruber, 1973; Jenkins and Norman, 1972, 1975; Jenkins and Sauber, 1966; Jeter, 1961; Knitzer and Allen, 1978; Maas and Engler, 1959).

The literature available to date has both highlighted such problems and raised issues regarding the provision of foster care services to biological parents of children in placement. It should be noted that this body of literature has focused exclusively on high school graduate and bachelor's degree level foster care workers who provide assessment, placement, and ongoing casework services to this client population. Although this body of literature does not directly address the research questions investigated by this study, or the exact subject population, it forms a base of background information on the problems in services to parents and whole families. Additionally, it provides initial research data on foster care workers' attitudes toward

parents and how these attitudes have impacted on services and service outcomes. This prior research has served as a foundation for this research study, which focuses on graduate level foster care clinicians who provide assessments, recommendations, and treatment services to children, and/or parents, and/or whole families receiving foster care services.

Problems in Services

Thus far, the research to date has highlighted the following problems in services to biological parents and families involved in the foster care system:

(1) Parents are typically not included in foster care planning and decision making (Blumenthal, 1984; Gruber, 1973, 1978; Jenkins and Norman, 1972, 1975; Knitzer and Allen, 1978);

(2) Parents are not included in visitation agreements; frequently they are discouraged from visiting their children and persuaded to stay on the periphery of their children's lives (Bush and Goldman, 1982; Eastman, 1982; Gruber, 1973, 1978; Knitzer and Allen, 1978; Laird,1979; Morisey, 1970; Overberger, 1984);

(3) Foster care services fail to reunify families. Children's placements are long-term or even life-term, lasting an average of five years and rarely used as a time limited, temporary intervention (Fanshel and Shinn, 1978; Gruber, 1973, 1978); and

(4) Bachelor's degree level workers typically have negative and disapproving attitudes toward parents, which impact upon services delivered and service outcomes (Fanshel, 1976; Jenkins and Norman, 1972,1975; Knitzer and Allen, 1978; Minuchin,1970).

Clinical Training Issues Raised in the Literature

Based on the previous studies, which have focused on high school and bachelor's degree level workers who lack graduate clinical training, several issues emerge involving the significance of advanced training and clinical orientation (Bush and Goldman, 1982; Eastman,1982; Goldstein, 1979; Herstein, 1970; Kadushin, 1980; Laird, 1979; Maluccio and Sinanoglu, 1981a,1981b; Maluccio, 1985; Morisey, 1970; Overberger, 1984; Stone, 1970). The issues raised are as follows:

(1) there is speculation that advanced training in a systemic clinical orientation holds a possible key role to the improvement of services to parents and families through imparting positive and non-blaming attitudes toward parents, and orienting the focus of services toward the whole family (George, 1970; Kline and Overstreet, 1972; Laird, 1979; Maluccio and Sinanoglu 1981a, 1981b); and

(2) conversely, there is speculation that training in intrapsychic clinical orientations, such as psychoanalytic and psychodynamic theories, further practitioners' negative views of parents by imparting blaming and negative attitudes toward parents' influence on and continued involvement with their children (Goldstein, 1979; Herstein, 1970; Maluccio, 1985; Stein, Gambrill and Wiltse, 1978).

Purpose of the Study

The clinical orientation issues just mentioned, in conjunction with the problems in services highlighted in the literature, combine to form the focus of this research. My aim is to address the lack of parental inclusion and involvement, lack of parent-child visitation, and lack of family reunification, by investigating the relationship between practitioners' clinical orientation, their attitudes, and the provision of services.

Prior to this study, there was no published research on graduate level foster care clinicians' beliefs about parents, nor on their attitudes toward parental involvement and family reunification. There were also no available data to address assertions made by foster care critics regarding the association between clinical orientation and one's attitude toward parents. This study intends to provide relevant data in these areas.

Background of the Study

Principles of Foster Care Services

Federal and state agencies provide guidelines for determining what services are to be provided to any child and family for whom foster care is being considered (Child Welfare League of America Standards for Foster Family Service, 1975; Massachusetts Office for Children Standards for the Licensure or Approval of Agencies Placing Children in Family Foster Care, 1978; and the Massachusetts Department of Social Services (DSS) Regulations Governing the Provision of Substitute Care, 1978; Federal Public Law 96-272: Adoption Assistance and Child Welfare Act of 1980). These foster care standards and regulations share many notions about the provision of services to children and families, and can be organized into three concepts or principles. These three principles are often used by researchers and critics as a basis for comparing those services actually provided with the stated goals and mandates of service (Horejsi,1979; Jenkins and Norman, 1972, 1975; Knitzer and Allen, 1978; Maas and Engler, 1959; Shapiro, 1976).

One principle of service is that foster care is to be used as a last resource, with children to be separated from their parents only after preventive and supportive services have been provided first. Foster care placement is then to be used only when these previous measures have failed to produce the desired result of enabling the child to remain with the family.

A second principle is that foster care services are services for families as well as for children. Parents are to participate in the intake and assessment process, have input into treatment or placement decisions, and are key to developing workable goals for the term of the foster care placement. They are to participate in decision making, actively maintain family ties, and be provided with treatment or other services to enable the family to be reunited.

A third principle is that foster care is to be a time-limited, temporary service. Its major function is to provide problem resolution services to the family, thereby improving the family's and child's level of functioning for the planned reunification. Placement is to be a short-term intervention of several weeks or months, rather than a permanent solution.

These service principles, and the state and federal standards from which they are derived, emphasize the importance of parental involvement and input. They address the necessity of carefully assessing the need for foster care placement, and of reviewing these plans frequently. They contain goals designed to reduce the need for foster care placement, provide short-term service, strengthen family

life, and reunify the family whenever possible. The primary issue, and a problem central to this research is that these goals are rarely achieved in the provision of services to biological families involved in the foster care system. As will be discussed further in Chapter 2, the average length of foster care placement is five years (Fanshel and Shinn, 1978; Gruber, 1973, 1978), with foster care used as a long-term, permanent solution rather than as a temporary respite intervention (Wiltse and Gambrill,1974). Biological parents are typically ignored by practitioners, discouraged from seeing their children, and excluded from the processes of foster care (Gruber,1973,1978; Knitzer and Allen, 1978).

A factor central to this, and one reported consistently in the literature, is the negative perception of and attitude toward parents held by foster care workers that have been studied to date. These workers are generally responsible for making determinations regarding the need for placement, placing children in foster homes, and providing ongoing casework services to foster care clients. These negative attitudes have been shown to relate significantly to the extreme lack of parent involvement, lack of services geared toward the family as a unit, and lack of family reunification (Fanshel and Shinn, 1978; Gruber, 1973,1978; Jenkins and Norman, 1972; Shapiro, 1976). Previous studies have highlighted the severe problems in services to parents and whole families, and have also raised issues regarding possible ways to impact upon these problems.

Significance of Clinical Orientation

One primary focus of this study was to investigate the relationship between theoretical clinical orientation and clinicians' attitudes toward this parent population. Critics of the foster care system have suggested that intrapsychic training imparts blaming and negative views of parents to clinicians, while others in the field have called for the use of a systemic orientation as a beneficial framework for practitioners' work with foster care clients (George, 1970; Minuchin, 1970; Kline and Overstreet, 1972; Laird, 1979; Maluccio, 1981a, 1985). Little in the literature was found to support the contention that a systemic approach was preferable. Thus, the investigation of this contention is the heart of this study.

Intrapsychic Theory

Goldstein (1979) holds the position that psychoanalytic theory, by focusing on perceived pathology, "emphasizes the impact of maternal qualities in causing emotional disorder in children", leading to various notions of mother blame, such as the "schizophrenogenic" mother. Maluccio (1981b) discusses the need for practitioners "to shift from a narrow focus on parents' pathology to a multi-faceted interventive approach to children and families in the context of their life situation and environment... (and) underscores the urgency of identifying, supporting and mobilizing the natural adaptive processes of parents and families" (p.11).

Minuchin (1970), a noted family theorist and practitioner,

addresses the 'parent blame' issue by discussing how poor families are viewed as sick, and a locus of pathology. He addresses the "misuse of this kind of undifferentiated diagnosis" based on conceptions related to dynamic psychiatry. These negative perceptions of parents determine that they are inadequate or inferior because they are poor or in need of some kind of assistance. Traditional psychological theories encourage clinicians to see a parent's need for help as proof of their pathology.

This lack of regard for biological parents has been shown in the literature to frequently result in:

(1) Families having the development of their cohesiveness, continuity, and appropriate family hierarchy seriously damaged by outsiders' interventions (Laird, 1979; Stone, 1970);

(2) Issues or problems not being addressed through placement, or through the limiting of parental involvement and contact with the children (Jenkins and Norman, 1972, 1975; Laird, 1979; Maas, 1971; Maluccio and Sinanoglu, 1981a, 1981b; Minuchin, 1970);

(3) Parents and children left with the long term effects of parental and filial separation and deprivation (Jenkins and Norman, 1972, 1975; Knitzer and Allen, 1978; Mnookin, 1977).

Systemic Theory

Foster care critics and researchers have asserted that training in systemic theory holds a potential key to the improvement of services for this foster care client population (Bush and Goldman, 1982; Eastman, 1982; Kline and Overstreet, 1972; Laird, 1979; Maluccio and Sinanoglu, 1981a, 1981b; Shapiro, 1976). To date, however, there had been little research done on these assertions regarding the potentials of systemic training, with the exception of a project cited

by Laird (1979), conducted by the Michigan Department of Social Services in 1977. This project encouraged workers to do intensive work with biological families, and workers were given several days training in systemic family assessment and intervention, and provided with follow-up consultation. The training emphasized the family-larger system interface, and workers were instructed to develop contracts with families for defining specific tasks and goals.

The outcome of this project showed that at the end of the first year, the percentage of children returned to their families within six months doubled over the previous year in all four project counties. This outcome demonstrates the significant impact a systemic orientation can have on service provision and foster care outcomes. This 1977 study, however, demonstrates the effectiveness of an experimental training project, rather than the relationship between clinical orientation and clinicians' attitudes toward parents, which the present study is concerned with.

Significance of This Study

Foster care clinical staff, comprised of therapists and clinical social workers, are confronted repeatedly with foster care's complications, and are often overwhelmed with their assessment and treatment tasks. Foster care has received little attention as a unique social service where there are many "families" and many different authority or parental figures with disparate power and unclear roles. To date there is little training available that offers preparation for

handling such complex treatment problems and issues.

In the broad area of service provision to parents and whole families, focusing attention on clinicians' clinical orientation and attitudes toward this client population has application to theoretical understanding, training and actual clinical practice with parents of children in foster care. It is hoped that through examining (a) the attitudes of trained clinicians, and (b) the clinical orientations associated with positive attitudes toward services that reflect the intended goals of foster care, implications for training can be derived for practitioners that work in the public sector with foster care clients.

Definition of Terms

Four categories of terms require definition as they have been used in the present study.

(1) Biological parents and families refers to both single and two parent families consisting of biological, natural or adoptive parents, as well families consisting of one legal parent and one significant other adult that functions as a parent. Biological parents are primarily referred to as parents in this study. (Foster parents are always referred to as such, and should not be confused with the term 'parents' or 'biological parents'.)

(2) Parental involvement refers to the inclusion of "biological

parents" in decision making, planning, and/or services related to their child's/childrens' foster care placement.

(3) The term systemic perspective or systemic theory orientation refers to a body of propositions or principles related to family functioning, that consider the family to be a system, or set of elements, organized into an interdependent whole. The family system interacts with other larger systems in the environment through a series of feedback loops. These larger systems concurrently interact with the family system, or elements of the family system, through feedback loops that function to signal to all members their degree of conformity or difference with some overall purpose of the system (Umbarger, 1983).

Related terms that are subsumed by the term systemic theory orientation are: family systems theory and ecological theory.

(4) The Longman Dictionary of Psychology and Psychiatry (1984) has been used to define the term intrapsychic theory, and two theories subsumed under this term: psychoanalytic theory and psychodynamic theory. Intrapsychic theory refers to a body of propositions pertaining to impulses, ideas, conflicts or other psychological phenomena that arise or occur within the mind or psyche (p.390). Included within this category are the following related terms:

(a) Psychoanalytic theory refers to the dynamics of the mind, attending to the inward world of feelings, fantasy, and early experiences (p.600-601).

(b) Psychodynamic theory refers to the motivational forces,

conscious and unconscious, within the individual that give rise to a particular psychological state. These forces include drives, wishes, emotions, and defense mechanisms (p.601). These underlying and often unconscious forces mold the personality, influence the attitudes, and produce emotional disorder (p.239).

Summary

The present study investigated the problems highlighted in the literature by examining the issues raised regarding the significance of orientation on clinicians' attitudes toward parents of children in placement and their involvement. Foster care service principles from federal and state guidelines and statutes were briefly described as they pertain to biological parents and families. These stated service expectations were shown to be infrequently and inadequately applied, resulting in severe discrepancies between stated goals of service and actual practice. A rationale was developed for investigating the association between clinical orientation and clinicians' attitudes, and the significance of the present study was described as it pertains to impacting upon long standing problems in the provision of services to parents of children in care.

CHAPTER II

REVIEW OF THE LITERATURE

Two separate areas of literature will be reviewed. The Foster Care Research review is divided into two sections. In the first section studies are discussed that highlight problems in services to biological parents and whole families involved in the foster care system. These studies are divided into four categories based on their content areas, but all address the major problems in service on which this study focused: (a) general worker attitudes toward parents, (b) parental inclusion in decision making and planning, (c) parent-child visitation, and (d) family reunification. The second section consists of a review of critiques and commentaries on the foster care system that specifically address problems in services to parents, and raise issues regarding: (a) foster care practitioners need for training, and (b) the significance of the clinical orientation of training.

The second literature review, Attitude Research, discusses attitudes as predictors of behavior, focusing on the research of Fishbein and Ajzen (1967, 1977, 1980). This section is important to the design of the study, as attitude was the focus, rather than actual behavior.

Foster Care Research

Several studies have been done on the provision of services to parents and families, and the efficacy of these services (Boehm,1958; Fanshel and Shinn, 1978; Gruber, 1973, 1978; Jenkins and Sauber 1966; Jenkins and Norman,1972; Jeter, 1963; Knitzer and Allen, 1978; Maas and Engler,1959; Shapiro, 1976). Little in the literature speaks to the successes of the foster care system as it has developed since the 1930s, but points mainly to the pervasive problems in services to parents.

To this researcher's knowledge, there has been no research on the attitudes of professionally trained clinicians toward this client population, nor on the level of involvement and collaboration these clinicians have with parents of children in care. Although the studies reviewed have researched a practitioner population of high school graduate and bachelors level foster care workers, rather than graduate level trained clinicians, this researcher believes these data are reflective of similar issues involving graduate level clinicians working with this client population. In addition, due to this lack of data on graduate level clinicians, this study seeks to contribute to the literature in this area.

The studies reviewed have been divided into four major categories: Baseline Data Studies consists of two national studies published in 1959 and 1963, which provide baseline data on foster care placements. Prior to these studies there were no raw data on the numbers of children in care, the kinds of services provided, the length of

placements, the frequency of return home, or the frequency of worker-parent contacts. These studies are repeatedly referred to in the literature, with no more recent data available.

Evaluation of Service Goals in Relation to Service Provision, consists of two studies whose focus was to assess how well stated service goals and standards were met by the agencies providing services. Each of these studies approached their assessment from different perspectives, and had different sources of data.

Workers' Attitudes Toward and Perceptions of Parents, is drawn from two longitudinal studies where practitioners who provided services to families and children were interviewed. In these studies, worker perceptions of and attitudes toward parents were found to strongly influence the discharge rate of children from care.

Parents' Perceptions of Services, is comprised of three studies published between 1972 and 1978. In these studies, parents were interviewed regarding the reason for placement, their perceptions of the agency and worker, their level of involvement, and their perceptions of workers' attitudes toward the family's reunification. Although this category of studies focuses on parents' perceptions and beliefs about foster care, rather than practitioners', these studies are important to include as they add validity to the studies on practitioners' perceptions of and attitudes toward parents.

Problems in Services

Baseline Data Studies

In the first national foster care study conducted, Maas and Engler(1959) collected data from a wide variety of regions across the United States. Nine communities were studied, ranging from rural counties to big cities of nearly one million population, with various racial, ethnic and economic groups included. Information was gathered from the 60 agencies involved with the families and children, with data collected on 4,281 children for April 1, 1957. This study compared children in foster care with those who were in adoptive homes, and with those who had returned home or had left care for other purposes.

Prior to this study there were no systematic nor comprehensive compilation of foster care data. For the first time, as part of this study, statistics were available on the level of parent involvement, length of placement, and frequency of return home. Some of Maas' and Engler's findings were as follows:

(1) More than 70% of the parents either had no relationship with the agencies responsible for the care of their children, or their relationships were erratic and untrusting. This statistic was derived from questionnaires, filled out by agency staff, that inquired about the existence, extent and nature of parental contact with the agencies (p.411). The staff had "no time for the continuous work with the parents of the children which could effect the rehabilitation of the home"(p.391). One could assume from this finding that there were also

little or no resources available to provide services to parents to prevent placement and a child's removal. One third of the children were visited by at least one parent, with 50% having infrequent or no parental contact.

(2) Children who were in care for more than 1 1/2 years tended to stay in care, with 64% of those who returned home being in care for less than 1 1/2 years. Of the 4,281 children studied, only 487 returned to their own families, with 971 in adoptive homes. In only 25% of the cases did staff report that it was probable that the children would return home. Twenty eight percent were in care for up to 1 1/2 years, 44% from 1 1/2 years to 5 1/2 years, with only 6% returning home when in care for the average placement length of 5 1/2 years.

In making recommendations based on this study, Joseph Reid, then President of the Child Welfare League of America, pointed to the lack of preventive early intervention services, and the lack of financial resources as the major reasons for placement (1959:381-2). He also states that "It is not possible to overemphasize the importance of every child welfare agency's concentrating on the families as a whole, and not just the individual child in care " (p.388), and that "frequently agencies fail to appreciate the dynamic of intrafamily relationships as a whole and work only with the child" (p.391).

Reid's innovative recommendations, made three decades ago, present a view that is consistent with more recently published critiques and recommendations that support the provision of services for the whole family, rather than for just the child (Bush and Goldman, 1982;

Eastman,1982; Fanshel,1976; Laird, 1979; Minuchin,1970).

In summary, Maas and Engler (1959) are frequently cited in the literature as a source of baseline data and statistics on foster care. Prior to this study there had been no research done on children in care or their families. It was conducted by social workers and sociologists, and was unique in its concern for the interplay and networking between agencies, families and children in the nine communities chosen for study.

In a study undertaken by Helen Jeter in 1961 for the U.S. Children's Bureau, in cooperation with the Child Welfare League of America, Jeter studied, 1) what problems were presented by the children receiving child welfare services, and 2) what services the agencies were providing. This was the first national study to include both public and private agencies who submitted data on a sampling basis, rather than reporting on 100% of their cases. The agencies involved were ones that were members of the Child Welfare League of America.

This study analyzed the data from public and private agencies separately, with public agency samples of 49,838 children representing a population of 377,000 children, and private agency samples of 12,368 children, representing a population of 49,000 children. Of this sampling, 47% receiving services from public agencies were in foster care placement, with 45% served by private agencies in care. Jeter states that "while it is part of good social work practice

to provide casework for parents of children in care" (p.85), 35% of parents involved with public agencies and 23% of those with private agencies were not receiving any services. For 64% (public) and 51% (private) of the children in foster care, the agencies reported the only plan for the child was the continuation of placement. For 12% and 13%, respectively, return to their parents was expected or planned.

Thirty one percent (public) and 23% (private) of the children in foster care had been in care 6 years or more, with the average mean length of placement being 4.6 years for public agencies and 3.6 years for private ones. Twenty two percent and 16% had been in care 6 years but less than 12 years, with 9% and 7% in care for 12 years or more. Aftercare services, directed toward the child's reintegration into the family, were provided to 4% and 2% of the cases studied.

Data from this study specifically related to the problems of biological parent involvement, and family reunification are: (a) child removal was the primary service provided, rather than preventive or supportive services, (b) 1/4 to 1/3 of the biological parents received no services, with the continuation of foster care the only plan for the child in over 2/3 of the cases, and (c) the length of placement was 6 years or more for 1/2 to 2/3 of the children in care.

These outcomes are clearly not consistent with the stated principles and goals of service outlined in Chapter I. These discrepancies will be found in much of the other research reported later on, and are cause for serious concern regarding the quality of services provided to parents and whole families. In the following

research to be reviewed, the specific issue of the discrepancy between service goals and what is actually provided, will be discussed.

Evaluation of Service Goals in Relation to Service Provision

In a comparative study conducted by Bernice Boehm in 1958 for the Child Welfare League of America, Boehm compared 30 children in foster care with 30 children in adoptive homes. This study served as a pilot for Maas' and Engler's (1959) nationwide study, and was conducted in "Harbor City", a northeast urban community with a population of 250,000.

A primary focus of this study was to assess the quality of casework services provided to parents, based on standards developed by Boehm. She used the following four standards as criteria:

> 1) The agency will have drawn the family into active participation in planning for the child's placement, 2) The agency will have made an evaluation of the family's potentiality for being reunited, 3) The agency will have worked planfully with the family toward the appropriate goals..., and 4) The agency will have maintained contact with the family on a regular basis, rather than as a sporadic response to emergency situations (p.18).

Based on these standards, only two families received adequate services among the children in foster care. Fourteen received inadequate services, and 14 received no services at all. These 28 families had no planful work done regarding decisions about care, or their child's return home. Boehm's standards are quite innovative for the time, and are now used as either formal guidelines or legal statues

for services today.

Boehm comments on the stated purpose of foster care, and cites the discrepancy between the goals and the actuality:

> For some time the field has been considering foster care as primarily a temporary form of care, in the hope of strengthening parental functioning so that the child can eventually be returned to her/his own family. To achieve this, a close relationship between the child and her/his family must necessarily be maintained during placement. However, our findings show that for a large proportion of children in foster care in Harbor City, the opposite is true (p.6).

She concludes there is a significant need for practitioners to develop a conceptual clarity and understanding in their work with families (p.29), and to learn to perceive the positive factors and strengths in the parent-child relationship so that practitioners will work actively to reunite the family. Boehm states that all too often, "foster care becomes a permanent way of life. If we are to avoid this undesireable solution, we must strengthen our skills in working effectively with this group of families" (p.30). This need is as salient today as it was in 1958, and was a significant rationale and basis for this research study.

Knitzer and Allen (1978) conducted a study for the Children's Defense Fund to evaluate seven states' provision of foster care services to children and families. The philosophical focus of this study was concerned with children's needs and children's rights, as well as governmental and administrative responsibility for enforcing

and ensuring these rights. An additional focus of this study was to assess how well these policies and practices met the needs of the families.

Demographics were gathered from a random sampling of 160 counties in the seven states studied in depth: Arizona, California, Massachusetts, New Jersey, Ohio, South Carolina and South Dakota. These states reflected different social service structures, different racial, religious, ethnic and economic populations from different geographic regions. Two to four weeks were spent in each state interviewing various levels of state officials, as well as foster care direct service workers. Two hundred people were interviewed in all.

Highlights of their findings replicate those of numerous parallel studies. A summary of their findings report that: (1) placement occurs by default, due to lack of preventive or supportive services; (2) placement occurs through coercion, due to unclear placement criteria and lack of due process; (3) the homes of relatives are ignored as possible placements; (4) parental visits are discouraged, or not allowed; and (5) other family contacts and maintenance of ties are discouraged through restrictions on sharing information about a child with their parents. In addition, no help is available to parents in the remediation of presenting problems, with no funds available for these restorative services, leaving parents by and large ignored (pp.15-26).

The interpretation applied to the data is summed up in the foreword to this study which states:

> The fact and drama of Children Without Homes all contribute to a single theme: that when the government assumes responsibility for children, it owes them the kind and degree of nurture children require for their development. This, as the report documents, it is tragically failing to do in myriad ways...repeatedly, it is demonstrated, families are permitted to fall apart, parents to throw in the sponge- when an investment of supportive services and aids would have given them the strength and security to function as parents...little is done to strengthen their ties to their own families. Many, who might with skillful strengthening of the home situation return to their own homes, remain in the 'limbo' of placement till they are grown (pp.x-xi).

In summary, these two studies share similar findings. They have addressed the wide discrepancy between how services are suppossed to be, and how they actually are. Consistently, parents are excluded from participating in making decisions regarding their child and family, and are ignored by foster care workers. Boehm (1958) found that parents were rarely provided with or included in services, and concluded that practitioner's skills in working with families must be improved. Knitzer and Allen (1978) found that the presenting family problems go unaided, the lack of preventive or supportive services lead to unnecessary placements, and that parental inclusion and involvement is discouraged or not allowed, with children rarely returning home. Both studies conclude that there is a major problem in service provision to parents and whole families, leading to outcomes that are significantly discrepant with stated service goals.

Workers' Attitudes Toward Parents

The two studies in this category both focus on parent-child visitation as a significant indicator of parental involvement and a child's subsequent return home. Both studies found workers' attitudes toward and evaluations of parents to be correlated with the level of casework activity with parents, the frequency of parental visiting, and the discharge rate of children from foster care. These two studies were designed to be two of three interdependent, longitudinal studies funded by the U.S. Children's Bureau, and conducted through the Columbia School of Social Work.

Fanshel and Shinn (1978) studied 624 children in New York City over a five-year period beginning in 1966. The children had been in care a minimum of 90 days, but had never before been in care. They ranged in age from 0 to 12 years, and represented 467 family groups. One major focus of this study was the frequency of parental visitation, researched through telephone interviews with agency caseworkers and through personal interviews with parents.

Parental visiting is frequently used as an indicator of parental involvement and potential for family reunification (Gruber,1973,1978; Horejsi,1979; Jenkins and Norman,1972, 1975; Jeter, 1963; Kadushin, 1980; Maas and Engler,1959). Fanshel and Shinn viewed visitation "as highly important for the welfare of the child" (p.85), and interviewed workers by telephone on four occasions during the five-year period regarding contact between parents and children. "The questions covered such details as the frequency with which fathers and mothers visited,

restrictions imposed by the agency on visiting, conditions preventing the parents from availing themselves of the opportunity to visit, and whether the child visited her/his parents at home" (p.87).

It was hypothesized there would be a significant association between parental visiting and discharge from foster care, and this was proven during all four data gathering occasions over the five-year period. During the first year of placement, "children who were visited the maximum permitted by the agency, or who were visited frequently, were almost twice as likely to be discharged as those not visited at all, or only minimally" (p.96). Fanshel and Shinn found that 86% of the children who were visited regularly by their parents were discharged from care. Sixty-six percent of the children visited minimally, or not visited at all during the first year of placement were in foster care 5 years later. "The strength of the relationship between visiting and discharge is impressive and demonstrates the centrality of visiting as a key element in the return of foster children to their own homes" (p.96).

They also found "the caseworker's evaluation of the mother was a significant predictor of visiting behavior" (p.485), and that the level of casework activity was a significant variable in parental visiting (p.483). Mothers who received more positive evaluations showed significantly higher visitation (p.107). There was also a positive association between the frequency of worker contact with the biological family and the frequency of visitation. In Jenkins' and Norman's (1975) sister study, which will be reviewed in the category of Parents' Perceptions of Services, the lack of encouragement for parental

visiting was a major complaint made by mothers (pp.67-69).

Fanshel's and Shinn's research falls short, however, in its analysis of the role workers have in visitation and family reunification. They suggest that workers were responsible for monitoring these successful visiting relationships, and had intervened early when they had faltered. They conclude that, " we need to know more about how individuals relate to their parenting responsibilities" (p.485), so that workers can continue to intervene early in faltering visitations.

It is my contention that this visitation success is not attributable to the 'workable' parent who can be prompted or prodded when they falter, or who have some different view of their parental responsibilites, as Fanshel and Shinn suggest. Rather, I contend the success of visitation and a child's return home is significantly connected to a worker's positive perception of the family, the worker's encouragement of the parent-child relationship, and the worker's ability to engage with parents in decision making concerning the child's return home. Certainly the role played by parents is significant, but given the disparate power between parents and practitioners, much of this success demonstrates the worker's ability to work with parents and to equalize some of this power disparity.

Lastly, Fanshel and Shinn found that 36.4% of the children were still in care at the end of 5 years, with 56.1% discharged. The remaining 7.5% were children placed in adoptive homes (4.6%), and children placed in institutions (2.9%). It was also found that adoption was not a viable source of permanence for children until after they had

been in care more than 5 years. A crucial issue raised by their study was "why so many children have become long-term wards of the system. Why is this system, intended to offer temporary haven to children, incapable of restoring large numbers of them to their own families?" (p.476)

In the longitudinal sister study conducted by Shapiro (1976), foster care workers were interviewed regarding their perceptions of mothers and the frequency of worker-parent contacts. Eighty four agencies participated, representing 2/3 private agencies and 1/3 public agencies, with data collected at four different times during the five-year period. Altogether, 1,107 workers gave 2,274 interviews because frequently one worker was assigned to the child, and another to the family. This necessitated double interviewing to get data on one child-family case.

Approximately 20% of the worker interviews, during all four interview periods, were seen as "problems" due to high worker turnover and low levels of training (p.10).

> Thus a research interview, which required the demonstration of at least a minimal degree of knowledge about a case, and some indication that something was being 'done', put some of the workers on the defensive... Experience indicated that the respondents were evasive principally because they were embarassed by their lack of knowledge (p.11).

This finding will be developed further in Section 2 of this literature review, as it raises issues regarding the lack of training of foster care workers, the need for advanced training, and the relationship

between training, services and service outcomes.

This worker sample represents only a fraction of the workers involved with the children and their families. Forty percent of the cases had experienced worker turnover by the time of the first interview, and more than 50% experienced worker turnover at each subsequent interviewing cycle (p.18). Children who continued in care by the time of the second interview had a median of 6 workers, with a range as high as 12. Children continuing in care through the third interview had a median of 7 workers, with a range as high as 16. For those in care throughout the 5 year study, the median number of workers was 9, with a range that reached 17. More than twice as many workers as were interviewed serviced the 616 children in this agency study, equaling a total of 2500 workers. This phenomenon, frequently cited as a major problem in services to children and families, leads one to wonder about the quality and consistency of services provided, particularly in light of Fanshel and Shinn's (1978) data showing a significant association between casework activity, visitation and family reunification.

One major area of inquiry was how mothers were perceived by their workers. It was found that "the worker's attitude influenced the discharge rate" during all phases of this study (p.118). Workers' perceptions of "maternal adequacy" played a major role in their decisions whether to plan toward returning a child home, or toward long-term placement or adoption. During the first interview , only 22% of the mothers impressed their workers as adequate, for 33% workers had

mixed feelings, with 37% considered very inadequate. "In later phases of the study, the proportion of mothers seen as inadequate rose to 52% by the final cycle with a corresponding decrease in those seen as adequate" (pp.37-8).

Qualitative data were gathered on how workers assessed the prospect of working with mothers, and at the time of the first interview they reported the outlook was good for 48%, but their optimism was guarded for 1/4 of this group. By the second interview, workers' pessimism increased somewhat, and by the third interview rose to 1/3, then dropped again by interview four. Shapiro sees workers' impressions as varying and fluctuating considerably over time, with this possibly due to the extremely large number of workers involved with these families, leading to inconsistent findings (p.39).

Data on the degree of worker-parent contact showed that at the time of the first interview, 22% of parents had no contact with their worker. This proportion rose reaching 26% by the fourth interview. Workers also did not contact relatives, and regarded them as "dubious resources and had little motivation to work with them... Despite the presence on many records of names and addresses of several relatives or friends, relatives were contacted infrequently" (p.30). Shapiro concludes that "In general, the picture of worker-family relations within the agency network was basically one of deterioration over time, both with respect to frequency of contact and to the evaluations of parents" (p.43).

Key findings from this study, relevant to worker attitudes toward

parents, parent involvement and family reunification are as follows:

"1) Workers question the necessity of placement in relatively few cases and predicted that more children would remain in care than actually did... suggesting a greater pessimism than is warrented either about the families involved or the system in which they work or their own capacities,

2) Over time, families with children in foster care have less contact with agency workers. These contacts are increasingly limited to the mother only, and these mothers are increasingly likely to be seen in an unfavorable light, accompanied by decreasing optimism about their ability to make homes for their children. Whatever the problem that precipitated placement, the difficulty encountered by the workers in assessing maternal adequacy is the key reason for continuing placement,

3) The worker's evaluation of the mother predicted the child's discharge from care. Unlike all the other variables examined, it contributed significantly to the discharge rate each time. It was superseded in importance only in the third year of placement, when the mother's determination to remove the children from care was stronger than other factors contributing to discharge" (pp. 195-197).

In summary, these two studies have very similar findings. Each clearly indicates the importance of assessing the worker's role in viewing parents negatively, thus limiting or discouraging a parent's participation in the foster care process. As a result of these negative evaluations, parents are both excluded from participating in decisions regarding their child, as well as discouraged from visiting. This ultimately leads to a child's permanent placement in foster care, based it seems, more on the worker's negative attitudes toward the parents, than on the real problems in the family.

One major limitation, however, of both these studies is that the criteria used by workers to arrive at their evaluations of parents were not specified. In the Shapiro study (1976), she cites the need for workers to have some standard of evaluation upon which to determine

"parental adequacy", and cites this lack of a standard as a major problem. In the Fanshel and Shinn (1978) study, it is unclear as to how they determined what led workers to perceive parents in negative or positive ways.

Parents' Perceptions of Services

This fourth research content area consists of three studies in which parents were interviewed regarding their families, and the foster care services they received. As mentioned previously, this current study has not investigated parents' attitudes and perceptions of foster care. Reviewing the literature on parents' perceptions of practitioners' attitudes, however, can lend validity to the data available on practitioners' attitudes, giving a more complete view of interactions and perceptions between these two groups.

In the studies reported in this section, data were gathered on the composition of the families, the reason for placement, the level of parent involvement, parents' perceptions of their roles and their worker's roles, the level of worker-parent contact, and their perceptions of the workers' attitudes toward family reunification. The results from these studies share many common findings, and show a significant lack of services to families.

Gruber's study (1973,1978) was originally designed to provide data to the 1970 Massachusetts Governor's Commission on Adoption and Foster Care. This commission was established to (a) identify important

problems in Massachusetts related to adoption and foster care, (b) evaluate existing procedures, and (c) make specific recommendations to the Governor and General Court for changes in the statutes or procedures. The purpose of Gruber's study was to identify the characteristics and problems of children in foster care in Massachusetts, under both public and private auspices. Based upon these findings, recommendations were to be forwarded to the Commission.

This study was divided into three phases, with data collected by questionnaire from the agency responsible for the child's supervision during phase one. In the second phase biological parents were interviewed, with the third phase consisting of interviews with foster parents. Of the 5,933 chidren in care on the data collection date of Nov. 18, 1971, data were available on 5,862. In addition, 160 interviews were conducted with biological parents.

This study asked exceedingly relevant questions and presents useful data on problems in services. In line with the areas of focus of the present study, Gruber's findings will be organized into the categories of (1) parental involvement and inclusion, and (2) family reunification.

1. Parental involvement and inclusion. Parents reported there was virtually no consideration of ways to keep their children home. Twenty three percent stated that placement could have been prevented if they had been able to receive quicker or more family counseling; 17% reported a homemaker would have prevented placement; and 29% reported day care would have prevented placement (pp.77-78).

Sixty percent felt excluded from participating in the placement process with their child, with 60% in contact with the foster care agency 2 weeks of less before the placement occurred, and 82% reporting they saw a social worker 6 times or less before the child left home. Sixty percent felt they did not see their child enough once in placement, with 37.5% of these reporting the social worker prohibited them from doing so, and 20% unable to visit because their child's foster home was too far away. While their child was in placement, 31% reported never seeing a social worker, with 57% not seeing one for 6 months. Seventy-five percent said they would never consider foster care placement for their child/children again (pp.78-79).

2. Family reunification. At the time of initial entry into foster care, 50% of the children were to be entering for a specific length of time with 33% assigned a specific discharge date, yet 83% had never been returned to their parents even for a trial period of time. Seventy-five percent of parents stated their social worker was either doubtful about reunification or clearly against it (pp.78-9); with less than 3% of the children discharged in less than 2 years, 4 months. The average length of placement was over 5 years, with 68% of the children being in care for more than 4 years but less than 8 years (pp. 16-17).

In Gruber's findings, parents report they were excluded from participating in foster care decisions, had little or no contact with practitioners, and their workers were doubtful about the family ever being reunited. Although this kind and quality of data do not specifically address the question of practitioners' attitudes toward

parents, it is certainly relevant to the issues of practitioner-parent collaboration, parental inclusion and family reunification. Through the examination of parents' perceptions of the foster care system, a consistent picture develops regarding the limited contact and collaboration between parents/families and the workers to which they are assigned. Parents' perceptions of workers' attitudes are consistent with the literature that has examined workers' perceptions and expectations of parents, and thus adds validity to these other studies.

The following two studies, both longitudinal sister studies of Fanshel's and Shinn's Children in Foster Care (1978), were published by Jenkins and Norman in 1972 and 1975, and resulted in two volumes: Filial Deprivation and Foster Care (1972) and Beyond Placement-Mothers View Foster Care (1975). Both focused on parents' attitudes toward and responses to foster care services, and studied the changes that had occurred in the circumstances of these families over the five-year period. A significant part of these studies focuses on parents' evaluations of services and their responses to presumed "help".

Filial Deprivation and Foster Care (1972) was primarily based on data collected from an initial interview with parents in 1966, when their children entered care. Mothers, fathers and other child caring persons were interviewed in their homes, with a study sample of 390 families.

Parents' perceptions of the foster care agencies were studied and

designated as: 1) "facilitator", helping families in time of need; 2) "usurper" of parental rights and responsibilities; and 3) "surrogate", fulfilling an appropriate role (p.153). In conjunction with this, parents' social attitudes were assessed and delineated into the concepts of "alienation", "trust" and "calculativeness" (p.143). The parents in this study were characterized by high "alienation" scores, which were significantly associated with low socioeconomic status and minority group membership (pp.146-7). "The strongest relationship was found between alienation as a social attitude and the perception of the agency as a usurper of parental rights" (p.159). What is most interesting in this finding are Jenkins' and Norman's conclusion that the parents have high alienation scores, rather than interpreting their data based on parents' perceptions of workers as usurpers of parental rights.

Jenkins' and Norman's conclusions center primarily on the lack of preventive and supportive services available to families. "It is apparent that the social service system as presently structured does not have the capability to provide basic preventive services to strengthen family life" (p.257). They also suggest "supportive services to families in their own homes could both reduce entry into care and accelerate early discharge of placed children" (p.263). These conclusions and recommendations are useful and well meaning, but do not address the salient issue raised by parents' view of workers/agencies as infringing upon, overriding, or usurping parental rights and responsibilities.

Jenkins and Norman (1975) report on two follow-up interviews held with parents 2 1/2 years after placement in 1968, and at the 5-year mark in 1971. Three hundred and four families were interviewed in 1968, and 257 were interviewed in 1971. Much of the loss from the original study sample of 390 families was accounted for by urban renewal, and resultant family relocation and loss of contact. This study provided an evaluation of foster care services from the point of view of parents, analyzing the problems leading to placement in relation to the change or lack of change in these original presenting problems over the five-year period.

The major change in families reported over the five year period was the discharge of the children from care. Seventy three percent were discharged to their mothers, with 26% discharged to other relatives. "The determination of the mother to have her child home was a key ingredient in the discharge process" (p.29). This finding is significant to this present study as it provides further rationale for the hypothesis that the inclusion of parents in foster care decisions can lead to more positive outcomes, e.g. more frequent family reunification. Even though in this case parental input was not necessarily asked for or encouraged, the fact of parental input and influence was key to determining a child's return home.

In evaluating foster care, 1/2 of the mothers stated they were satisfied about the placement, 1/4 were negative and disapproving, and 1/4 were ambivalent. "Even though a majority of mothers expressed satisfaction with the child care received, most of them felt placement

to be a last alternative, and few would recommend it to other mothers in need of help" (p.134). In regards to problem resolution, 2/3 of the mothers stated self-help was the most important factor in improving the situation, with the placement agency seen as aggravating problems in 1/3 of the cases (p.93). Agencies were also criticized for keeping children from parents and not giving parents information about their children (p.78).

An additional component of this study explored the role expectations mothers had as clients. It was found that mothers had a very clear idea about what was expected of them by their workers, and "the major categories into which their (the mothers') perceptions fell included; to be 'undisguised' (authentic), to be 'controlled', or to be 'acquiescent' "(pp.134-5). The authors conclude that this means workers need to know the role expectations their clients have, so a mother's behavior can be better interpreted. This analysis does not look at the interactional pattern between worker and parent regarding collaboration, parent involvement, or the power disparity between parents and workers. It is my contention that mothers behave in these ways to calibrate this lack of collaboration, and/or to modify the power differential between themselves and their worker(s). Mothers' perceptions of what roles workers expect from them are confirmed further by the following data on workers' attitudes toward parents.

Jenkins and Norman consider that a factor "contributing to poor client perceptions of the system may be the workers' attitudes toward clients, and their acceptance or rejection of families in need of

services" (p.137). They then generalize on the difficulties of working with hard to reach, unmotivated and resistent clients, and do not deal with the issues raised by workers 'rejecting' or 'accepting' clients. Their analysis focuses on a blameful evaluation of the parent in relationship to the worker, and avoids looking at the attitudes of the worker as limiting or not allowing a partnership or sense of mutual endeavor between themselves and their clients. It is not surprising that a majority of mothers perceived their role to be either "acquiescent" or "controlled" in relation to their workers.

Jenkins and Norman conclude their study with a call for a "no-fault foster care system", which provides supportive and preventive services. They also cite George (1970), who discusses the "vicious circle engendered by the system...of active hostility and passive interaction towards natural parents, which forces or allows them to alienate themselves from their children. This alienation, in turn, is used as evidence against the parents and proof of their disinterest", as well as stressing parental inadequacy rather than structural faults (p.139). Although they do not have a systemic or interactional view of the issues between workers and parents, they are able to conclude that "Practitioners need to re-examine the role of biological parents with emphasis on strengths and capacities, rather than pathology and deficits " (p.142).

This study is a good beginning analysis of the problems in services to parents and families, but these authors fail to appreciate the implications of workers' attitudes toward parents, and how these

attitudes impact upon parental involvement, services, and service outcomes. With the exception of the one quote from George (1970), these authors appear to have an ambiguous stance about the impact of workers' attitudes, and like other foster care researchers, appear to have no theoretical framework available to them for analyzing or conceptualizing these interactional problems and biases. It is my suspicion that most of the researchers reviewed thus far hope change will occur through increased humanitarianism, funding, or good will. I believe, rather, that workers need a strong systemic and interactional framework from which to assess needs and determine services if they are to make less negative and disrupting interventions with families.

Findings from these three studies in the category of Parents' Perceptions of Services assess workers as not helpful to parents, as withholding information from parents, or keeping parents from their children. These findings confirm the data found in other foster care research that has highlighted the problem of negative worker attitudes toward parents, and its relationship to discouraging parental involvement and family reunification.

Problems in Services: A Summary

In this literature review, problems in services have been highlighted in the areas of (1) worker attitudes toward parents, (2) parental inclusion in decision making and planning, and (3) family reunification. Although the exact statistics or focus may vary from

study to study, there is a general consensus on the following problems:

a. There is virtually no availability or utilization of preventive or supportive services to prevent placement.

b. There is a significant lack of parental involvement in decision making regarding the terms of the placement, visitation, or in worker-parent contact or collaborations.

c. Worker attitudes toward and evaluations of parents are a significant factor in family reunification and case planning. Most frequently these attitudes are negative and disapproving.

d. Placements are not temporary, but average 5 1/2 years in 50% of the cases entering care (Horejsi,1979:16). The longer a child remains in care the less likely they are to return home.

e. Remediation of the presenting problem, which would lead to family reunification, is either not a service considered or provided, or is not indicative of family reunification.

These findings provide necessary background information on long standing problems in services to parents and whole families. Using these findings as a backdrop, critiques will be presented in the following section that raise issues regarding the genesis and continuation of these problems, as well as make suggestions regarding avenues for remediation.

Issues Raised

Many in the field have critiqued service provision to biological parents and whole families, and share a consensual view of the problems that have been highlighted in the research studies. The critiques to be reviewed here raise issues regarding possible avenues of remediation of these long standing service problems, focusing on: (1) the limited usefulness and frequent destructiveness of traditional psychological

theory in conceptualizing services, (2) the need for the development of a more useful and clear theory base appropriate to foster care's complexity, and (3) suggestions and speculations that systemic theory perspectives can play a significant role in the remediation of problems in services to families. In line with these three areas of focus, a brief description of these critiques' analyses and conclusions will be given.

Morisey (1970) addresses the continuum of parent-child relationships in foster care, and based on the Child Welfare League of America's Foster Care Standards states, "the purpose of services is to preserve the parent-child relationship to the fullest extent possible", and cites the wide discrepancies between this statement of purpose and actual practices (p.148). She sees the failure to promote this relationship as stemming not only from organizational and staffing problems, but from community and professional values and attitudes toward the mother.

These negative attitudes have evolved historically, initially based in the 19th century on the "desire to remove a child from a bad environment", with the intent to prevent the return of the child to her/his own family (p. 149). Later, practice reflected the Freudian emphasis on childrens' separation trauma, focusing on helping children separate from their parents, with little attention paid to the future parent-child relationship. More contemporary research has underscored the significance of the outcome of placement, rather than

limiting its purview to the psychological complications of separation for the child (p. 151).

Herstein (1970) discusses the limitations of psychoanalytic theory and sees it as "inadequate to aid the worker in arriving at the manifold decisions that s/he must make... and that psychoanalytic theory in general, and separation theory in particular, do not form an adequate basis for deciding many complex questions in foster care" (p.173). Stone (1970) also addresses the need to re-examine fragmented and outdated theoretical concepts that underlie foster care services (p.3).

Goldstein (1979) raises many issues regarding the negative influence psychoanalytic theory has had on practitioners' attitudes toward and assessments of mothers. She discusses psychoanalytic theory's "emphasis on the impact of maternal qualities in causing emotional disorder in children...and that the adjectives to describe mothers are endless,... e.g. masochistic, narcissistic, sadistic, abusive, cold, rejecting, passive, dependent, overprotective" (p.152). She points out that women were described by Freud as "less ethical, with less sense of justice, more envious, weaker in social interest, more vain, narcissistic, secretive, insincere, passive, childlike and incomplete" (p.153). She sees this theory base as destructive and blameful, focusing the cause of all and any problems on the inadequacies of the mother.

Laird (1979) agrees that a major influence on current foster care practice has been traditional psychological theory.

> Historically our knowledge and training were shaped by psychoanalytic and child development theories, and was largely confined to the understanding of individuals. We have been trained... to attempt to understand and diagnose a variety of adult and child pathologies... which often leads to the removal of children and to treatment of individual family members...and the treatment of the emotionally damaged child becomes a long expensive process with what often seem limited gains (p.182).

Stein, Gambrill and Wiltse (1978) suggest that "a basic change that must occur is to move away from the pathological view of human behavior that historically has dominated practice courses...(and that this) overemphasis on the pathological has been an obstacle to case planning and service delivery" (p.137). Minuchin (1970) asserts a view that discusses how poor families are generally viewed as sick and a locus of pathology. He believes that our concepts of problems and services have seen these problems as existing within the individual, and discusses the " misuse of this kind of undifferentiated diagnosis" based on conceptions related to dynamic psychiatry.

In connection with these criticisms of the impact of psychoanalytically based services, are suggestions for worker training in a clearer and more useful theory base appropriate to the foster care situation. Stone (1970), in summarizing the recommendations made at the 1967 National Conference on Foster Care discusses the need for the development of a clearer base of theory drawn from the knowledge of many disciplines for the purpose of improving practice with children and families (p.270). Boehm (1958) believes there is a significant need

for practitioners to develop a conceptual clarity and learn to perceive the positive factors and strengths in the parent-child relationship in order to aid in family reunification.

Nearly three decades later, Overberger (1984) reiterated the need for training related to parent involvement, requiring new efforts for most foster care practitioners. "Training must develop the knowledge, skills and appropriate attitudes for working with parents, attributes now largely lacking in many staff" (p.148). Specifically, staff must be trained to understand the importance of parents to children, and the relationship of parent involvement to return home. Staff need new skills so they can " form nonjudgemental relationships with parents, use new treatment techniques, and assess family problems and strengths" (p.149).

Not only have critics highlighted the impact of intrapsychic theories on the provision of services to parents and families, and called for the development of an appropriate theoretical basis from which to determine services, but they have also suggested that systemic theory may hold a key role in remediating these long standing problem areas.

Minuchin (1970) discusses that little attention has been paid to the ways in which the systems surrounding the individual maintain or program her/his responses. He suggests that services designed to impinge upon the family, rather than the entire system, are part of this limited conceptualization (p.88), and sees foster care as an intervention that fragments the family and increases their difficulties. He suggests organizing services according to a

conceptual framework that views the larger ecosystem, and takes into account the effect on the whole family system of interventions geared only to the individual. Others also discuss the need to enlarge practitioners' conceptual purview to include the influence of environmental factors on family functioning (Stein, Gambrill and Wiltse, 1978), and to understand the complexity of foster care's unique structure and function (George, 1970).

Many in the field have called directly for training in and the implementation of systemic theory perspectives in order to remediate problems. Maluccio (1981a) addresses the need for changing perspectives on work with parents, and highlights the use of a systemic theoretical framework "that relies on a broad array of knowledge from such disciplines as general systems theory, ecology, evolutionary biology, cultural anthropology, social psychology...Its main thrust lies in addressing the interface between people and their environments" (p.11). Germain (1979) names this synthesis of systemic knowledge "an ecological perspective", whereby practitioners seek to change and enhance the interactions between people and their environment. In addition, Maluccio (1985) calls for family therapy as a means of getting away from the medical model and preoccupation with parental psychopathology, as well as a persistent tendency to deal with parents in a way that says to them, "you're at fault" (p.150).

Goldstein (1979) believes systemic theories, such as ecological or family system perspectives, are an alternative conceptual approach to employ in remediating blameful views of

parents, particularly views of mothers (p.159). Since these systemic perspectives provide for a multi-interactional view of problems, rather than a blameful perspective focusing on the mother, they involve taking into consideration all forces that impinge on the caretaker-child relationship.

Kline and Overstreet (1972) suggest that

> systems theory offers a promising framework for a more useful conceptualization of services than has been available in the past. Within this frame of reference all the individuals and social institutions that participate in each placement situation can be viewed in their interactions and transactions, their reciprocal influence on each other, and the fluid states of equilibrium and disequilibrium within the service system (p.1).

Lastly, Laird (1979) addresses the issue of social service workers being "slow to recognize the far reaching destructive effects that policies, programs and service delivery approaches have on delicate but vital human systems" (p.176). She believes these practices are a result of a lack of understanding of family systems, which have ultimately undermined the family. Laird suggests all foster care practitioners receive training in systems theory, and believes that "Concepts from family system theorists, from ecological and general systems theory, and from communication theory, are aids to understanding and assessing the transactional relationships among family members and between the family and its environment" (p.182). Laird also makes note that in the last 25 years the interdisciplinary 'family therapy movement' has not "clung to older 'medical model'

approaches" but has instead generated new ways of thinking about and working with families that are key to improving services to parents (pp.182,184).

Summary of Foster Care Research

As the literature has shown, stated service expectations are infrequently and inadequately applied by workers, resulting in severe discrepancies between the stated goals of service and actual practice. Workers' negative attitudes toward parents were shown to be directly correlated with the lack of services provided to parents, with these negative attitudes effecting the level of casework activity, the inclusion of parents in decision making, the frequency of visitation between children and their parents, and the frequency of family reunification.

This review has highlighted the serious problems of lack of parental involvement and inclusion, and workers' negative attitudes toward parents of children in care. Correlated with these negative worker attitudes are the extreme length of placement and lack of family reunification. Typically placements are long-term or even life-term for children, and rarely used as a temporary intervention. The long standing nature of these problems, and the consistency with which they are reported, have led critics to raise issues regarding these problems' genesis and continuation, as well as make suggestions regarding possible avenues for remediation. They cite the historical use of a destructive theory base, and the lack of use of a theoretical

framework appropriate to foster care's complexities, as primary reasons for the continuation of these problems. Additionally, they have raised issues regarding areas for remediation of these service problems, suggesting that training in systemic theory can play a key role in remediating these long standing problems.

Given that workers' attitudes toward parents effect placement decisions, services provided and service outcomes, this study has examined the association between clinical orientation and clinicians' attitudes toward (a) parents, (b) parental inclusion in decision making, (c) parent-child visitation, and (d) family reunification. The following part of Chapter II, Attitude Research, will review attitude literature relevant to the relationship between attitudes and behavior, and include a discussion of attitudes as reliable predictors of behavior when appropriate areas of inquiry and measurement are developed.

Attitude Research

Introduction

Historically the concept of attitude was defined by Gordon Allport, who in 1935 reviewed one hundred different definitions of attitude and concluded that most researchers " basically agreed that an attitude is a learned predisposition to respond to an object or class of objects in a consistently favorable or unfavorable

way...this bipolarity in the direction of an attitude [i.e.,the favorable versus the unfavorable] is often regarded as the most distinctive feature of the concept" (Fishbein,1967:477).

Fishbein (1967) takes this early concept of attitude and develops it further by delineating the determinants or consequents of an individual's attitude. Based on the belief that an attitude is actually derived from many statements an individual makes with respect to a given object and anticipated actions, Fishbein views statements about the object (i.e., beliefs) and statements about actions toward that object (i.e., behavioral intentions) as indicants of an individual's attitude (p.479). These indicants are seen as independent of, but related to, the concept of attitude.

The present study used these two indicants of a person's attitude as the major foci of the research instrument. Thus, the instrument examined clinicians' beliefs about and behavioral intentions toward: (a) parents of children in foster care; (b) parental involvement in decision making; (c) visitation; and (d) family reunification.

Attitudes as Predictors of Behavior

In a review of the attitude research literature Borg and Gall (1983) state that "A review of research on the effectiveness of attitude measures as predictors of behavior indicated that general attitude measures are not very accurate measures of specific behavior. However, recent works suggest that specific behaviors can

be predicted from the measures of attitudes toward the specific behavior" (pp. 341-2).

Fishbein and Ajzen (1975, 1977, 1980) have made significant contributions to this area. They discuss the relationship between attitude and behavior, and argue that

> a person's attitude toward an object influences the overall pattern of her/his responses to the object, but that it need not predict any given action. According to this analysis, a single behavior is determined by the intention to perform the behavior in question. A person's intention is in turn a function of her/his attitude toward performing the behavior and her/his subjective norm. It follows that a single act is predictable from the attitude toward that act (1977:888).

Their analysis "attempts to specify the conditions under which attitudes can or can not be expected to predict overt behavior" (p.889), and finds that people's actions are related to their attitudes when the "nature of the attitudinal predictors and behavior criteria are taken into consideration" (p.889).

A cornerstone of their theory is that the components (entities) of attitudinal predictors and behavioral criteria must have correspondence with one another in order to be valid predictors of behavior. These components consist of four elements: the action, the target at which the action is directed, the context in which the action is performed, and the time at which it is performed. An attitudinal predictor is said to correspond to the behavioral criterion to the extent that the attitudinal components are identical in all four elements with the behavioral components (1977:890), and "Although in

theory correspondence is defined in terms of all four elements involved...examination of the target and action elements is sufficient" (1977:891). In this present study, the specific acts/actions represent a class of behaviors equal to 'inclusion', with the target of these behaviors being 'parents of children in foster care'.

Many studies concerning the attitude-behavior issue have obtained measures with little or no correspondence between the elements of attitudinal and behavioral entities. These studies have had inconsistent or insignificant results, which has led to inconsistent evidence that there is a significant relationship between attitude and behavior (Fishbein, 1967). "Usually studies are measured toward a class of people in general without reference to any particular action" (Fishbein and Ajzen, 1977:892). Based on Fishbein's and Ajzen's (1967, 1977, 1980) hypothesis that attitudes can be signficant predictors of behavior when the behaviors and attitudes measured are specific and related, this dissertation study will focus closely on the correspondence between target and action elements of attitudinal predictors and behavioral criteria.

In addition, Fishbein and Ajzen (1980) see intention as the immediate determinant of behavior, so that when an appropriate measure of intention is obtained, it will provide the most accurate prediction of behavior (p.41). The likelihood that a person will engage in a given behavior is termed a behavioral intention,

i.e.: I do, I do not, intend to _____.

A single action can therefore be predicted from the corresponding

'behavioral intention' (p.54) through assessing the person's attitude toward performing the behavior under consideration. Two major factors determine a person's behavioral intentions; an attitudinal component and a normative component. This idea is expressed clearly in the following diagram (Figure 1) "Factors Determining A Person's Behavior" from Fishbein and Ajzen (1980:8).

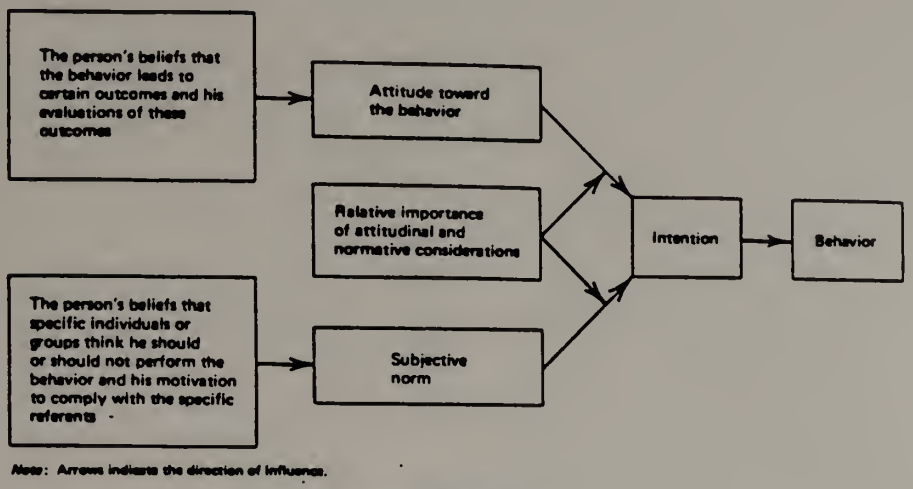


FIGURE 1
Factors determining a person's behavior.

Based on these notions, instrument items were designed to measure the correspondence between the target and action elements, i.e., examining the relationship between a person's attitude toward a specific action or behavior (such as visitation or decision making) in relation to a specific target (parents of children in foster care).

In summary, the foster care literature suggests a correlation between attitudes toward parents and service outcomes. This correlation, however, was derived from studies whose evaluative methods were not based on quantitative measures assessing specific attitudes toward specific behaviors (Jenkins and Norman, 1972, 1975; Fanshel and

Shinn, 1978; Shapiro,1976). It was important, therefore, to conduct an exploratory study of clinicians' attitudes toward the specific target of "biological parents of children in foster care," in relation to the specific class of actions (behaviors/behavioral intentions) that have been defined as "involvement and inclusion," i.e. involvement in decision making, parent-child visitation.

CHAPTER III

METHOD

This chapter includes a description of (a) the research design, (b) the sample of respondents, (c) the instrumentation and its development, (d) the procedure, and (e) the hypotheses, along with relevant means of analysis.

Research Design

The purpose of this study was to investigate the relationship between clinical orientation and clinicians' attitudes toward four other variables ascertained to be important from a review of the relevant literature: (1) general beliefs about biological parents, (2) parental inclusion in decision making, (3) parent-child visitation, and (4) family reunification. In order to accomplish this, a survey was conducted using a questionnaire developed by this researcher. This instrument consisted of five sections, with each section addressing one of the five variables mentioned above. Sections 1 through 4 measured attitudes using the semantic differential technique, with Section 5 gathering data on clinical orientation and other descriptive data about participants using multiple choice and numerically quantified items.

Chi-square analyses were used to assess items in Sections 1 through 4 of the questionnaire with the four clinical orientation measures determined from data gathered in Section 5. A fifth clinical

orientation measure was developed by this researcher to describe each respondents degree of systemic orientation, and this measure was also tested via chi-squares with questionnaire items in Sections 1 through 4.

Limitations of this Design

There are several limitations in developing an attitude survey questionnaire that uses the correlational research method. These limitations are discussed in the literature, and are listed below: (1) This kind of design can only identify possible causal relationships, therefore one cannot conclude that a particular clinical orientation leads to more favorable attitudes. This study was therefore envisioned as an initial investigation, with a future study needed to measure attitudes toward parents before and after clinical training, using experimental and control groups (Borg and Gall, 1983:408-9, 571). 2) Attitude scales are direct self-report measures which have the primary disadvantage to the researcher of never being a sure measure of the degree to which the subjects' responses reflect their true attitudes (Borg and Gall, 1983:342). Self-administered questionnaires, however, tend to minimize the effects of interviewer threat and the over-reporting of socially desireable attitudes (Bradburn and Sudman, 1979). 3) A paper and pencil questionnaire cannot replicate actual interactions, assessments and responses. Research on attitudes, however, is commonly conducted by means of paper and pencil reports using the semantic differential technique. This technique has much flexibility in its design, and due to its generality is used in a

variety of contexts, and is "probably today's most widely used attitude measuring instrument" (Fishbein and Ajzen, 1975:76). This technique has been shown to have high reliability (Tittle and Hill, 1967:213), and overall has a favorable performance in its validity as an attitude measurement (Heise, 1969; Lemon,1973). Semantic differential scaling also has the design flexibility to use self-referenced items, i.e. the use of 'I' or 'me' pronouns, which makes it more specific to the individual subject (Tittle and Hill, 1967:212).

There are, however, two areas of concern with the semantic differential technique: (a) its tendency to have response bias based on the use of extreme bipolar adjectives that influence the social desirability of certain responses (Lemon,1973:109), and b) its tendency to create a 'set' of responses due to desirable things appearing on one side of the continuum and undesirable things appearing on the other side (Tittle and Hill,1967:213; Lemon, 1973). The first concern has been minimized in this study's instrument through (a) the use of "filler adjectives to disguise the obvious purpose of the instrument as much as possible" (Lemon, 1973:109), and (b) designing questions and using adjective opposites that do not have as extreme or severe a connotation. The second concern has been addressed through frequently alternating the position of positive and negative adjectives on the scale to inhibit a 'set' of responses (Lemon, 1973).

Sample

The respondents were 148 master's and doctoral degree clinicians who provide treatment services to clients in the foster care system. These clients were defined as foster children, their biological parents/families, or foster families. The respondents were practicing in 31 agencies located in Massachusetts, and had been working with this client population in a clinical capacity within the past 12 months.

The agency sites were selected from master lists provided by the Massachusetts Association of Community Mental Health Service Providers, and the central office of the Massachusetts Department of Mental Health. These sites included community mental health centers, child guidance clinics, and other private, non-profit agencies. These agencies receive funding from state or federal grants and contracts, private third party insurance companies, Medicaid, Medicare and from fees paid directly by clients. Treatment services are provided regardless of clients' ability to pay, with foster care clients generally receiving services under a grant or contracted program, or through Medicaid.

The use of clinicians located in these community-based sites allowed for a population of respondents trained in many different clinical orientations, working with a wide range of clients and client problems. At such sites, clinicians normally spend 50% to 60% of their time providing clinical services. In Massachusetts these sites are typically the ones utilized by foster care clients and foster care referral sources due to their ability to accept Medicaid payments

for services. All children in foster care have Medicaid benefits that can be used to pay for treatment services for themselves and for their families.

In order to contact the clinicians, each of the 71 agency sites was contacted so that the sample would attain both urban and rural representation from all regions of Massachusetts. Cluster sampling was used to select these master's and doctoral degree clinicians since it was impossible to obtain a list of all members of this specific population of clinicians.

Thirty five agencies agreed to participate, with 31 sites (43.7%) returning 148 usable questionnaires. An additional 48 completed questionnaires were unusable, due to respondents' lack of graduate training, lack of experience with foster care clients within the past 12 months, or clinical training and practice orientation that was inappropriate to this study's design.

Of the 148 respondents, 93 were female and 54 were male, with one unspecified. Respondents' ages ranged from 24 to 63 years, with a mean age of 37 (see Table 1).

One hundred and twenty nine respondents (87.1%) held master's degrees, of which 77 were Master's in Social Work degrees. Seventeen held doctorates, and two had M.D. degrees. The mean length of time since obtaining their highest graduate degree was 6.8 years, ranging from "less than one year ago" to 36 years ago (see Table 2). One hundred and eight (72.9%) respondents had received the majority of their clinical training at a university or college graduate program and

34 (23.0%) on the job; the remainder had received most of their clinical training at an institute or were self-taught.

TABLE 1

FREQUENCY DISTRIBUTION OF RESPONDENTS' AGES

Age	Absolute Frequency	Adjusted Frequency	Cumulative Frequency
24-30 yrs.	26	17.8%	17.8%
31-35 yrs.	43	29.5%	47.3%
36-40 yrs.	36	24.7%	71.9%
41-45 yrs.	20	13.7%	85.6%
46-50 yrs.	14	9.6%	95.2%
51-55 yrs.	4	2.7%	97.9%
56-63 yrs.	3	2.1%	100.0%
Unspecified	2		

TABLE 2

LENGTH OF TIME SINCE OBTAINING GRADUATE DEGREE

Years Ago	Frequency
Less than 1 year	14
1 - 5	63
6 - 10	41
11 - 15	14
16 - 20	6
21 - 25	4
26 - 36	4
Unspecified	2

The mean years of clinical experience was 8.8, ranging from "one year or less" to 36 years. Respondents had worked with clients involved in foster care for a mean of 6.9 years, ranging from "less than one year" to 29 years (see Table 3). "Clients involved in foster care" were defined as foster children, or their biological parents/families, or foster families. The total number of foster care clients seen by respondents within the preceeding 12 months was 1,839; ranging from one to 200 per clinician, with a mean of 12.4 and a mode of 5, representing 19 cases (see Table 4).

TABLE 3

LENGTH OF RESPONDENTS' CLINICAL EXPERIENCE

Years	General Clinical Experience Frequency	Foster Care Experience Frequency
1 yr. or less	7	13
1 yr. 1 mo. to 5 yrs.	45	52
5 yrs. 1 mo. to 10 yrs.	48	56
10 yrs. 1 mo. to 15 yrs.	29	14
15 yrs. 1 mo. to 20 yrs.	12	9
20 yrs. 1 mo. to 25 yrs.	4	1
25 yrs. 1 mo. to 36 yrs.	3	2
Unspecified		1

TABLE 4

NUMBER OF FOSTER CARE CLIENTS SEEN BY RESPONDENTS IN PREVIOUS 12 MONTHS

# Of Clients	Absolute Frequency	Relative Frequency	Cumulative Frequency
5 or Less	72	48.6%	48.6%
6 - 10	41	27.7%	76.3%
11 - 15	13	8.8%	85.1%
16 - 20	7	4.7%	89.8%
21 - 50	9	6.1%	95.9%
75 - 200	6	4.1%	100.0%
1,839 Total Clients	148		

The primary clinical orientation of respondents' graduate training had been 73.6% intrapsychic, and 26.4% systemic. Their current primary practice orientation was reported as 61.2% intrapsychic and 38.8% systemic. A secondary practice orientation was reported by 72.3% of the respondents. Of these, 30.8% reported an intrapsychic orientation, 43.0% reported a systemic orientation, and 26.2% reported other orientations. Of the 91.2% of respondents that reported on the clinical orientation of their postgraduate training, 43.2% reported intrapsychic training, 43.2% systemic training, and 4.7% training in other orientations (see Table 5).

TABLE 5

DISTRIBUTION OF CLINICAL ORIENTATION FOR FOUR ORIENTATION VARIABLES

1. **Graduate Training Orientation** (N= 148)

Orientation	Absolute Frequency	Adjusted Frequency	Overall Orientation
Psychodynamic	86	58.1%	
Psychoanalytic	23	15.5%	Intrapsychic 73.6%
Ecological	14	9.5%	
Systemic	25	16.9%	Systemic 24.4%

2. **Primary Practice Orientation** (N= 147)

Orientation	Absolute Frequency	Adjusted Frequency	Overall Orientation
Psychodynamic	77	52.4%	
Psychoanalytic	13	8.8%	Intrapsychic 61.2%
Ecological	11	7.5%	
Systemic	46	31.3%	Systemic 38.3%

TABLE 5 --- Continued

3. **Secondary Practice Orientation** (N= 107)

Orientation	Absolute Frequency	Adjusted Frequency	Overall Orientation
Psychodynamic	26	24.3%	
Psychoanalytic	7	6.5%	Intrapsychic 30.8%
Ecological	5	4.7%	
Systemic	41	38.3%	Systemic 43.0%
Cognitive	8	7.5%	
Behavioral	8	7.5%	Other 26.2%
Other	12	11.2%	

4. **Postgraduate Training Orientation** (N= 135)

Orientation	Absolute Frequency	Adjusted Frequency	Overall Orientation
Psychodynamic	52	38.5%	
Psychoanalytic	12	8.9%	Intrapsychic 47.4%
Ecological	1	.7%	
Systemic	63	46.7%	Systemic 47.4%
Other	7	5.2%	Other 5.2%

The four clinical orientation items just mentioned (questionnaire items 5.9, 5.10, 5.11, 5.13), were used to develop a scale for assigning a "systemic orientation score" to each respondent. The development of this scale is discussed more fully in the Hypotheses section of this chapter (see Table 7, Systemic Orientation Scale: Scoring). These scores ranged from 0 to 5, with zero equal to 'not at all systemic' and five equal to 'totally systemic'. These six scores were reduced into three groupings: (1) zero and one were combined into the category "little or no systemic orientation"; (2) scores two and three were combined into the category "some systemic orientation"; and (3) scores four and five were combined into the category "primary systemic orientation" (see Table 6).

TABLE 6
FREQUENCY DISTRIBUTION OF SYSTEMIC SCORE

Score	Absolute Frequency	Relative Frequency	Combined Relative Frequency
	Little Or No Systemic Orientation		
0	43	29.0%	
1	26	17.6%	46.6%
	Some Systemic Orientation		
2	25	16.9%	
3	25	16.9%	33.8%
	Primary Systemic Orientation		
4	20	13.5%	
5	9	6.1%	19.6%

Discussion of demographics. This group of clinicians were characterized by extensive exposure to and practice with foster care clients. They averaged 8.8 years of clinical experience and 6.9 years of foster care experience, working with an average of 12 foster care clients within the previous 12 months. The amount of experience specific to the parent population under investigation can not be discerned from the data collected. It can be assumed, however, that foster care clinicians must conceptually consider the existence of biological parents of children in care, even if they do not actually work with them directly.

The vast majority of respondents (73.6%) received graduate clinical training in intrapsychic orientations, with 26.4% reporting systemic graduate clinical training. This reflects the assertions of foster care critics that intrapsychic concepts underlie the provision of foster care services (Germain, 1979; Laird, 1979; Morisey, 1970; Stone, 1970).

Respondents current primary clinical orientation was reported as 61.2% intrapsychic and 38.8% systemic. For intrapsychic clinicians, this is a 12% drop from the number that had reported intrapsychic graduate training; and for systemic clinicians, this is a 12% increase in the number that had reported systemic graduate training. This shift is reflective of a trend in the data showing that clinicians are primarily trained in intrapsychic theory in graduate school; maintain an intrapsychic orientation as their current practice orientation, with 12% shifting to a systemic practice orientation; continue this shift

with 43.0% reporting a systemic secondary practice orientation and 30.8% reporting an intrapsychic secondary orientation; and concluding with equal percentages reporting systemic (47.4%) and intrapsychic (47.4%) postgraduate clinical training. This trend is possibly reflective of the influence of ecological and systemic training programs in this region (University of Connecticut School of Social Work and Univerity of Massachusetts School of Education), as well as ecologically oriented foster care theoreticians in this region (Germain, 1979; Maluccio and Sinanoglu, 1981a, 1981b).

Instrumentation

This section will be divided into two parts that provide: (1) an overview of the development of the instrument, and (2) a description of its components. For additional clarification, please see Appendix A: The Study Instrument.

Research begun two decades ago on foster care workers' perceptions of parents was the only literature available to have addressed the issue of how parents of children in care are perceived (Fanshel and Shinn, 1978; Gruber, 1973,1978; Jenkins and Norman, 1972,1975; Shapiro, 1976). This previous research was conducted through interviews and reviewing case reports, and examined a different subject sample of untrained direct service workers that did not provide treatment services. Additionally, in a review of the attitude and perception literature there were also no appropriate instruments

available to assess clinicians' attitudes toward this client population (Robinson and Shaver,1973; Shaw and Wright, 1967). Due to the lack of an already existing instrument, a survey questionnaire was specially designed for this study.

Development of the Instrument

A two stage process that consisted of pilot testing instrument #1, and then revising and retesting instrument #2 was used. Instrument #1 (N=7), was tested in December 1985 and consisted of 18 typed pages on 8 X 11 inch paper. It was sent to nine graduate level foster care clinicians working in community mental health settings. These participants were selected for their years of experience, their varying clinical orientations, and the variety of their therapeutic roles with this client population.

These nine clinicians were asked for suggestions and criticisms regarding the content and format of pilot instrument #1, and were asked to comment on anything unclear or problematic. This researcher requested these suggestions both by phone and in the cover page of the initial instrument. Clinicians were asked to write their comments or suggestions on their questionnaire. Seven of these initial pilot instruments were returned.

Comments and suggestions made were reviewed, and based upon information gathered from the initial instrument several changes were made in the design of instrument #2. These changes are as follows: (1) The questionnaire was shortened. Pilot instrument #1 took respondents 1 to 1 1/2 hours to complete. In order to maximize the

return rate, it was important that the final pilot #2 instrument take 15-20 minutes to complete. Many original items were eliminated as they were extraneous, repetitive or irrelevant to the focus of the study.
(2) Several items were initially unclear to respondents. These were re-worked to assure their focus was on specific "beliefs about" and "behavioral intentions toward" parents of children in care (Fishbein and Ajzen, 1975,1980). All items for final inclusion address one or both of these indicants of attitudes, focusing on four significant variables: parents, parental involvement in decision making, parent-child visitation, and family reunification.
(3) In the revised pilot instrument #2, five distinct sections were developed to address each of the five variables under study.

Pilot instrument #2 was tested in May of 1986 (N=6), and consisted of eight typed pages on 8 X 11 inch paper. There were 34 numbered questions, consisting of semantic differential scales, an eight item grid, multiple choice questions and blanks for numerically quantified responses, making up a total of 63 items. It was distributed to 6 graduate level foster care clinicians who were each timed to assure the questionnaire could be completed in a 15-20 minute time period. These 6 participants were interviewed regarding each of the items contained in pilot instrument #2, and were asked for comments, suggestions and criticisms. Based on responses to instrument #2, several areas of the instrument were modified. These modifications are as follows:

1) Adverbs were used in conjunction with several of the semantic

differential scales, i.e. extremely, quite, slightly, neutral. It was hoped that the use of a midpoint labeled "neutral" would limit the number of midpoint responses based on a response set.

(2) It was suggested that the instructions at the beginning of the questionniare address the issue of the broad and varied range of foster care cases clinicians work with. It was hoped that this would focus respondents on their 'general' attitudes toward parents of children in care, rather than on 'specific' attitudes toward particular clients.

(3) In Section 1 of the instrument, which measured beliefs about parents, it was suggested that the questions be phrased in the past tense, so that responses would be based upon clinicians' experience, rather than on what they might have liked to have occurred.

These suggestions were incorporated into the final instrument, which is described in the following part of this chapter.

Description of the Instrument

The final instrument consisted of 63 questions reproduced at 79% reduction to fit on both sides of two sheets of 8" X 11" white paper. These two sheets of paper were folded in half and stapled in the center to create an eight sided booklet format consisting of the cover page and 7 numbered pages of questions. (See Appendix A: The Study Instrument).

Section 1 investigated clinicians' general beliefs about and attitudes toward biological parents of children in care. This section contained three main items for measuring clinicians' beliefs about:

(a) the negative or positive influence of parents on their children; (b) parents' importance or unimportance to the growth and development of their child; and (c) parents' capabilites. In order to disguise the primary focus of the first two items, inquiry was also made about the influence and importance of significant other people, i.e. foster parents, case worker, therapist. The third item consisted of seven pairs of adjective opposites, i.e. helpful/harmful, to ascertain clinicians' attitudes toward parents' capabilities.

Section 2 consisted of three semantic differential formats measuring clinicians' attitudes toward parental inclusion in decision making. The first format was designed as an eight question grid addressing four foster care service decisions, i.e. placement, visitation, return home. For each decision listed, information was requested about: (a) how strongly clinicians felt that parents should be invited to attend meetings where these decision were being made and/or discussed; and (b) how strongly they felt that parents should influence these decisions. The second format contained four items and used the semantic differential technique to gather data on (a) clinicians' perceptions of parental input, i.e. helpful/harmful, and (b) how satisfied they generally were with the decisions parents made. The third format consisted of two items to assess clinicians' normative beliefs regarding parental inclusion in decisions.

Section 3 contained nine items and measured clinicians' attitudes toward visitation, as well as gathered data on the frequency of parent-child contact generally recommended by respondents. Item 1 gathered

data on how much contact clinicians think parents want with their children, and item 2 gathered data on how much contact clinicians generally recommend. Items 3 and 4 were multiple choice questions used to numerically quantify the frequencies associated with the previous two items. Items 5-7 gathered data on clinicians' attitudes toward parent-child contact, and item 8 measurd clinicians' intentions to encourage contact. Item 9 assessed clinicians' normative beliefs about encouraging visitation.

Section 4 gathered data on clinicians' attitudes toward family reunification, and contained eleven items. Item 1 measured clinicians' attitudes toward parents' abilities to provide a home for their child/children. Items 2-7 consisted of six pairs of adjective opposites measuring clinicians' attitudes toward reunification, i.e. desireable, valuable. Items 8 and 9 inquired about the percentage of cases in which clinicians recommended a child return or not return home. Item 10 gathered data on the frequency of clinicians' intentions to encourage reunification and item 11 investigated clinicians' normative beliefs about reunification.

Section 5 consisted of 13 items and gathered data on clinicians' clinical orientation, as well as descriptive data about respondents. Five items measured clinicians' clinical orientation. These items requested clinicians to report (a) the clinical orientation of their graduate training; (b) the primary clinical orientation they use in their practice; (c) the secondary orientation they use, if any; (d) the orientation of training they have received since completion of

their graduate degree; and (e) the one or two clinical authors that have most influenced their treatment practice. Descriptive data gathered in this section referred to respondents' sex, age, highest graduate degree attained, year degree attained, years of clinical experience, years of experience with foster care clients, number of foster care cases in the past twelve months, and where they received the majority of their clinical training.

Procedure

The procedure used to conduct this study was an adaptation of Dillman's (1978) Total Design Method. Dillman's method for mail surveys focuses on stimulating the response rate, and is based on an eight week time frame for the implementation and completion of the research process. Dillman's method was modified as follows:

(1) At each of the 71 sites, the executive directors or clinical directors were initially contacted through an introductory recruitment letter (Appendix B: Study Correspondences). At agencies that had more than one site or more than one program, each received this introductory letter, totaling 80 letters mailed to 71 agencies. Each introductory letter contained a self-addressed stamped postcard (Postcard #1, Appendix B), to be returned to this researcher within one week, requesting the following information: (a) the approximate number of master's and doctoral level clinicians on staff that worked with foster care clients; (b) the agency contact person to whom questionnaires

should be sent for distribution and collection, (c) the agency person to contact if a presentation about this research project was desired, (d) the agency person to contact if further information was desired regarding implementation of this study; and (e) a place to check off designating that the agency would not participate in the study. So as to clearly identify these return postcards, each was coded with an agency site number [#1-#71].

Recruitment letters and return postcards were remailed to those that did not respond, with a maximum repetition of three mailings, three weeks apart. This resulted in a response from 60 of the 71 agencies contacted. Of these 60 agency site respondents, 35 agencies agreed to participate in the study. Of the 25 agencies that did not participate, the primary reason stated for not participating was the lack of a foster care client population at the given site.

Additionally, as a result of suggestions from agency directors, the return date for questionnaires was extended to September 1, 1986, rather than the initial deadline of August 1.

(2) For those agencies that indicated on the return postcard how many staff worked with foster care clients, and to whom questionnaires should be sent, questionnaires were mailed to the designated contact person. Instructions, consent forms, and a self-addressed stamped return envelope were also included (See Appendix B).

(3) For those agencies that requested a presentation, arrangements were made for this researcher to attend a staff meeting and distribute the survey. Clinicians were then asked to fill out the

15-20 minute questionnaire and briefly told that the purpose of the study was to get their opinions about important foster care issues. The completed questionnaires were then collected by this researcher, with this personal contact, as well as the elimination of a time lag between receiving and returning the questionnaires, positively affecting the return rate. At the six sites where questionnaires were distributed and collected, approximately 95% of those present completed the questionnaire. This resulted in 62 completed questionnaires collected in this manner (31.6% of the total 196 questionnaires returned);

(4) Two weeks prior to the return deadline of September 1, a Thank you/Reminder Postcard (Appendix B) was mailed to all 29 agencies that had received questionnaires in the mail, thanking them for participating in the study and requesting questionnaires be returned by the September 1 deadline.

(5) To the six sites that did not return their questionnaires during the week following the September 1 deadline, a Reminder Letter (Appendix B) was sent. This resulted in one agency returning their completed questionnaires;

(6) The remaining 5 agency sites that had not returned questionnaires were contacted by phoned. This resulted in 2 agencies returning completed questionnaires, and one agency returning uncompleted questionnaires that had not been distributed. Two sites did not return any questionnaires even though they had agreed to participate in the study.

Thus, 31 of the 35 participating agency sites returned 196

completed questionnaires. Of this total number of completed questionnaires, 148 were usable, with 48 unusable due to respondents' lack of graduate training, lack of experience with foster care clients, or lack of a clinical orientation appropriate to the design of this research.

The following part of this chapter describes the hypotheses, and discusses the development of a systemic orientation scale used to analyse the data.

Hypotheses

This study investigated four hypotheses. These hypotheses were derived from the foster care literature that highlights problems in services to biological parents, and suggests that clinical orientation is important in relation to these long standing problems. The literature has suggested (a) that traditional intrapsychic theory has limited usefulness and possibly a destructive influence on services to families involved in foster care (Goldstein,1979; Herstein,1970; Minuchin,1970; Morisey,1970); and (b) that systemic perspectives more adequately address foster care's complexities (Germain,1979; Laird,1979; Maluccio 1981a; Minuchin,1970).

The hypotheses focus on clinical orientation, and speculate that clinicians with training in systemic perspectives, or who use a systemic perspective in their practice, will report more positive attitudes toward the four foster care target problem areas that were

investigated in this study. The hypotheses are as follows:

Hypothesis 1

Clinicians with graduate training in systemic theory will report more positve attitudes toward: (a) parents of children in foster care; (b) parental involvement in decision making; (c) parent-child visitation; and (d) family reunification.

Hypothesis 2

Clinicians with a systemic primary practice orientation will report more positive attitudes toward all four target problem areas (see Hypothesis 1).

Hypothesis 3

Clinicians with a systemic secondary practice orientation will report more positive attitudes toward all four target problem areas.

Hypothesis 4

Clinicians with postgraduate training in systemic theory will report more positive attitudes toward all four target problem areas.

In summary, these four hypotheses were tested in Sections 1 though 5 of the instrument. Items in Sections 1 through 4 addressed the four major problem areas involving clinicians' attitudes towards parents and parental involvement, and were tested using chi-square analyses with the four clinical orientation variables measured in Section 5 of the instrument. In addition, responses in Section 5 were used to develop a systemic orientation scale that will be discussed in

the following section of this chapter.

Development of the Systemic Orientation Scale

In order to test the hypotheses and analyse the data, a scale was developed to measure each respondent's degree of systemic orientation. It should be noted that all responses indicating either a systemic, an ecological, or a family systems orientation were considered to be "systemic". The scoring of the Systemic Orientation Scale was based on responses to items 5.9, 5.10, 5.11 and 5.13 in Section 5 of the instrument (Table 7). These items in Section 5 were used as the determinants of clinical orientation for the four hypotheses tested in this study. Chi-square analysis was used to examine the "systemic score" with attitude items in Sections 1-4 of the instrument.

The Systemic Orientation Scale was based on respondent's self-report of the clinical orientation (1) of their graduate training (item 5.9); (2) they primarily use in their practice (item 5.10); (3) they secondarily use in their practice (item 5.11); and (4) of any training they'd received since completing their graduate degree (item 5.13). These four clinical orientation items were each assigned points and then totaled to yield a final score representing the extent of respondents' systemic exposure and the degree of their systemic orientation.

The final scores ranged from 0 to 5, with 0 = no systemic orientation, and 5 = primary systemic orientation. Points were assigned

to each of the four questionnaire items previously discussed in the following manner:

(1) For all four items, only those responses that indicated a systemic orientation, i.e. ecological or systemic, were assigned points. Any other responses were assigned no points. Blank items were assigned no points, with the exception of item 5.11 which is described below in #4.

(2) Item 5.9, which requested information on the clinical orientation of respondents' graduate training, was assigned 1 point.

(3) It was decided that item 5.10, which asked clinicians to report the primary clinical orientation they now use in their practice, described clinicians' most salient orientation, and this item's response would receive 2 points if a systemic orientation was reported.

(4) Item 5.11, which requested information on clinicians' secondary practice orientation, was assigned 1 point. If this item was left blank, and the respondent had answered item 5.10 (Primary Practice Orientation) with a systemic response, 1 point was added into the "systemic score". This calculation was based on the assumption that this configuration suggested the respondent was strongly committed to a systemic orientation and did not employ any other secondary clinical orientation.

(5) Item 5.13, which requested information on the clinical orientation of any postgraduate training received, was assigned 1 point if a systemic orientation was indicated. Please refer to Table 7 on the following page.

TABLE 7

SYSTEMIC ORIENTATION SCALE: SCORING

Item 5.9 Graduate Training Orientation	Item 5.10 Primary Practice Orientation	Item 5.11 Secondary Practice Orientation	Item 5.13 Postgraduate Training Orientation	Total Systemic Score
1 Point	2 Points	1 Point, or if blank and item 5.10 was reported as Systemic, 1 Point is added to Systemic Score.	1 Point	Range of Scores 0 to 5

Scoring Examples: Orientation Responses and Points Assigned

Item 5.9 Graduate Training	Item 5.10 Primary Practice	Item 5.11 Secondary Practice	Item 5.13 Postgraduate Training	Total Score
Example A				
Psychoanalytic Assigned 0 pt.	Psychodynamic Assigned 0 pt.	Systemic Assigned 1 pt.	Systemic Assigned 1 pt.	2
Example B				
Psychodynamic Assigned 0 pt.	Systemic Assigned 2 pts.	Psychodynamic Assigned 0 pts.	Systemic Assigned 1 pt.	3
Example C				
Ecological Assigned 1 pt.	Ecological Assigned 2 pts.	Blank Assigned 1 pt.	Psychodynamic Assigned 0 pt.	4

Summary

This chapter presented four hypotheses relating to the interaction of systemic clinical orientation with beliefs about parents of children in foster care and attitudes toward parental involvement in services. A design for a quantified, instrumented study of master's and doctoral level foster care clinicians was presented. The sample, the instrument and its development, procedures, and the development of a systemic orientation scale to be used in analysing the data were described.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter is divided into two main sections. In the first section, data relevant to the hypotheses are presented for each orientation variable in the four problem areas under investigation: clinicians' attitudes toward (a) parents of children in foster care; (b) parental involvement in decision making; (c) parent-child visitation; and (d) family reunification. Items in each of these areas were analyzed by chi-square with the four clinical orientation variables. After presenting findings for each hypothesis, results and discussion will be presented for chi-square tests with the systemic score.

In the second section of this chapter, trends in the data are presented and discussed. Means and standard deviations for each questionnaire item by orientation variable and systemic score are presented in Appendix C.

Hypotheses

Hypothesis 1:

Clinicians with graduate training in systemic theory will report more positive attitudes toward: (a) biological parents of children in foster care; (b) parental involvement in decision making; (c) parent-child visitation; and (d) family reunification.

Data on the orientation of clinicians' graduate training were gathered in item 5.9 of the questionnaire. Those subjects who responded to this item with a systemic orientation (N= 39) were compared with those having an intrapsychic (N= 109) orientation. No statistically significant differences were found for any of the four problem areas. Thus, the findings do not support Hypothesis 1.

Hypothesis 2:

Clinicians with a systemic primary practice orientation will report more positive attitudes toward the four target problem areas.

Data on clinicians' primary practice orientation were gathered in item 5.10 of the questionnaire. Only data from clinicians reporting a systemic (N= 57) or an intrapsychic (N= 90) orientation were analyzed. Two items described below were found to support the hypothesis that systemic clinicians had more positive attitudes. This hypothesis has only limited acceptance due to the limited number of items that showed

significance. Please refer to Table 8: Relation of Primary Practice Orientation and Attitudes, on the following page.

(a) General attitudes toward parents: no statistically significant differences were found.

(b) Attitudes toward parental involvement in decision making: Item 2.3 requested respondents to rate their satisfaction with the decisions parents make about foster care. For this item, 40.4% of the systemic and 34.8% of the intrapsychic clinicians reported satisfaction with the decisions biological parents make. Conversely, only 15.8% of the systemic clinicians and 41.6% of the intrapsychic clinicians reported dissatisfaction with these decisions. (Chi-square = 12.15 with 2 degrees of freedom, p= .002).

(c) Attitudes toward parent-child visitation: Item 3.3 requested respondents to quantify what they believed to be frequent contact between parents and their children in foster care; 59.6% of the systemic clinicians chose the category of highest frequency (contact two times a week), while 41.6% of the intrapsychic clinicians chose this category. (Chi-square = 8.72 with 3 degrees of freedom, p= .03).

(d) Attitudes toward family reunification: no statistically significant differences were found.

TABLE 8
HYPOTHESIS 2: RELATION OF PRIMARY PRACTICE AND ATTITUDES
Chi-squares, Means and Standard Deviations

Attitude Areas	Significant Items	Chi-square	df	p	Group	n	M	SD
Parents	None							
Decision Making	#2.3 Satisfaction	12.15	2	.002				
					Systemic	57	4.42	1.19
					Intrapsychic	89	3.84	1.42
Visitation	#3.3 Frequent Contact	8.72	3	.03				
					Systemic	57	6.51	.71
					Intrapsychic	89	6.39	.54
Reunification	None							

Hypothesis 3:

Clinicians with a systemic secondary practice orientation will report more positive attitudes toward the four target problem areas.

Data on clinicians' secondary practice orientation were gathered in item 5.11. Only data from clinicians reporting a systemic (N= 46) or an intrapsychic (N= 33) orientation were analyzed. In two problem areas, five items described below were found to support the hypothesis that systemic clinicians have more positive attitudes toward parents and parental involvement in decision making. Please refer to Table 9: Relation of Secondary Practice Orientation and Attitudes.

(a) General attitudes toward parents: Item 1.3a requested respondents to rate parents as being capable or incapable of being parents. Of the systemic respondents, 44.2% reported positive attitudes toward parents' capabilities, while only 19.4% of the intrapsychic clinicians reported positive attitudes. (Chi-square= 5.68 with 2 degrees of freedom, p=.05).

Item 1.3c requested respondents to rate parents as helpful or harmful. Of the systemic respondents, 44.4% reported positive attitudes toward parents' helpfulness, while only 9.1% of the intrapsychic clinicians reported positive attitudes. (Chi-square= 11.49 with 2 degrees of freedom, p=.003).

(b) Attitudes toward parental involvement in decision making: Item 2.2c asked respondents whether they found involving parents in decisions stabilizing or disruptive. Twice as many systemic clinicians

(60.9%) reported parents were stabilizing as did the intrapsychic group (30.3%). (Chi-square= 7.21 with 2 degrees of freedom, p=.02).

Item 2.3 requested respondents to rate their satisfaction with the decisions parents make about foster care. (See previous discussion of this item under Hypothesis 2). In this cross-tabulation 41.3% of the systemic clinicians reported satisfaction with the decisions parents make, while only 27.3% of the intrapsychic clinicians reported satisfaction. (Chi-square = 10.37 with 2 degrees of freedom, p=.005).

Item 2.5 measured clinicians' normative beliefs regarding whether parents' thought they should be included in the planning of foster care services. In this cross-tabulation 95.6% of the systemic clinicians and 78.8% of the intrapsychic clinicians reported that parents thought they should be included. (Chi-square= 6.05 with 2 degrees of freedom, p=.04).

(c) Attitudes toward parent-child visitation: no statistically significant differences were found.

(d) Attitudes toward family reunification: no statistically significant differences were found.

TABLE 9
HYPOTHESIS 3: RELATION OF SECONDARY PRACTICE AND ATTITUDES
Chi-squares, Means and Standard Deviations

Attitude Areas	Significant Items	Chi-square	df	p	Group	n	M	SD
Parents	#1.3a Capable	5.68	2	.05				
					Systemic	43	3.84	1.56
					Intrapsychic	31	2.97	1.38
	#1.3c Helpful	11.49	2	.003				
					Systemic	45	4.02	1.37
					Intrapsychic	33	3.09	1.07
Decision Making	#2.2c Stabilizing	7.21	2	.02				
					Systemic	46	4.83	1.48
					Intrapsychic	33	3.88	1.29
	#2.3 Satisfied	10.37	2	.005				
					Systemic	46	3.91	1.40
					Intrapsychic	33	4.15	1.30
	#2.5 Parents Think	6.05	2	.04				
					Systemic	45	6.29	1.12
					Intrapsychic	33	5.85	1.20
Visitation	None							
Reunification	None							

Hypothesis 4:

Clinicians with postgraduate training in systemic theory will report more positive attitudes toward the four target problem areas.

Data on clinicians' postgraduate training were gathered in item 5.13. Only data from clinicians reporting a systemic (N= 64) or an intrapsychic (N= 64) orientation were analyzed. This hypothesis was strongly supported in the area of family reunification, with five out of the 11 items in this area found to be significant. Please refer to Table 10: Relation of Postgraduate Training Orientation and Attitudes.

(a) General attitudes toward parents: no statistically significant differences were found.

(b) Attitudes toward parental invovlement in decison making: no statistically significant differences were found.

(c) Attitudes toward parent-child visitation: no statistically significant differences were found.

(d) Attitudes toward family reunification: Item 4.2a asked clinicians whether they believed family reunification to be usual or unusual. For this item, 67.2% of the systemic clinicians and 43.5% of intrapsychic clinicians believed reunification to be usual. (Chi-square= 7.13 with 2 degrees of freedom, p=.02).

Item 4.2b requested clinicians to rate whether they believed family reunification to be possible or impossible. For this item, 85.7% of the systemic clinicians and 65.1% of the intrapsychic clinicians believed reunification to be possible. (Chi-square= 7.44 with 2 degrees of freedom, p= .02.)

Item 4.2c asked clinicians whether they believed reunification to be important or unimportant. For this item, 87.5% of the systemic and 65.1% of the intrapsychic clinicians reported positive attitudes toward its importance. (Chi-square= 10.01 with 2 degrees of freedom, p=.006).

Item 4.2d asked clinicians whether they believed reunification to be valuable or worthless. For this item, 90.6% of the systemic and 71.4% of the intrapsychic clinicians reported positive attitudes toward its value. (Chi-square= 7.67 with 2 degrees of freedom, p= .02).

Item 4.6 measured clinicians normative beliefs regarding whether their colleagues, whose opinions they valued, thought they should encourage reunification. For this item, 69.8% of the systemic and 48.4% of the intrapsychic clinicians believed their colleagues supported their encouraging reunification. (Chi-square= 6.05 with 2 degrees of freedom, p= .04).

TABLE 10
HYPOTHESIS 2: RELATION OF POSTGRADUATE TRAINING AND ATTITUDES
Chi-squares, Means and Standard Deviations

Attitude Areas	Significant Items	Chi-square	df	p	Group	n	M	SD
Parents	None							
Decision Making	None							
Visitation	None							
Reunification	#4.2a Usual	7.13	2	.02	Systemic	64	4.75	1.30
					Intrapsychic	62	4.02	1.56
	#4.2b Possible	7.44	2	.02	Systemic	63	5.37	1.05
					Intrapsychic	63	4.84	1.26
	#4.2c Important	10.01	2	.006	Systemic	64	5.80	.96
					Intrapsychic	63	4.98	1.58
	#4.2d Valuable	7.67	2	.02	Systemic	64	5.86	1.02
					Intrapsychic	63	5.14	1.37
	#4.6 Colleagues Think	6.05	2	.04	Systemic	63	5.14	1.40
					Intrapshycic	62	4.52	1.39

In the following part of this section, results for chi-square tests with the created systemic score will be presented. This will be followed by a discussion of the results for the hypotheses and systemic score.

Systemic Score

As previously discussed in Chapter III, the four orientation variables in Section 5 of the instrument were combined to yield a score representing each respondents' degree of systemic orientation. This score was then analysed with all items in Sections 1 through 4 of the questionnaire to test the overarching supposition that clinicians with a systemic theory orientation will report more positive attitudes.

Only significant findings on clinicians in the "Little or No Systemic Orientation" group (N=69, score of 0 or 1), and the "Primary Systemic Orientation" group (N=29, score of 4 or 5) are reported. Please refer to Table 11: Relation of Systemic Score and Attitudes. In two foster care problem areas, four items were found to support this overarching research supposition.

(a) General attitudes toward parents: no significant differences were found.

(b) Attitudes toward parental involvement in decision making: no significant differences were found.

(c) Attitudes toward parent-child visitation: Item 3.3 requested respondents to quantify what they believed to be frequent contact between parents and their child/children, with 55.2% of the "Primary

Systemic" group choosing the category of highest frequency (contact two times a week), while 38.2% of the "Little or No Systemic" group chose this category. (Chi-square= 15.5 with 6 degrees of freedom, p= .01). This item was also found to be significant in testing Hypothesis 2 (p= .03), where there was a similar difference (18%) between the intrapsychic and systemic groups.

(d) Attitudes toward family reunification: As in the testing of Hypothesis 4, this area had the largest number of significant findings.

Item 4.2b asked clinicians whether they believed family reunification was possible or impossible. For this item 82.1% of the "Primary Systemic" group and 69.1% of the "Little or No Systemic" group believed reunification to be possible. (Chi-square= 13.94 with 4 degrees of freedom, p= .007). This item was found to be significant at the .02 level in testing Hypothesis 4.

Item 4.2f measured the positivity of clinicians' beliefs regarding the desireability or undesireability of reunification. For this item 93.1% of the "Primary Systemic" group, and 66.2% of the "Little or No Systemic" group believed reunification was desireable. (Chi-square = 9.24 with 4 degrees of freedom, p= .05).

Item 4.6 measured clinicians' normative beliefs regarding whether their colleagues thought they should encourage reunification. For this item, 69% of the "Primary Systemic" group, and 49.3% of the "Little or No Systemic" group reported positive attitudes. (Chi-square= 10.30 with 4 degrees of freedom, p=.03). This item was also found to be significant at the .04 level in testing Hypothesis 4.

TABLE 11
HYPOTHESIS 2: RELATION OF SYSTEMIC SCORE AND ATTITUDES
Chi-squares, Means and Standard Deviations

Attitude Areas	Significant Items	Chi-square	df	p	Group	n	M	SD
Parents	None							
Decision Making	None							
Visitation	#3.3 Frequent Contact	15.5	6	.01				
					Primary	29	6.38	.86
					Little/No	68	6.35	.54
Reunification	#4.2b Possible	13.94	4	.007				
					Primary	28	5.39	1.32
					Little/No	68	4.90	1.22
	#4.2f Desireble	9.24	4	.05				
					Primary	29	5.86	1.22
					Little/No	68	5.03	1.44
	#4.6 Colleagues Think	10.30	4	.03				
					Primary	29	5.00	1.79
					Little/No	67	4.58	1.30

Discussion of Findings for Hypotheses and Systemic Score

Significance was found for three of the four hypotheses, and for the systemic score that was created and assigned to each respondent. Overall, the data support the hypotheses and confirm predictions regarding the greater positivity of systemic clinicians. The strongest support was found in the area of family reunification that contained eight out of the 16 significant items reported.

Results differed from predictions for Hypothesis 1 in which no significant differences were found between the systemic and intrapsychic groups. The number of respondents who had received systemically oriented graduate training (N=39) was so small as to produce a statistically insignificant number of respondents, thereby providing a possible explanation for the inconsistency. This finding may also attest to the greater influence of training received more recently than in graduate school, since respondents reported completing their graduate degree a mean of 6.8 years ago. This is supported by the fact that an equal number of respondents reported receiving systemic (N=64) and intrapsychic (N=64) postgraduate training, which was the variable that had the largest number of significant items, showing the greatest positive influence of systemic training on attitudes.

For Hypotheses 2 and 3, regarding the positivity of a systemic primary practice and secondary practice orientation on clinicians' attitudes toward parental involvement in decision making, systemic clinicians more frequently were satisfied with the decisions parents made. Additionally, for the secondary practice orientation variable,

systemic clinicians found parental involvement to be stabilizing, and believed parents thought they should be involved in decision making. The significance of these particular items confirm predictions regarding systemic clinicians' greater positivity toward parental involvement. Contrary to expectation, however, systemic clinicians did not report significantly greater positivity toward parents being invited to attend meetings or influence foster care decisions discussed or decided at such meetings.

For primary practice (Hypothesis 2) and the assigned systemic score, systemic respondents when asked to quantify frequent contact between parents and children chose the category of highest frequency. This confirms predictions regarding the greater positivity of systemic clinicians toward parent-child visitation, and supports speculations in the literature regarding the influence of a systemic theory orientation on: (a) promoting the parent-child relationship (Morisey, 1970); and (b) not seeing parents as a destructive influence or a locus of pathology (Goldstein, 1979; Laird, 1979; Maluccio, 1981a; Minuchin, 1970).

In addition, speculations in the literature had suggested that a systemic orientation would encourage an interactional perspective that views the child and parents in an environmental context (Minuchin, 1970; Stein, Gambrill and Wiltse, 1978), and take a more blame-free view of parents (Bloomfield, 1982; George, 1970; Goldstein, 1979). This research supports these speculations and the previous findings in the literature regarding the connection between frequent visitation and

more frequent return home (Fanshel and Shinn, 1978; Gruber, 1973, 1978; Maas and Engler, 1959).

Findings from this study point to a strong connection between a systemic orientation and whether one supports both frequent visitation and family reunification. The greatest number of significant items were found for systemic clinicians in the family reunification area for the postgraduate and systemic score orientation variables. Given systemic clinicians' strong positivity toward frequent visitation and family reunification's possibleness, usualness, importance, value, desireability and colleagial support for same, there is strong evidence to support this association.

Additionally, the systemic score proved to be a valid way to reduce the data by collapsing the four orientation variables into a single variable. It reflected findings similar to those found for the four separate orientation variables, and was one additional way to assess the relationship between the positivity of attitudes and clinical orientation. One of the limitations of the systemic score, however, may be the inclusion of the graduate training variable into the score's calculation. This variable showed no significant findings, and is possibly the least significant orientation variable due to respondents' limited exposure to systemically oriented graduate training, as well as its temporal position in relation to respondents' more recent trainings.

Additional Findings: Trends in the Data

Based on the overarching supposition that clinicians with a systemic orientation will report more positive attitudes toward biological parents and their involvement in decision making, visitation or reunification, there are meaningful trends in the data to report. These trends also support speculations in the literature regarding the potential impact of a systemic perspective on the long standing foster care problems in services to parents and whole families.

The consistency of these trends, as well as their magnitude, strengthen the argument that there is a relationship between positive attitudes and a systemic orientation. While statistical findings do not reflect or show these trends to any great extent, possibly with a larger sample more significance would be found. It is important, however, to report on these trends and patterns in the data as they are particularly meaningful to the central supposition of this study.

These trends were analysed by cross-tabulating the four clinical orientation variables and the systemic scores assigned to each respondent, with attitude responses for each of the items in Sections 1 through 4 of the instrument. Percentages calculated in the chi-square tables will be presented representing the frequency of positive attitude responses for the systemic and intrapsychic orientation groups. Please refer to Appendix D: Percentages Of Positive Attitude Responses For Systemic And Intrapsychic Clinicians For Each Item By Orientation Variable.

The three trends that will be presented are:

(1) An overall trend in the proportion of items in which systemic clinicians reported more frequent positive attitudes than did intrapsychic clinicians. These proportions, across the five cross-tabulations, were found to be three to six times greater for the systemic group.

(2) An overall trend, most strongly found in the area of reunification, in which systemic clinicians reported at least 10% greater frequencies in their positive attitudes.

(3) An overall trend, contrary to predictions, in which the intensity of frequencies of positive attitudes reported by these two orientation groups mirrored each other. As one group reported more or less frequent positive attitudes, so did the other group.

These trends will be presented and discussed for each orientation variable. In addition, those items for which intrapsychic clinicians reported more frequent positive attitudes will be discussed.

Graduate Training Variable:

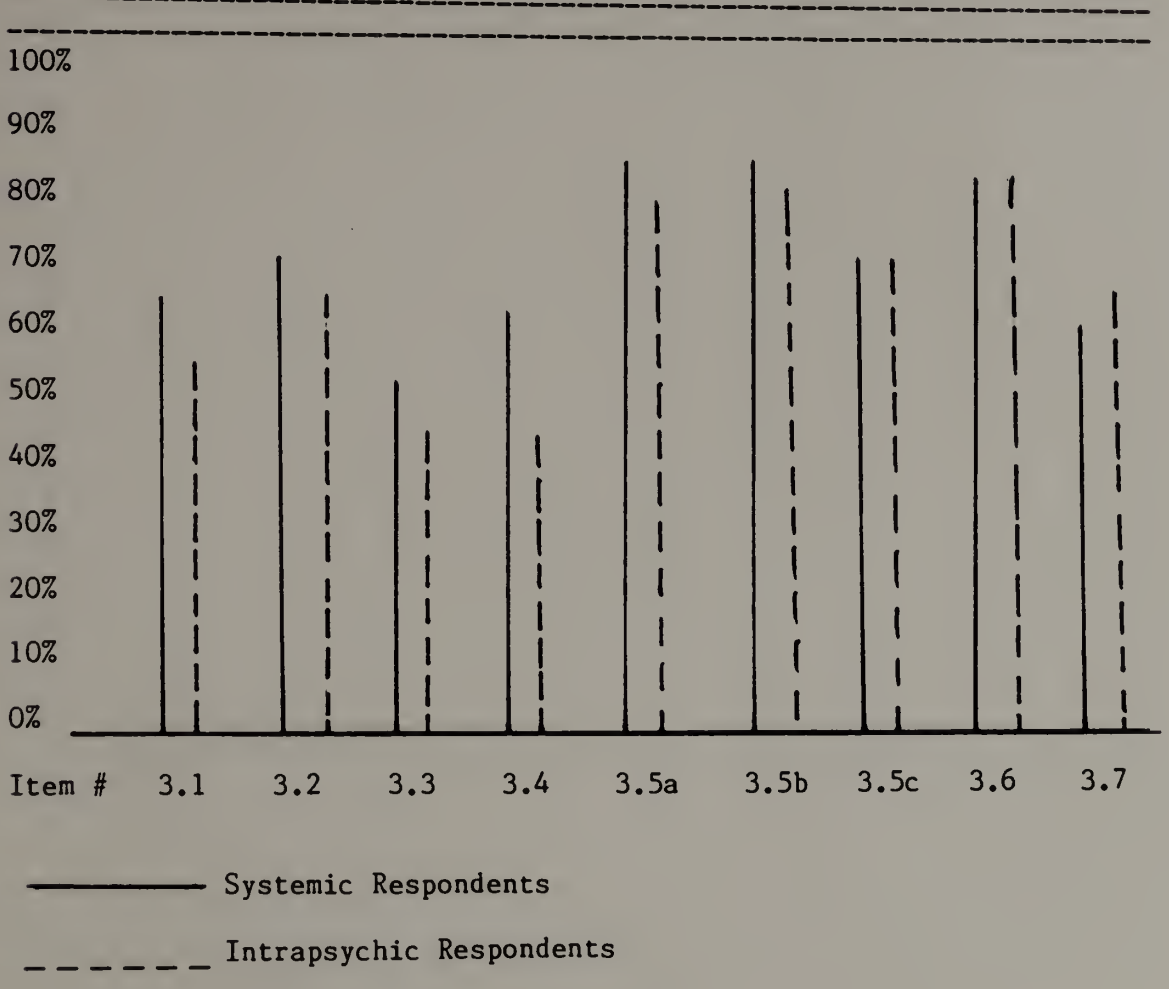
For this variable, representing Hypothesis 1, the ratio of systemic to intrapsychic clinicians reporting more frequent positive attitudes is almost 3:1. In 29 items, systemic clinicians reported more frequent positive attitudes than did intrapsychic clinicians. In three items, systemic and intrapsychic clinicians reported the same frequencies of positive attitudes, and in 11 items intrapsychic clinicians reported more frequent positive attitudes.

On nine items, systemic clinicians reported 10%-20% more frequent positive attitudes than did intrapsychic clinicians. Although none of these items were statistically significant, these substantially greater frequencies support the hypothesis. Systemic clinicians had considerably more frequent positive attitudes toward parents' capabilites, usefulness, and essentialness. They perceived parents as believing clinicians should involve them in decision making, and that parents wanted frequent contact with their children. Systemic clinicians, when asked to quantify "infrequent contact" between parents and children, chose the categories of highest frequency (1-2 times a month). They also more often saw parents as capable of providing a home, and that family reunification was both important and desireable.

For the 11 items in which intrapsychic clinicians reported more frequent positive attitudes, this greater frequency clustered around the area of parental involvement in decision making. Intrapsychic clinicians more frequently believed that parents should be invited to meetings where foster care placement was being discussed, and influence decisions regarding visitation and return home. They also more frequently thought parental decisions were clarifying and stabilizing, and that their colleagues thought they should ask for parents' opinions. In addition, intrapsychic clinicians reported more frequent positive attitudes toward parents' strength and stability, more frequently reported their colleagues thought they should encourage visitation, made more frequent recommendations that a child return home, and believed that family reunification was usual.

For this graduate training variable, 34 out of 43 items showed less than a 10% difference between the positive attitude frequencies reported by these two groups. More divergent attitudes had been anticipated, and this similarity in the intensity of frequencies may reflect more general or global attitudes held by practitioners toward this client population. An example of these similarlities is represented in Figure 2.

FIGURE 2
VISITATION ITEMS CROSS-TABULATED WITH GRADUATE TRAINING VARIABLE: PERCENTAGES OF POSITIVE ATTITUDE RESPONSES FOR THE SYSTEMIC AND INTRAPSYCHIC GROUPS.



Discussion: The proportion of positive responses by systemically trained clinicians in relation to those of intrapsychically trained clinicians confirms predictions and supports Hypothesis 1. In one third of the items, however, results differed from those anticipated. One possible explanation for this variation may be found in the clustering of those items where more frequent positive attitudes were reported.

In three of the four problem areas investigated, clinicians with systemic graduate training reported more frequent positive attitudes on the vast majority of questionnaire items. These areas were: general attitudes toward parents, visitation, and reunification. Only in the area of parental involvement in decision making did intrapsychic clinicians report positive attitudes as frequently as did systemic clinicians.

It had been expected, based on principle tenets of systemic theory that focus on the "executive role" of parents in the family, that systemic respondents would support parental decision making. This unexpected similarity between these two groups, however, is possibly the result of a significant factor regarding intrapsychically trained clinicians that was overlooked by this researcher. There is a long standing tradition in social work of meeting with parents, whether through the conventional home visit, or the customary case review. Given that 52% of the sample (N=77) held Masters in Social Work degrees, 77% (59) of which were intrapsychically trained in graduate school, may account for the frequency with which this group reported inviting parents to attend meetings.

Primary Practice Variable

This variable, representing Hypothesis 2, reflects similar findings as were reported for the previous orientation variable. The ratio of systemic to intrapsychic clinicians reporting more frequent positive attitudes is almost 3:1. On 31 items systemic clinicians reported more frequent positive attitudes, and on 11 items intrapsychic clinicians reported more frequent positive attitudes. On one item these two groups reported the same frequency of positive attitudes.

On 14 items systemic clinicians reported 10%-24% more frequent positive attitudes than did the intrapsychic group. These substantially greater frequencies again support Hypothesis 2, confirming speculations in the literature regarding the relationship between a systemic primary practice orientation and more positive attitudes. This group had considerably greater positivity toward (a) the importance of parents to the growth and development of their child; (b) parents influencing decisions regarding return home and termination of parental rights; and (c) frequent visitation. Nine out of these 14 items clustered in the area of reunification, showing greater positivity toward (a) parents' capacity to provide a home; (b) reunification's usualness, importance, value and desireability; (c) recommending reunification frequently and quantifying a child's return home with greater frequency, as well as recommending a child not return home with quantified smaller frequency than the intrapsychic group; and (d) believing their colleagues thought they should encourage reunification.

For the 11 items in which intrapsychic clinicians reported more

frequent positive attitudes, seven of these items clustered around the area of general attitudes toward parents. This finding ran counter to predictions, and was inconsistent with all other findings. This group reported greater positivity toward parents' influence, capabilities, strength, helpfulness, usefullness, stability, and nurturance. In addition they believed parents should be invited to meetings regarding placement, parental involvement in decisions was stabilizing, and that their colleagues believed they should ask parents for their opinions and encourage visitation.

For this variable, 29 out of 43 items showed <10% difference between the positive attitude frequencies reported by these two groups. This similarity in the intensity of frequencies had not been anticipated, and again may reflect more broad based and global attitudes held by respondents toward parents of children in care.

Discussion: The 3:1 proportion of positive attitude responses reported by systemic primary practice clinicians, in relation to intrapsychic clinicians, confirmed predictions and supports Hypothesis 2. The area of strongest positivity was family reunification, where nine out of the 11 items showed 10%-24% greater positive frequencies.

For approximately one third of the items, however, results differed from those predicted, particularly in the area measuring general attitudes toward parents. In this problem area, intrapsychic clinicians reported more frequent positive attitudes in seven out of the nine items. This finding is unique and inconsistent with any other findings since in no other chi-square tests, across all orientation

variables, were similar results found. Within this orientation variable, in no other area did intrapsychic clinicians report frequent or consistent positivity, with only 4 out of the remaining 34 items showing more frequent positive attitudes for the intrapsychic group. Thus, there is no context for understanding if or how these more positive attitudes are related to the other foster care problem areas of parental involvement in decisions, visitation and reunification.

Secondary Practice Variable

Similar to the two preceding variables, the ratio of systemic to intrapsychic clinicians reporting more frequent positive attitudes is almost 3:1. For 30 items systemic clinicians reported more frequent positive attitudes, while in 11 items intrapsychic clinicians reported more frequent positivity. For two items these two groups reported the same frequencies.

On 9 items systemic clinicians reported 10%-35% more frequent positive attitudes. Five of these items were shown to be statistically significant, thus lending strong support to the relationship between a systemic secondary practice orientation and more positive attitudes as theorized in Hypothesis 3. Systemic clinicians reported substantially more frequent positivity toward parents' influence, capabilities, helpfulness and usefulness. They believed parents should influence placement decisions, were satisfied with the decisions parents made, saw their involvement as stabilizing, and believed parents thought they

should be involved in decisions. They also strongly believed reunification was good for children.

For the 11 items in which intrapsychic clinicians reported more frequent positive attitudes, these greater frequencies were scattered throughout three problem areas; parental involvement in decision making, visitation and reunification. This group more frequently believed: (a) parents should be invited to meetings regarding placement, visitation, and return home; (b) parents should influence decisions regarding return home; and (c) that their colleagues thought they should ask for parents' opinions. In addition, they (d) believed parents should have frequent contact with their children, and quantified this by choosing the categories of highest frequency for the "frequent" and "infrequent" contact items; and (e) believed family reunification was valuable, and recommended it frequently.

For this variable 34 out of the 43 items showed less than a 10% difference between the positive attitude frequencies reported by these two groups. Again, this similarity in intensity of frequencies possibly reflects more general, societal attitudes toward parents of children in care, even though for some items there were strong differences between these two groups.

Discussion: The proportion of positive attitudes reported by systemic clinicians in relation to those reported by intrapsychic clinicians confirmed predictions and support Hypothesis 3. This variable, however, has an interesting demographic interplay between the two orientation groups.

As has been previously mentioned in this chapter, intrapsychic clinicians show more frequent positivity toward the inclusion of parents in meetings. In three out of four items they reported more frequently that parents should be invited to meetings than did the systemic group. Only in one out of four items did they report more frequent positivity toward parents influencing foster care decisions discussed or decided at these meetings. This finding is consistent with the supposition that social workers (52% of sample) have a tradition of meeting with parents, but this tradition does not necessarily extend to parents making or influencing decisions regarding the implementation of foster care services. This pattern of intrapsychic positivity may also be accounted for by the fact that 26 out of the 33 respondents (79%) that reported an intrapsychic secondary practice orientation had reported a systemic primary practice orientation, thus identifying themselves as primarily systemic.

Even though the systemic group did not report as frequent positivity toward inviting parents to meetings, this group more frequently reported support for parental influence on foster care decisions. This finding is also consistent with the systemic perspective that views parents as decision makers. The systemic group also extended their positivity to general attitudes toward parents, visitation and reunification, thus supporting findings in the literature that associate attitudes toward parents with parental involvement, visitation, and return home (Gruber, 1973, 1978; Fanshel and Shinn, 1978; Knitzer and Allen, 1978).

Postgraduate Training Variable

For this variable the ratio of systemic to intrapsychic clinicians reporting more frequent positive attitudes is 6:1. On 36 items systemic clinicians reported more frequent positive attitudes, while on only 6 items intrapsychic clinicians reported more frequent positivity. On one item these two groups reported the same frequency.

On 15 items systemic clinicians reported 10%-24% more frequent positive attitudes. These considerably greater frequencies lend strong support to the relationship between a systemic theory perspective and more positive attitudes as presented in Hypothesis 4. Systemic clinicians reported substantially more frequent positivity toward: (a) believing that parents thought they should be involved in planning foster care services; (b) frequent parent-child contact, as well as viewing this contact as beneficial and good for families; and (c) family reunification's usualness, possibleness, importance, value, desireability, and being good for children. In addition, they recommended reunification frequently and believed their colleagues thought they should encourage reunification.

For the six items in which intrapsychic clinicians reported more frequent positive attitudes, these greater frequencies were in the areas of general attitudes toward parents and parental involvement in decision making. This group more frequently believed parents were (a) useful, stable and nurturing; and (b) that parents should influence visitation, were satisfied with parental decisions, and believed their colleagues thought they should ask for parents' opinions.

For this variable 28 out of the 43 items showed less than a 10% difference between the positive attitude frequencies reported by these two groups. This has been found consistently across all orientation variables, possibly showing the broad based influence of general societal norms on attitudes.

Discussion: For this variable the ratio of positivity for systemic clinicians was higher than for any other variable, showing strong support for the association between postgraduate training and more frequent positive attitudes. This enhanced positivity is possibly due to respondent's having received recent systemic training. Since respondents were only asked for the primary orientation of training received since completing their graduate degree, the recency of such training can not be ascertained. It can be assumed, however, that respondents' receive at least annual in-service trainings through their agencies, or through attending conferences. The importance of this trend lies in the fact that an equal number of respondents received systemic and intrapsychic postgraduate training, with the systemic group reporting a significantly larger ratio of positivity.

This variable showed twice as large a ratio of positivity for systemic clinicians as did the graduate training variable, leading one to consider the greater influence of postgraduate training on attitudes toward this client population. In addition, systemic postgraduate training had been experienced by half of the clinicians responding to this orientation item. This may be a result of systemically oriented trainings and conferences available in Massachusetts, influenced by

such schools as the University of Connecticut, University of Massachusetts, Boston Family Institute and Cambridge Family Institute, to name a few.

Systemic Score Variable

As previously discussed, a systemic scale was created to synthesize the orientation variables, with a score assigned to each respondent in order to test the overarching supposition that clinicians with a "primary" systemic orientation would have more frequent positive attitudes than do clinicians with "little or no" systemic orientation. This supposition was strongly supported by the 3.5 to 1 ratio of more frequent positive attitudes reported by the "primary" group in relation to the "little or no" group. On 33 items, "primary" clinicians reported more frequent positive attitudes, while on 9 items "little or no" clinicians reported more frequent positivity. On one item these two groups reported the same frequencies.

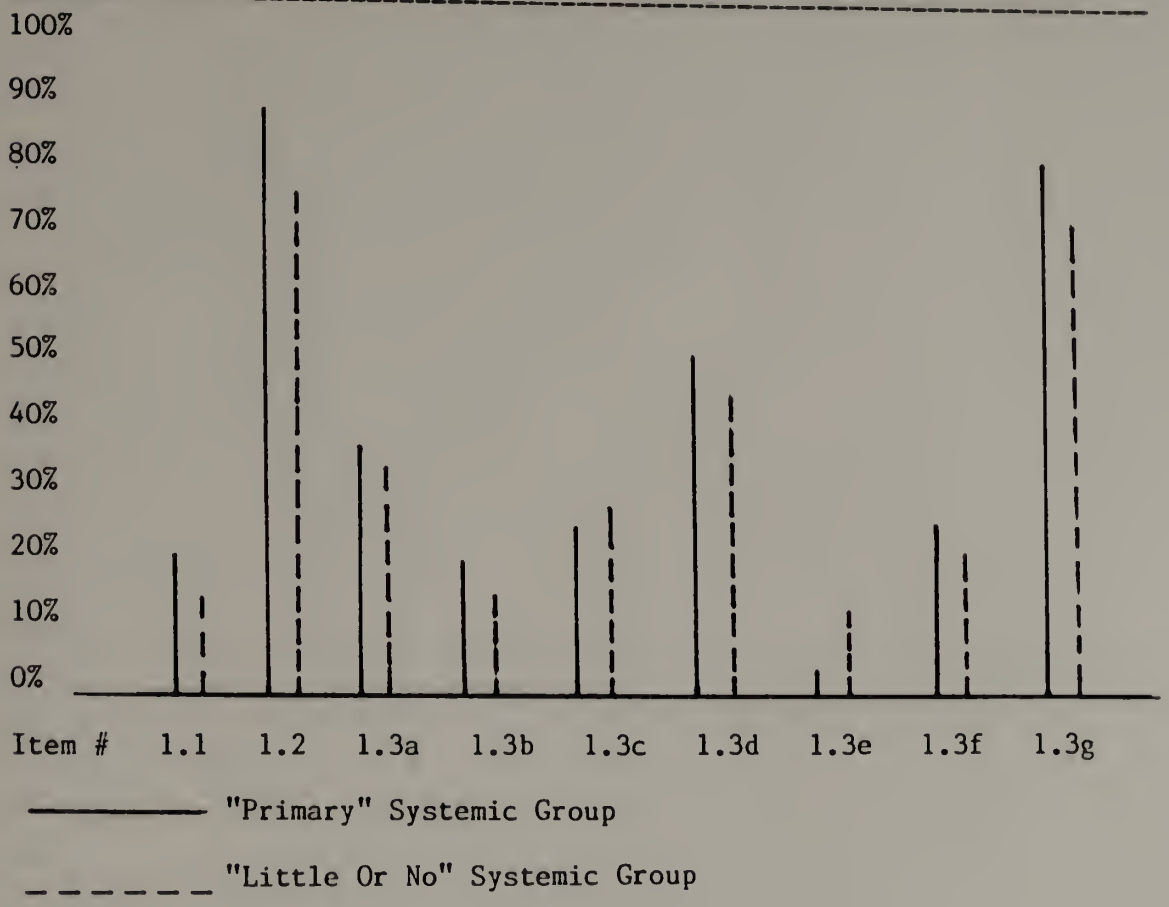
On 17 items the "primary" clinicians reported 10%-28% more frequent positive attitudes. The area of strongest positivity was family reunification, for which all 11 items showed more than 10% greater frequencies. This group believed: (a) parents were important to the growth and development of their child; (b) parents should influence decisions regarding placement and termination of parental rights, as well as perceived parents as thinking they should be involved in planning services; (c) parents should have frequent contact with their

children; and (d) family reunification was usual, possible, important, valuable, good for children, and desireable. In addition they believed parents were capable of providing a home, recommended reunification frequently, and believed their colleagues thought they should encourage reunification.

For the nine items in which the "little or no" systemic orientation group reported more frequent positive attitudes, these greater frequencies mostly clustered in the area of parental involvement in decision making. This group reported more frequent positivity toward (a) parents being invited to meetings regarding placement, return home and termination of parental rights, as well as parents influencing visitation decisions; and (b) they believed parental input to be stabilizing, with their colleagues believing they should ask for parents' opinions. In addition, they believed parents to be helpful and stabile, and that their colleagues thought they should encourage visitation.

For this variable 26 out of 43 items showed less than a 10% difference between the positive attitude frequencies reported by these two groups. This variable had the fewest items showing similarity in intensity of frequencies, which may be the result of the influence of a systemic orientation on the "primary" group. These similarlites prevail, however, and are represented in Figure 3 on the following page.

FIGURE 3
GENERAL ATTITUDE ITEMS CROSS-TABULATED WITH SYSTEMIC SCORE VARIABLE: PERCENTAGES OF POSITIVE ATTITUDE RESPONSES FOR THE "PRIMARY" SYSTEMIC AND "LITTLE OR NO" SYSTEMIC GROUPS.



Discussion: As has been discussed throughout this section on trends in the data, a great deal of meaningful data were reported that support the overarching supposition behind this research. Through the use of the systemic score variable, created to discern the influence of systemic orientation on attitudes, these trends confirm those reported for the other four orientation variables.

These patterns/trends clearly support the supposition that there is an association between a systemic orientation and positive attitudes

toward parents and parental involvement. The overall proportion of more positive responses, as well as their greater frequencies, add support to the statistical findings related to this supposition and offer some confirmation of speculations in the literature regarding the influence of clinical orientation on attitudes (George, 1970; Germain, 1979; Goldstein, 1979; Kline and Overstreet, 1972; Laird, 1979; Maluccio and Sinanoglu 1981a, 1981b; Minuchin,1970; Stein, Gambrill and Wiltse, 1978).

Summary

In the first section of this chapter, significant results relevant to the four hypotheses were presented. These results, analysed by chi-square tests, were reported for each orientation variable and the systemic score in the four target problem areas investigated. Significance was found for three of the four hypotheses, and the systemic score. Strongest significance was found in the area of family reunification that contained eight out of the 16 significant items. Due to the limited amount of significant data, there is partial support for three of the four hypotheses tested.

In the second section of this chapter, meaningful trends in the data were presented and discussed that support the research hypotheses and confirm speculations in the literature. These trends, although not statistically significant, are important in their repetition and pattern. This was demonstrated in the ratio of items, ranging from 3:1 to 6:1, in which systemic respondents reported more frequent positivity than intrapsychic respondents.

Results from this study also lend support to previous research findings that discussed visitation as an important indicator of family reunification, with attitudes toward parents correlated with the frequency of visitation and resultant discharge from care (Fanshel and Shinn, 1978; Maas and Engler, 1959; Shapiro, 1976). Across all clinical orientation variables and the systemic score, systemic clinicians more frequently reported that (a) parents wanted frequent contact with their children in placement; (b) parent-child visitation was beneficial, necessary and good for families; and (c) they encouraged frequent visitation. In addition, the item measuring clinicians' recommendations for frequent contact between parents and children showed more frequent positivity for the systemic group in three of the four orientation measures and the systemic score variable.

Reflective of this prior research, this support for visitation relates to the finding that the most intense differences in positivity between these two groups were found in the area of reunification. Across all orientation variables and the systemic score measure, systemic respondents reported more frequent positivity on over 70% of the reunification items. For two orientation variables and the systemic score measure, 82%-100% of the reunification items showed at least a 10% greater frequency of positivity for the systemic group.

Thus, the consistency and magnitude of these trends confirm previous research findings and support speculations in the literature regarding the possible influence of a systemic orientation on positive attitudes toward foster care services to parents and whole families.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

The purpose of this research was to investigate, with a graduate level clinical population, the relationship between clinical orientation and clinicians' attitudes toward four salient foster care problem areas: general attitudes toward parents, parental involvement in decision making, visitation and reunification. Previous research had highlighted the severe discrepancies between stated principles of foster care and its actual practice. Service principles were infrequently and inadequately applied, resulting in limited parental involvement, infrequent parent-child visitation and infrequent family reunification. This prior research had associated these service problems with negative attitudes toward parents held by foster care practitioners, none of whom had graduate degrees.

In addition, the literature had raised issues regarding the influence of clinical orientation on attitudes toward parents and parental involvement. Foster care critics had speculated that training in systemic theory might lead to the improvement of service to parents and families through imparting positive and non-blaming views of parents, and by orienting services toward the whole family. Conversely, the literature had speculated that training in intrapsychic clinical orientations, such as psychodynamic and psychoanalytic theories, imparted blaming or negative attitudes toward parents, leading to disruption of the parent-child relationship through limiting visitation and reunification, and orienting services toward the

individual child. With this prior research as background, this study set out to test these speculations regarding the association between graduate level clinical orientation and attitudes toward parents and parental involvement.

Respondents' clinical orientation was indicated by four different measures reflective of the orientation of (a) their graduate training; (b) their current primary practice; (c) their secondary practice; and (d) their postgraduate training, if any. A scale was created so as to reflect each respondent's degree of systemic orientation. This provided for five clinical orientation measures (variables) to use in chi-square analysis with the 43 attitude items in the instrument.

These five orientation variables allowed for many comparisons between clinical orientation and instrument items measuring attitudes toward parental involvement in services, which resulted in a large number of findings in support of the hypotheses and speculations in the literature. In this chapter the general salience of these results will be discussed in order to facilitate a broader understanding of conclusions and their implications.

Major Findings

The most important finding from this research is the strong association between a systemic orientation and more frequent positive attitudes toward parental involvement in services and family reunification. This finding had been hypothesized, and speculated in

the literature, and results strongly supported it. Additional findings presented both lend support to this association as well as show similarities between these two orientation groups that had not been anticipated.

As was discussed in Chapter I, earlier foster care research studied a population of high school and undergraduate level practitioners, and found these untrained workers to have highly negative attitudes toward parents. Contrary to predictions, this study found that while respondents with a systemic theory orientation were more likely to have positive attitudes than intrapsychic clinicians, both groups had generally negative attitudes toward parents.

An example of this is demonstrated by responses to the first item on the scale, which asked respondents to report on the negativity or positivity of parents' influence on the growth and development of their child in care. For this item, systemic clinicians were more frequently positive than non-systemic clinicians, but only an average of 23.7% of systemic respondents reported positive attitudes. On seven out of the nine items measuring general attitudes, only 5.3% to 44.3% of all systemic respondents reported positive attitudes toward parents. Intrapsychic clinicians reported similar frequencies, with this section showing no significant differences between these two groups. (Please refer to Appendix D).

An additional finding that ran counter to predictions showed these two orientation groups had similar positivity toward involving parents in decision making. Although systemic respondents reported more

frequent positivity, with some items found to be significantly more positive, both groups reported similar frequencies of positivity toward: (a) inviting parents to meetings (in the 80%-97% range); (b) parents influencing decisions discussed or decided at these meetings (in the 52%-76% range); and (c) being satisfied with the decisions parents made (in the 27%-41% range).

It had not been anticipated that intrapsychic clinicians would so frequently report inviting parents to meetings, nor was it anticipated that systemic respondents would so infrequently show positivity toward parents influencing decisions. In addition, it had not been anticipated that systemic respondents would be so infrequently satisfied with the decisions parents made. Again, systemic respondents were overall more frequently positive, but the difference between these two groups had been anticipated to be considerably larger.

The differences between these two groups became more pronounced in the areas of visitation and reunification. Systemic respondents supported frequent parent-child contact, and believed frequent contact to be necessary and good for families. The area of reunification showed 50% of all significant differences between these two groups. In addition, in 34 out of a possible 55 chi-square analyses regarding reunification, systemic respondents reported at least 10% more frequent positive attitudes.

An additional finding, that had not been anticipated, was the similarity in the intensities of frequencies reported by these two groups. Across orientation variables in three problem areas (excepting

the area of reunification), as one group reported more or less frequent positivity, so did the other group (See Appendix C: Means and Standard Deviations).

In prior research, negative general attitudes toward parents had been associated with lack of parental involvement, visitation and reunification. This study found, on the contrary, that negative general attitudes toward parents did not have strong correlations with systemic clinicians' reported attitudes toward and behavioral intentions regarding parental involvement in decision making, visitation and reunification. In reporting their attitudes toward specific foster care activities, i.e. encouraging frequent visitation, systemically oriented clinicians' self-reports were considerably more positive in these three areas than they had been in the general attitude area.

Lastly, it had been anticipated there would be a considerably smaller percentage of systemic respondents in the sample than intrapsychic respondents. This was not found to be true, with 25%-50% of all respondents reporting a systemic orientation in some part of their graduate or postgraduate experience. It was surprising to find such widespread exposure to systemic theory in Massachusetts, resulting in 53.3% of respondents being assigned a systemic score reflective of "some" to "primary" systemic orientation.

Conclusions

The extent of these two groups' general negativity toward parents, and the intensity of their negativity, suggests that societal norms are harsh on those parents that do not raise their own children and have need for their child/children to live outside the home for periods of time. There is certainly a possibility that attitudes toward parents would vary depending upon the reasons for foster care placement, yet this study asked respondents to consider their general experiences rather than specific cases, with this possible variation not being discernible. It is not clear, however, if this extreme negativity is also a result of class bias toward those parents involved in state run child welfare services, since a very different standard would probably be applied toward parents sending their children to boarding school, or to a school friend's or relative's home if they were middle or upper class. It is interesting, however, that systemic respondents, regardless of their general negativity, are significantly more positive toward visitation and reunification.

Based on their positivity in these two areas, systemic respondents appear most focused on working on the primary goal of foster care, family reunification. Systemic theory emphasizes that treatment use tasks, contracts and timeframes through which to evaluate or achieve stated goals. Systemic principles, therefore, seem well suited to the foster care situation and address many of the problems highlighted in the literature regarding the importance of frequent visitation and its association to a child's return home.

In addition, findings reflect that an intrapsychic orientation does not lead to as strong a focus on the phases and outcomes of foster care. Intrapsychic theory is neither task nor goal-specific; rather, it focuses on insight, achieved through long-term treatment of the individual. This theory base seems far less relevant to involving biological parents and reuniting families. These conclusions are important for future research, training, and clinical practice.

Future Research Implications

Given that one major finding pointed to the negativity of systemic respondents' general attitudes toward parents, it would be important to do additional research on:

(1) discerning possible variations in respondents' attitudes depending on differing reasons for placement. This might be done using case vignettes to alter the situations surrounding placement;

(2) the possible class bias of respondents, which might be evaluated through the inclusion of a demographic variable inquiring about respondents' social class, or through questions about middle and upper class alternatives to foster care;

(3) why these primarily negative attitudes do not seem to influence reported behavioral intentions toward parental inclusion and family reunification. Can systemic concepts influence specific behavioral intentions, regardless of general attitudes? Is there a need for systemic training to address clinicians' attitudes more directly? Is

there a self-report bias in relation to parental inclusion and family reunification? In addition, what systemic concepts are most useful in improving attitudes and resultant behaviors? What concepts do foster care clinicians use in their practice, and how are these correlated with more positive attitudes toward parents, parental involvement and reunification?

A related area of future research would address the drift/pattern in the data where reported attitudes were primarily negative in the first section of the instrument, and became increasingly more positive in each subsequent section. This drift was most evident for systemic respondents, but is applicable to both orientation groups. Further research would control for this drift by shifting the order of questionnaire items, or distributing various formats to different respondents to see if this pattern reflects the content of items, or a bias that develops during the course of completing the questionnaire. It would also be important to refine the instrument by evaluating respondents' notions about the meaning of each item. This would correct for items that were unclear or had inconsistent results.

An additional area of further research would test the applicability of systemic concepts to improving attitudes, using a pretest-posttest control-group design. This would be a longer term study possibly to be conducted through a clinical degree program. Additionally, further inquiry is needed using observational and case review research methods that are not dependent on respondents' self-report. Through reviewing case notes and outcomes, combined with a

paper and pencil attitude survey or interview and data collection on clinical orientation, further research might be able to more closely evaluate respondents' attitudes, and how they relate to their clinical orientation and actual practice.

Implications for Training and Clinical Practice

As was discussed earlier, testing speculations in the literature regarding the usefulness of a systemic perspective in foster care services was a major purpose behind this research study. If findings confirmed these speculations, then there could be research data available to support the relationship between a systemic theory perspective and the greater potential for more adequate services being provided to families.

Implications for training are clear. Continuing to train clinicians in intrapsychic theory, who will work in public sector social service programs, is not an adequate means through which to improve services to families. On the basis of earlier foster care research and findings from this study, intrapsychic theory, as it applies to the foster care situation, appears to contribute to negative attitudes which have been associated with services falling seriously short of their intended goals and outcomes. These goals have been delineated in the most recent federal foster care statute, the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), which mandates that services prevent placement, involve parents and reunite families.

Training, instead, would focus on concepts from models of systemic and ecological family theory, training practitioners in useful and active ways of working with parents given the inherent complexities of foster care. In an unpublished paper (1985), this researcher delineated three family theory models and their concepts that appear particularly suitable for such trainings: the structural model (Aponte, 1979; Aponte and Van Deusen, 1981; Haley, 1980; Minuchin, 1974); the Milan model (Selvini Palazzoli et al., 1980); and the Mental Research Institute's brief treatment model (Bodin, 1981; Watzlawick et al., 1967; Watzlawick et al., 1974). Concepts from these models would be applicable to assessments, diagnoses and therapeutic interventions with families, and would provide clinicians with new frameworks for perceiving and evaluating parents from a more neutral and constructive perspective. In addition, they would be useful in helping clinicians assess how their own involvement with the family effects family functioning and continuity.

Based on findings regarding the negativity of both systemic and intrapsychic respondents' general attitudes toward parents, it appears that clinical training needs to address the ways in which individuals' values and attitudes impact on their assessments of and interventions with families. These issues need to be addressed overtly and concretely, not expecting that good intentions, or empathy, or even systemic notions will overcome cultural bias or prejudice. It is important for clinicians to be able to delineate the differences between cultural or societal attitudes toward this client population that are not valid and not

useful in their work, i.e. classism, and those attitudes that may be a direct function of any given parent's severe inability to parent or who is dangerous to their child. Some of these distinctions can be clarified and addressed through training in systemic and ecological concepts, i.e. the inappropriateness of a clinician's punitive attitude toward parents, but issues of general prejudice toward a class of people are ones that need to be delineated from those appropriate negative evaluations that function to protect children from abusive and harmful situations. These distinctions seem to be lacking in all trainings, regardless of orientation.

Lastly, there are practice implications to consider based on the finding that only an average of 39% of the systemic respondents were satisfied with the decisions that parents made about foster care. Even though in two out of five chi-square analyses systemic respondents were significantly more positive than the intrapsychic group, their overall lack of satisfaction is important to the issue of parental involvement, particularly in relation to frequent visitation and family reunification. Does this finding mean that parents' decisions are difficult to implement? Does it mean that systemic clinicians want visitation and reunification conducted under their terms, rather than parents' terms, or that parents' decisions are evaluated as not useful and overridden or ignored? Is this finding a reflection of systemic respondents' support for visitation and reunification regardless of their evaluation of parental decisions? Based on data from this study it is unclear how this lack of satisfaction impacts on actual practice with

parents, yet it is important to consider how practice is effected, and what possible steps are necessary in order to achieve greater correspondence between parental decision making and clinicians' support of these decisions.

Summary

This study's primary contribution has been its testing of theoretical speculations regarding the influence of clinical orientation on attitudes toward parents of children in care. At this time a large majority of clinical graduate programs stress training in the intrapsychic orientations of psychodynamic and psychoanalytic theory, and produce a large majority of clinicians that work in the public sector with foster care clients (New York Times, 4/30/85: C1,C9). This study's significance lies in its potential to draw attention to an alternative theory base, systemic theory, that may result in service outcomes that more closely reflect the goals and principles of foster care services.

APPENDIX A

THE STUDY INSTRUMENT

The Role of Biological Parents in Foster Care

Margaret Kierstein
1986

THE ROLE OF BIOLOGICAL PARENTS IN FOSTER CARE

Controversy exists about the role of biological parents in foster care. Professionals do not agree about how, when, in what capacity, and to what degree biological parents should be involved. This study seeks your opinions on their role.

This questionnaire covers a variety of topics that are important aspects of foster care. These topics include: the influence of significant adults, case planning and decision making, parent-child visitation, children remaining in care, and family reunification.

Typically the range and type of foster care cases professionals work with is very broad. In responding to this questionnaire, please consider issues in general, rather than focusing on specific instances or cases.

Please note: Whenever the word "parent" or "parents" is used, it will mean biological parent/parents.

SECTION I:

Instructions: For each of the following questions, a seven point rating scale is used. Please make a check mark in the place that best describes your opinion.

(1.1) Consider the growth and development of a foster child. In your experience, what kind of influence have the following people had?

Caseworker:	Extremely Positive	____:	____:	____:	____:	____:	____:	____:Extremely Negative
Biological Parents:	Extremely Positive	____:	____:	____:	____:	____:	____:	____:Extremely Negative
Therapist:	Extremely Positive	____:	____:	____:	____:	____:	____:	____:Extremely Negative
Foster Parents:	Extremely Positive	____:	____:	____:	____:	____:	____:	____:Extremely Negative

(1.2) How important have the following people been to the growth and development of the child?

Foster Parents:	Highly Important	____:	____:	____:	____:	____:	____:	____:Not at all Important
Biological Parents:	Highly Important	____:	____:	____:	____:	____:	____:	____:Not at all Important
Caseworker:	Highly Important	____:	____:	____:	____:	____:	____:	____:Not at all Important
Therapist:	Highly Important	____:	____:	____:	____:	____:	____:	____:Not at all Important

(1.3) Generally, biological parents of children in foster care placement are:

Capable of being Parents _____:_____:_____:_____:_____:_____:_____: Incapnble of being Parents
extremely quite slightly neutral slightly quite extremely

Weak _____:_____:_____:_____:_____:_____:_____: Strong

Helpful _____:_____:_____:_____:_____:_____:_____: Harmful

Useless _____:_____:_____:_____:_____:_____:_____: Useful

Stnble _____:_____:_____:_____:_____:_____:_____: Unstable

Depriving _____:_____:_____:_____:_____:_____:_____: Nurturing

Essential _____:_____:_____:_____:_____:_____:_____: Unessential

SECTION II:

(2.1) Instructions: For each of the following questions, circle one of the numbers, 1 through 7, that describe how strongly you feel about: (a) parents being invited to meetings where the decisions in the left hand column are being discussed or decided; and (b) parents influencing these decisions. In responding, please consider your general feelings about this, and not your feelings regarding specific cases or instances.

	How strongly do you feel that parents should be invited to attend meetings?							How strongly do you feel that parents should influence these decisions?						
DECISIONS:	Strongly Favor						Strongly Oppose	Strongly Favor						Strongly Oppose
(A) Need for foster care placement	1	2	3	4	5	6	7	1	2	3	4	5	6	7
(B) Visitation	1	2	3	4	5	6	7	1	2	3	4	5	6	7
(C) Child's return home	1	2	3	4	5	6	7	1	2	3	4	5	6	7
(D) Termination of parental rights	1	2	3	4	5	6	7	1	2	3	4	5	6	7

Instructions: For each of the following questions, please check the place that best describes your opinion.

(2.2) I find involving parents in decisions about their child is

Confusing _____:_____:_____:_____:_____:_____:_____: Clarifying
extremely quite slightly neutral slightly quite extremely

Helpful _____:_____:_____:_____:_____:_____:_____: Harmful

Disruptive_____:_____:_____:_____:_____:_____:_____: Stabilizing

(2.3) In general, how satisfied are you with parents' decisions about foster care ?

Satisfied _____:_____:_____:_____:_____:_____:_____: Dissatisfied

(2.4) Generally my colleagues think

I should _____:_____:_____:_____:_____:_____:_____: I should not
ask for parent's opinions.

(2.5) Generally parents think

I should _____:_____:_____:_____:_____:_____:_____: I should not
involve them in the planning of foster care services.

SECTION III:

Instructions: For each of the following questions, please check the place that best describes your opinion.

(3.1) In general, how much contact do biological parents want with their children in foater care placement?

Frequent Contact _____:_____:_____:_____:_____:_____:_____: Infrequent Contact

(3.2) Generally, how much contact do you think biological parents should have with their child/children in placement?

Frequent _____:_____:_____:_____:_____:_____:_____: Infrequent

(3.3) I consider "Frequent" contact to be: (Please check one)

_____ 2 times a week
_____ 1 time a week
_____ 1 time every 2 weeks
_____ 1 time a month
_____ 1 time every 6 weeks
_____ 1 time every 2 months
_____ 1 time every 6 months

(3.4) I consider "Infrequent" contact to be: (Please check one)

_____ 1 time every 2 weeks
_____ 1 time a month
_____ 1 time every 6 weeks
_____ 1 time every 2 months
_____ 1 time every 4 months
_____ 1 time every 6 months
_____ 1 time a year

(3.5) Contact between parents and their children in placement is:

Beneficial_____:_____:_____:_____:_____:_____:_____:Unbeneficial
extremely quite slightly neutral slightly quite extremely

Necessary_____:_____:_____:_____:_____:_____:_____:Unnecessary

Bad for Families _____:_____:_____:_____:_____:_____:_____: Good for Families

(3.6) Generally, I encourage parents to have

Frequent _____:_____:_____:_____:_____:_____:_____:Infrequent
contact with their children in care.

(3.7) My colleagues think

I should _____:_____:_____:_____:_____:_____:_____:I should not
encourage visitation.

SECTION IV:

Instructions: As in the previous questions, please place a check mark in the place that best describes your opinion.

(4.1) In my experience, parents whose children go into foster care, are

Capable _____:_____:_____:_____:_____:_____:_____: Incapable
of ever being able to provide a home for their children.

(4.2) Family Reunification

Unusual _____:_____:_____:_____:_____:_____:_____: Usual
extremely quite slightly neutral slightly quite extremely

Impossible_____:_____:_____:_____:_____:_____:_____: Possible

Important _____:_____:_____:_____:_____:_____:_____: Unimportant

Valuable _____:_____:_____:_____:_____:_____:_____: Worthless

Bad for Children _____:_____:_____:_____:_____:_____:_____: Good for Children

Desirable _____:_____:_____:_____:_____:_____:_____: Undesireable

(4.3) In approximately _____% of my foster care cases, I recommend that children return home.

(4.4) In approximately _____% of my foster care cases, I recommend that children not return home.

(4.5) I encourage family reunification

Infrequently _____:_____:_____:_____:_____:_____:_____: Frequently

(4.6) Most of my colleagues, whose opinion I value, think

I Should _____:_____:_____:_____:_____:_____:_____:I Should Not
encourage family reunification.

SECTION V:

Instructions: In this last section of the questionnaire, please respond to the following questions as indicated at the end of each statement.

(5.1) Your sex? (Circle One)
(a) Female
(b) Male

(5.2) Your age? _____

(5.3) Highest degree attained? _____

(5.4) What year did you attain your highest degree? _____

(5.5) Where did you receive the majority of your clinical training? (Circle one)
(a) University or college graduate program
(b) Training institute
(c) On-the-job training
(d) Workshops
(e) Self-taught
(f) Other_____

(5.6) How long have you been a practicing clinician? _____

Please note: For questions #5.7 and #5.8 the term "clients involved in foster care" refers to foster children, and/or foster parents, and/or biological parents of children in care.

(5.7) How long have you been a clinician working with clients involved in foster care?

_____

(5.8) What is the approximate number of clients involved in foster care you've worked with in the last 12 months?

_____

(5.9) What was the primary clinical orientation of your graduate training? (Circle one)
(a) Psychodynamic
(b) Psychoanalytic
(c) Ecological
(d) Cognitive
(e) Systemic
(f) Behavioral
(g) Other_____

(5.10) What primary clinical orientation do you now use in your practice?
(Circle one)
(a) Psychodynamic
(b) Psychoanalytic
(c) Ecological
(d) Cognitive
(e) Systemic
(f) Behavioral
(g) Other_____

(5.11) Secondary practice orientation, if any? _____

(5.12) What clinical authors have most influenced your treatment practice? Please list the one or two who have been most influential, along with the author's clinical orientation.

(a) Author_____, Orientation_____

(b) Author_____, Orientation_____

(5.13) Whathas been the primary clinical orientation of any training you may have received since completing your graduate degree?
(Circle one)
(a) Psychodynamic
(b) Psychoanalytic
(c) Ecological
(d) Cognitive
(e) Systemic
(f) Behavioral
(g) Other_____

YOUR HELP IS GREATLY APPRECIATED. THANK YOU.
PLEASE USE THE SPACE BELOW IF THERE ARE ANY COMMENTS YOU WISH TO MAKE.

APPENDIX B

STUDY CORRESPONDENCES

INTITIAL RECRUITMENT LETTER #1, MAILED TO EXECUTIVE OR CLINICAL DIRECTORS REQUESTING THEIR AGENCY'S PARTICIPATION

P.O. Box 294
Sunderland, MA. 01375
June 23, 1986

(NAME AND ADDRESS OF DIRECTOR)

Dear :

I am in the process of gathering data for dissertation research being conducted in conjunction with the Human Services and Applied Behavioral Sciences Division at the University of Massachusetts, Amherst, School of Education.

The focus of this research is to investigate masters and doctoral level clinicians' opinions about the role of biological parents in foster care services. Currently controversy exists about the role of biological parents, and professionals do not agree about how, when, in what capacity, and to what degree biological parents should be involved. In order that the results of this survey may best represent clinicians that work with foster care clients in Massachusetts, all agencies that are members of the Massachusetts Association of Community Mental Health Service Providers, or community mental health centers affiliated with the Department of Mental Health, have been requested to participate in this study.

I am requesting your permission to distribute a 15 minute survey questionnaire, during the month of July, to master and doctoral level clinicians on your staff who work in a therapeutic, assessment or consulting capacity with any one of the following foster care client populations: foster children, foster parents, foster families, biological parents, or biological families. Participants' responses will be completely confidential, and no identifying material will be used in evaluating or reporting findings.

I am available to give a brief introduction and explanation of this study to your staff, and deliver and collect the completed questionnaires; or I will mail questionnaires with complete instructions and consent forms to your agency, along with return postage. The results of this research will be available to your agency, as well as the individual participants.

A self-addressed stamped postcard is enclosed requesting information about your agency's participation in this study. Please fill in the appropriate information and return it by the date specified on the postcard.

Sincerely,

Margaret Kierstein, L.C.S.W.

RETURN POSTCARD 'A' MAILED WITH RECRUITMENT LETTERS #1 AND #2

Instructions: Please fill in and return this postcard by _____

(1) Approximately how many master and doctoral level clinicians at your agency work with any of the following foster care client populations: foster children, foster parents, foster families, biological parents or families of children in placement? _____

(2) Please send questionnaires to the following person(s) so they may be distributed: _____

_____

[If there is more than one program at your agency that serves foster care clients, please list the appropriate administrative staff to contact.]

(3) Please contact the following person so you can arrange to give a brief presentation about the study, and distribute and collect the questionnaires:

_____

(4) Please contact the following person(s) regarding implementation of this study:

_____

_____

____This agency will not participate in this study.

____Other:_____

_____

THANK YOU.

[Agency code #_____]

RECRUITMENT LETTER #2, MAILED TO EXECUTIVE OR CLINICAL DIRECTORS THAT DID NOT RESPOND TO RECRUITMENT LETTER #1

P.O. Box 294
Sunderland, MA. 01375
July 16, 1986

Dear Colleague:

Approximately three weeks ago I wrote to you requesting your agency's participation in a dissertation study about foster care, focusing on the role of biological parents of children in placement. This research is being conducted in conjunction with the Human Services and Applied Behavioral Sciences Division at the University of Massachusetts, Amherst, School of Education, and has been undertaken based on the belief that additional information is necessary about clinical services to clients involved in foster care. A self-addressed stamped postcard was enclosed for your use in responding to this initial inquiry. As of today your postcard has not yet been received.

Since this study seeks to represent the views of master and doctoral level clinicians that work with foster care clients throughout Massachusetts, it is hoped that as many agencies as possible will participate. All agencies that are members of the Massachusetts Association of Community Mental Health Service Providers, or community mental health centers affiliated with the Department of Mental Health, have been selected to participate in this study.

I am writing to you again to request your permission to distribute a 15 minute survey questionnaire, to master and doctoral level clinicians on your staff who work in a therapeutic, assessment or consulting capacity with any one of the following foster care client populations: foster children, foster parents, foster families, biological parents or families of children in placement. Participants' responses will be completely confidential, and no identifying material will be used in evaluating or reporting findings.

I will mail questionnaires with complete instructions and consent forms to your agency, along with return postage; or I am available to give a brief introduction and explanation of this study to your staff, and deliver and collect the completed questionnaires. The results of this research will be available to your agency, as well as the individual participants.

In the event that your return postcard has been misplaced, a replacement is enclosed that requests information about your agency's participation in this study. Please fill in the appropriate information and return it by the date specified on the postcard. Your cooperation is greatly appreciated.

Sincerely,

Margaret Kierstein, L.C.S.W.
(413) 584-4935

P.S. A number of agencies have requested that they be able to complete and return the survey questionnaires by Sept. 1st due to staff vacations. The return date for questionnaires has been changed to Sept. 1st to make participation in this study as workable as possible for cooperating agencies.

RECRUITMENT LETTER #3, MAILED TO EXECUTIVE OR CLINICAL DIRECTORS THAT DID NOT RESPOND TO LETTERS #1 AND #2

P.O. Box 294
Sunderland, MA. 01375
August 4, 1986

Dear Colleague:

During June and July you received letters requesting your agency's participation in a 15 minute questionniare survey about foster care, focusing on the role of biological parents of children in placement. Self-addressed stamped postcards were enclosed for your use in responding to these inquiries. As of today we have not yet received your response regarding your agency's participation in this study.

The large number of agencies already participating is very encouraging. But, whether we will be able to describe accurately how Massachusetts clinicians feel on this important social service and clinical issue depends on the participation of all agencies throughout Massachusetts that are members of the Massachusetts Association of Community Mental Health Service Providers, or community mental health centers affiliated with the Department of Mental Health. Since this study seeks to represent the views of master and doctoral level clinicians that work with foster care clients throughout the state, it is extremely important that as many agencies as possible participate.

This is the first statewide study of this type that has ever been done. Therefore, the results are of particular importance to many clinicians and policy makers considering what kinds of services to provide to parents of children in placement. The usefulness of our results depends on how accurately we are able to describe what the clinicians of Massachusetts think.

It is for these reasons that I am writing to you again to request your permission to distribute a 15 minute survey questionnaire, to master and doctoral level clinicians on your staff who work in a therapeutic, assessment or consulting capacity with any one of the following foster care client populations: foster children, foster parents, foster families, biological parents or families of children in placement. Participants' responses will be completely confidential, and no identifying material will be used in evaluating or reporting findings.

I will mail questionnaires with complete instructions and consent forms to your agency, along with return postage. The results of this research will be available to your agency, as well as the individual participants.

Please fill in the enclosed self-addressed stamped postcard with the appropriate information and return it by the date specified on the postcard. Your contribution to the success of this study will be appreciated greatly.

Sincerely,

Margaret Kierstein, L.C.S.W.
In conjunction with the Human Services
and Applied Behavioral Sciences Division
School of Education
University of Massachusetts
Amherst, Mass.
(413) 584-4935

RETURN POSTCARD 'B' MAILED WITH RECRUITMENT LETTER #3

Instructions: Please fill in and return this postcard by _____
[If your agency will not be participating in this study, please check choice #4 and return this postcard.]

(1) Approximately how many master and doctoral level clinicians at your agency work with any of the following foster care client populations: foster children, foster parents, foster families, biological parents or families of children in placement? _____

(2) Please send questionnaires to the following person(s) so they may be distributed: _____
_____

(3) Please contact the following person regarding implementation of this study:
_____
_____

(4) ____This agency will not participate in this study.

____Other:_____
_____

THANK YOU.

[Agency code #_____]

THANK YOU/REMINDER POSTCARD MAILED TO ALL PARTICIPATING AGENCIES

Dear Colleague:

Within the last several weeks you received questionnaires for distribution to your clinical staff, seeking their opinions on the role of biological parents in foster care services.

If these questionnaires have already been completed and returned, please accept my sincere thanks. If not, please return the completed questionnaires this week, to be received by _____.

Since this is the first statewide study of this type that has ever been done, it is extremely important that questionnaires be completed and returned so that the results may accurately represent the opinions of Massachusetts clinicians.

Again, thank you for your assistance.

Sincerely,

Margaret Kierstein, L.C.S.W.
(413) 584-4935

P.S. The results of this study will be available by early winter, and will be mailed to you in early 1987.

REMINDER LETTER MAILED TO THOSE AGENCIES THAT DID NOT RETURN COMPLETED QUESTIONNAIRES BY SEPTEMBER 1ST DEADLINE

September 12, 1986

(NAME AND ADDRESS OF DIRECTOR/CONTACT PERSON)

Dear :

Within the last few weeks you have received two postcards asking that "The Role of Biological Parents in Foster Care" survey questionnaires be returned. Conducting a statewide study of this type, utilizing agency sites as the point of contact and linkage to staff working with foster care clients, is a very involved process that could not be accomplished without your support and help. I want to thank you for your help and assistance thus far, and wish to ask for your continued assistance in this final stge of the study. It is important that as many questionnaires be filled out and returned as possible, in order to accurately represent the opinions of Massachustts clinicians.

Please ask staff at your agency to complete and return the questionnaires within the next week, so they may be returned by **September 22**. If questionnaires have been misplaced, please phone (413) 584-4935 and ask for replacements. These will be mailed to you immediately.

Again, thank you.

Sincerely,

Margaret Kierstein, LCSW
P.O. Box 294
Sunderland, Mass. 01375

INSTRUCTIONS MAILED WITH QUESTIONNAIRES TO PARTICIPATING AGENCIES

Instructions for Distributing and Returning the Questionnaires:
Enclosed please find consent forms, questionnaires, and a self-addressed stamped return envelope.

Instructions:

---The questionnaire will take approximately 15 minutes to complete. It is suggested that the questionnaires and consent forms be distributed to staff at your regular staff meeting, with staff given 15-20 minutes to complete the questionnaires and sign the consent forms.

---Please give each staff member participating in this study a copy of the consent form for them to read and sign.

The consent forms contain (a) a brief description about the focus of the study, (b) a statement regarding the assurance of staff confidentiality and anonymity in filling out the questionnaire, (c) instructions for requesting a copy of the results of the study, and (d) a space at the bottom for staff to sign and date giving me permission to use their responses to this questionnaire survey.

---Please distribute one questionnaire to each staff member. Each questionnaire contains self-explanatory instructions for completeing each section.

Each questionnaire is coded with an agency number so a return rate may be calculated.

Please instruct staff to NOT sign their completed questionnaires.

---Please collect the questionnaires and consent forms separately to assure staff confidentiality and anonymity.

---Return questionnaires and consent forms in the self-addressed stamped envelope that has been provided.

Several agencies have requested that they be able to complete and return the questionnaires by Sept. 1st due to staff vacations. The return date has been extended till Sept. 1st to to make participation in this study as workable as possible for cooperating agencies. Please, however, return the completed questionnaires and consent forms prior to the Sept. 1st deadline if at all possible.

THANK YOU

CONSENT FORM

Dear Colleague,

This study seeks to gather information about foster care from clinicians in Massachusetts that work in a therapeutic, assessment or consulting capacity with any one of the following foster care client populations: foster children, foster parents, foster families, biological parents or families of children in care.

Although the focus of this research is on the role of biological parents in services, it is not necessary that clinicians work directly with this population. Due to the often complex and clinically difficult nature of foster care, there is a great need for additional information about how clinicians envision the role of biological parents in foster care services. It is hoped that treatment and service issues can be better understood as a result of this survey.

In order that the results of this survey may best represent the thinking of foster care clinicians in Massachusetts, it is important that each questionnaire be completed and returned. To achieve this representation, all agencies that are members of the Massachusetts Association of Community Mental Health Service Providers, or community mental health centers affiliated with the Department of Mental Health, have been selected to participate in this study.

Please be assured of complete confidentiality. The questionnaires delivered to your agency have been coded to only identify the agency site, so a return rate can be calculated. You are specifically requested to **not** sign your questionnaire, to ensure your confidentiality. Your participation in this study is voluntary, and you may withdraw your consent or discontinue participation at any time. Please sign this letter below giving me permission to use your responses to this survey. These signed letters will be collected separately from the questionnaires.

The results of this research will automatically be made available to each agency participating in the study. If you wish to have a summary of the results mailed to you personally, please send a postcard with your name and address to the address below, requesting "a copy of the results".

I give my consent to participate in the research study being conducted by Margaret Kierstein, L.C.S.W., P.O. Box 294, Sunderland, Ma. 01375. I understand that participation in this study is voluntary and confidential.

Date:_____ Signature:_____

APPENDIX C

MEANS AND STANDARD DEVIATIONS FOR EACH QUESTIONNAIRE ITEM BY ORIENTATION VARIABLE AND SYSTEMIC SCORE

MEANS AND STANDARD DEVIATIONS FOR EACH ITEM
BY GRADUATE TRAINING ORIENTATION

Item	Intrapsychic Group (N=109) M	SD	Systemic Group (N=39) M	SD
General Attitudes				
1.1 Parental Influence	3.44	1.29	3.59	1.27
1.2 Parental Importance	5.83	1.40	6.31	1.21
1.3a Capable	3.53	1.51	3.78	1.70
1.3b Strong	3.46	1.25	3.33	1.20
1.3c Helpful	3.71	1.31	3.56	1.29
1.3d Useful	4.40	1.13	4.72	1.30
1.3e Stable	2.80	1.22	2.36	.93
1.3f Nurturing	3.29	1.20	3.13	1.36
1.3g Essential	5.42	1.48	5.92	1.24
Decision Making				
2.1a Invite Re: Placement	6.36	.90	6.44	1.02
2.1b Invite Re: Visitation	6.27	1.11	6.31	1.22
2.1c Invite Re: Return Home	6.42	1.04	6.54	1.07
2.1d Invite Re: Rights	6.11	1.60	6.21	1.44
2.1e Influence Placement	5.01	1.67	5.00	1.64
2.1f Influence Visitation	5.36	1.49	5.00	1.67
2.1g Influence Return Home	5.26	1.61	5.21	1.60
2.1h Influence Rights	4.70	1.80	5.16	1.82
2.2a Clarifying	5.53	1.30	5.44	1.48
2.2b Helpful	5.39	1.50	5.51	1.30
2.2c Stabilizing	4.59	1.41	4.44	1.71
2.3 Satisfied	4.02	1.39	4.21	1.28
2.4 Colleagues Think	5.29	1.37	4.85	1.70
2.5 Parents Think	5.99	1.27	6.21	.86
Visitation				
3.1 Parents Want	4.53	1.43	4.69	1.28
3.2 Should Have	5.03	1.43	5.18	1.14
3.3 Frequent Contact Is	6.44	.54	6.41	.79
3.4 Infrequent Contact Is	4.66	1.72	5.28	1.40
3.5a Beneficial	5.45	1.05	5.72	1.12
3.5b Necessary	5.70	1.12	6.03	.99
3.5c Good For Families	5.28	1.24	5.44	1.19
3.6 Encourage Visitation	5.55	1.03	5.74	1.12
3.7 Colleagues Think	5.15	1.17	5.00	1.34
Reunification				
4.1 Parents Capable	3.97	1.41	4.62	1.58
4.2a Usual	4.31	1.48	4.49	1.50
4.2b Possible	5.04	1.14	5.37	1.17
4.2c Important	5.26	1.37	5.74	1.16
4.2d Valuable	5.35	1.25	5.85	1.11
4.2e Good For Children	5.11	1.19	5.62	1.18
4.2f Desireable	5.25	1.42	5.77	1.20
4.3 Recommend Reunification	*5.61	3.24	6.36	3.47
4.4 Not Recommend Reunification	*4.72	2.88	4.90	2.99
4.5 Encourage Reunification	4.90	1.29	4.92	1.60
4.6 Colleagues Think	4.86	1.30	4.84	1.73

* Values ranged from 1-12, where 1= 0% of the time and 12= 100% of the time.

MEANS AND STANDARD DEVIATIONS FOR EACH ITEM
BY PRIMARY PRACTICE ORIENTATION

Item	Intrapsychic Group (N=90) M	SD	Systemic Group (N=57) M	SD
General Attitudes				
1.1 Parental Influence	3.47	1.38	3.46	1.14
1.2 Parental Importance	5.71	1.42	6.33	1.19
1.3a Capable	3.67	1.56	3.47	1.58
1.3b Strong	3.44	1.25	3.41	1.23
1.3c Helpful	3.79	1.32	3.48	1.25
1.3d Useful	4.44	1.18	4.55	1.21
1.3e Stable	2.88	1.24	2.38	.98
1.3f Nurturing	3.31	1.21	3.13	1.29
1.3g Essential	5.39	1.44	5.80	1.42
Decision Making				
2.1a Invite Re: Placement	6.31	.92	6.47	.95
2.1b Invite Re: Visitation	6.17	1.18	6.46	1.05
2.1c Invite Re: Return Home	6.37	1.08	6.58	.99
2.1d Invite Re: Rights	6.10	1.55	6.23	1.56
2.1e Influence Placement	4.88	1.68	5.21	1.64
2.1f Influence Visitation	5.17	1.52	5.40	1.58
2.1g Influence Return Home	5.06	1.69	5.54	1.44
2.1h Influence Rights	4.53	1.81	5.30	1.73
2.2a Clarifying	5.43	1.33	5.63	1.38
2.2b Helpful	5.29	1.46	5.63	1.40
2.2c Stabilizing	4.60	1.47	4.47	1.56
2.3 Satisfied	3.84	1.42	4.42	1.19
2.4 Colleagues Think	5.29	1.33	5.02	1.65
2.5 Parents Think	5.99	1.25	6.14	1.08
Visitation				
3.1 Parents Want	4.54	1.42	4.61	1.37
3.2 Should Have	4.89	1.42	5.36	1.23
3.3 Frequent Contact Is	6.39	.54	6.51	.71
3.4 Infrequent Contact Is	4.63	1.71	5.16	1.54
3.5a Beneficial	5.40	1.04	5.70	1.10
3.5b Necessary	5.60	1.16	6.09	.93
3.5c Good For Families	5.22	1.26	5.46	1.18
3.6 Encourage Visitation	5.41	.99	5.89	1.10
3.7 Colleagues Think	5.11	1.12	5.11	1.37
Reunification				
4.1 Parents Capable	3.89	1.40	4.51	1.53
4.2a Usual	4.15	1.47	4.65	1.46
4.2b Possible	5.02	1.16	5.27	1.15
4.2c Important	5.16	1.38	5.74	1.19
4.2d Valuable	5.21	1.25	5.89	1.10
4.2e Good For Children	5.04	1.21	5.54	1.17
4.2f Desireable	5.15	1.42	5.75	1.24
4.3 Recommend Reunification	*5.06	3.23	6.89	3.09
4.4 Not Recommend Reunification	*4.93	3.06	4.54	2.64
4.5 Encourage Reunification	4.67	1.32	5.23	1.39
4.6 Colleagues Think	4.65	1.26	5.14	1.60

* Values ranged from 1-12, where 1= 0% of the time and 12= 100% of the time.

MEANS AND STANDARD DEVIATIONS FOR EACH ITEM
BY SECONDARY PRACTICE ORIENTATION

Item	Intrapsychic Group (N=33) M	SD	Systemic Group (N=46) M	SD
General Attitudes				
1.1 Parental Influence	3.36	1.30	3.85	1.35
1.2 Parental Importance	6.00	1.60	6.04	1.25
1.3a Capable	2.97	1.38	3.84	1.56
1.3b Strong	3.30	1.24	3.44	1.34
1.3c Helpful	3.09	1.07	4.02	1.37
1.3d Useful	4.30	1.02	4.69	1.24
1.3e Stable	2.48	.94	2.60	1.09
1.3f Nurturing	3.06	1.17	3.20	1.31
1.3g Essential	5.82	1.21	5.71	1.31
Decision Making				
2.1a Invite Re: Placement	6.55	.83	6.49	.94
2.1b Invite Re: Visitation	6.39	1.14	6.27	1.23
2.1c Invite Re: Return Home	6.70	.77	6.40	1.27
2.1d Invite Re: Rights	6.12	1.71	6.20	1.56
2.1e Influence Placement	4.75	1.65	5.17	1.60
2.1f Influence Visitation	5.28	1.42	5.25	1.62
2.1g Influence Return Home	5.44	1.39	5.27	1.72
2.1h Influence Rights	4.75	2.02	4.93	1.84
2.2a Clarifying	5.55	1.28	5.60	1.37
2.2b Helpful	5.33	1.45	5.63	1.10
2.2c Stabilizing	3.88	1.29	4.83	1.48
2.3 Satisfied	4.15	1.30	3.91	1.40
2.4 Colleagues Think	5.15	1.58	5.02	1.44
2.5 Parents Think	5.85	1.20	6.29	1.12
Visitation				
3.1 Parents Want	4.39	1.37	4.72	1.41
3.2 Should Have	5.00	1.37	5.00	1.21
3.3 Frequent Contact Is	6.50	.67	6.41	.65
3.4 Infrequent Contact Is	5.25	1.34	4.74	1.76
3.5a Beneficial	5.42	.94	5.47	1.10
3.5b Necessary	5.70	1.13	5.71	1.18
3.5c Good For Families	5.06	1.12	5.27	1.30
3.6 Encourage Visitation	5.52	1.06	5.57	1.09
3.7 Colleagues Think	5.00	1.30	5.13	1.05
Reunification				
4.1 Parents Capable	4.00	1.58	4.11	1.43
4.2a Usual	4.42	1.46	4.42	1.42
4.2b Possible	5.12	1.14	5.11	1.21
4.2c Important	5.48	1.40	5.44	1.16
4.2d Valuable	5.79	.96	5.42	1.16
4.2e Good For Children	5.21	1.24	5.20	1.20
4.2f Desireable	5.64	1.14	5.32	1.39
4.3 Recommend Reunification	*5.70	3.42	5.41	3.27
4.4 Not Recommend Reunification	*4.42	2.88	4.24	2.64
4.5 Encourage Reunification	4.79	1.54	4.58	1.40
4.6 Colleagues Think	4.76	1.52	4.60	1.29

* Values ranged from 1-12, where 1= 0% of the time and 12= 100% of the time.

MEANS AND STANDARD DEVIATIONS FOR EACH ITEM
BY POSTGRADUATE TRAINING ORIENTATION

Item	Intrapsychic Group (N=64) M	SD	Systemic Group (N=64) M	SD
General Attitudes				
1.1 Parental Influence	3.46	1.38	3.56	1.23
1.2 Parental Importance	5.97	1.44	6.13	1.30
1.3a Capable	3.58	1.60	3.64	1.54
1.3b Strong	3.41	1.28	3.50	1.25
1.3c Helpful	3.54	1.29	3.81	1.32
1.3d Useful	4.52	1.24	4.52	1.13
1.3e Stable	2.79	1.30	2.62	.99
1.3f Nurturing	3.40	1.31	3.24	1.21
1.3g Essential	5.37	1.66	5.80	1.27
Decision Making				
2.1a Invite Re: Placement	6.38	.93	6.46	.91
2.1b Invite Re: Visitation	6.22	1.19	6.32	1.16
2.1c Invite Re: Return Home	6.45	1.08	6.48	1.11
2.1d Invite Re: Rights	6.09	1.66	6.14	1.62
2.1e Influence Placement	4.84	1.70	5.05	1.68
2.1f Influence Visitation	5.25	1.48	5.18	1.67
2.1g Influence Return Home	5.01	1.77	5.29	1.56
2.1h Influence Rights	4.60	1.93	4.83	1.81
2.2a Clarifying	5.42	1.46	5.59	1.24
2.2b Helpful	5.30	1.55	5.47	1.40
2.2c Stabilizing	4.42	1.52	4.56	1.49
2.3 Satisfied	3.98	1.44	4.11	1.29
2.4 Colleagues Think	5.34	1.47	4.92	1.51
2.5 Parents Think	5.94	1.27	6.14	1.16
Visitation				
3.1 Parents Want	4.50	1.51	4.72	1.24
3.2 Should Have	4.88	1.55	5.22	1.24
3.3 Frequent Contact Is	6.36	.63	6.48	.62
3.4 Infrequent Contact Is	4.73	1.78	5.02	1.55
3.5a Beneficial	5.39	1.15	5.60	1.04
3.5b Necessary	5.66	1.24	5.92	.94
3.5c Good For Families	5.13	1.32	5.44	1.16
3.6 Encourage Visitation	5.41	1.08	5.72	1.06
3.7 Colleagues Think	4.98	1.13	5.14	1.32
Reunification				
4.1 Parents Capable	3.98	1.58	4.36	1.43
4.2a Usual	4.02	1.56	4.75	1.30
4.2b Possible	4.84	1.26	5.37	1.05
4.2c Important	4.98	1.58	5.80	.96
4.2d Valuable	5.14	1.37	5.86	1.02
4.2e Good For Children	5.11	1.28	5.47	1.14
4.2f Desireable	5.22	1.45	5.63	1.29
4.3 Recommend Reunification	*5.34	3.35	6.72	3.13
4.4 Not Recommend Reunification	*5.17	3.16	4.22	2.49
4.5 Encourage Reunification	4.66	1.40	5.21	1.36
4.6 Colleagues Think	4.52	1.39	5.14	1.40

* Values ranged from 1-12, where 1= 0% of the time and 12= 100% of the time.

MEANS AND STANDARD DEVIATIONS FOR EACH ITEM BY SYSTEMIC SCORE

Item	Little or No Systemic Group (N=69) M	SD	Primary Systemic Group (N=29) M	SD
General Attitudes				
1.1 Parental Influence	3.33	1.36	3.41	1.24
1.2 Parental Importance	5.65	1.47	6.21	1.21
1.3a Capable	3.62	1.52	3.57	1.57
1.3b Strong	3.46	1.22	3.62	1.32
1.3c Helpful	3.67	1.29	3.55	1.27
1.3d Useful	4.36	1.19	4.83	1.27
1.3e Stable	2.96	1.28	2.34	.81
1.3f Nurturing	3.35	1.26	3.28	1.41
1.3g Essential	5.20	1.52	5.69	1.56
Decision Making				
2.1a Invite Re: Placement	6.23	.96	6.31	1.11
2.1b Invite Re: Visitation	6.09	1.23	6.21	1.32
2.1c Invite Re: Return Home	6.32	1.09	6.31	1.31
2.1d Invite Re: Rights	5.96	1.67	5.90	1.82
2.1e Influence Placement	4.77	1.72	5.10	1.76
2.1f Influence Visitation	5.19	1.50	5.03	1.82
2.1g Influence Return Home	4.99	1.69	5.14	1.68
2.1h Influence Rights	4.48	1.80	4.93	1.93
2.2a Clarifying	5.38	1.32	5.52	1.41
2.2b Helpful	5.22	1.53	5.34	1.57
2.2c Stabilizing	4.50	1.47	4.34	1.63
2.3 Satisfied	3.88	1.36	4.21	1.18
2.4 Colleagues Think	5.34	1.30	4.59	1.72
2.5 Parents Think	5.96	1.19	6.31	.97
Visitation				
3.1 Parents Want	4.51	1.42	4.59	1.32
3.2 Should Have	4.80	1.49	5.14	1.27
3.3 Frequent Contact Is	6.35	.54	6.38	.86
3.4 Infrequent Contact Is	4.57	1.74	5.12	1.66
3.5a Beneficial	5.33	1.08	5.45	1.21
3.5b Necessary	5.51	1.21	5.86	1.09
3.5c Good For Families	5.17	1.28	5.28	1.36
3.6 Encourage Visitation	5.38	.99	5.69	1.14
3.7 Colleagues Think	4.99	1.15	4.69	1.39
Reunification				
4.1 Parents Capable	3.85	1.40	4.52	1.62
4.2a Usual	4.07	1.51	4.79	1.52
4.2b Possible	4.90	1.22	5.39	1.32
4.2c Important	5.09	1.46	5.93	.92
4.2d Valuable	5.16	1.30	6.00	1.04
4.2e Good For Children	5.01	1.22	5.62	1.15
4.2f Desireable	5.03	1.44	5.86	1.22
4.3 Recommend Reunification	*5.09	3.24	7.07	3.06
4.4 Not Recommend Reunification	*5.32	3.16	4.90	2.88
4.5 Encourage Reunification	4.63	1.36	5.17	1.65
4.6 Colleagues Think	4.58	1.30	5.00	1.79

* Values ranged from 1-12, where 1= 0% of the time and 12= 100% of the time.

APPENDIX D

PERCENTAGES OF POSITIVE ATTITUDE RESPONSES FOR EACH ITEM BY ORIENTATION VARIABLE AND SYSTEMIC SCORE

PERCENTAGE OF POSITIVE ATTITUDE RESPONSES FOR EACH ITEM
BY GRADUATE TRAINING ORIENTATION

Item	Systemic Responses	Intrapsychic Responses
General Attitudes		
1.1 Parental Influence	23.1	19.4
1.2 Parental Importance	89.7	82.6
1.3a Capable	44.4*	34.0
1.3b Strong	12.8	19.8
1.3c Helpful	30.8	29.9
1.3d Useful	56.4*	44.9
1.3e Stable	2.6	10.3
1.3f Nurturing	20.5	18.7
1.3g Essential	89.7*	77.6
Decision Making		
2.1a Invite Re: Placement	92.3	97.2
2.1b Invite Re: Visitation	92.3	92.6
2.1c Invite Re: Return Home	94.9	92.6
2.1d Invite Re: Rights	87.2	86.1
2.1e Influence Placement	68.4	67.0
2.1f Influence Visitation	65.8	73.8
2.1g Influence Return Home	68.4	70.4
2.1h Influence Rights	68.4	59.3
2.2a Clarifying	82.1	84.1
2.2b Helpful	79.5	79.6
2.2c Stabilizing	48.7	51.9
2.3 Satisfied	41.0	35.2
2.4 Colleagues Think	64.1	72.2
2.5 Parents Think	94.9*	85.0
Visitation		
3.1 Parents Want	66.7*	56.9
3.2 Should Have	71.1	67.0
3.3 Frequent Contact Is	53.8	46.3
3.4 Infrequent Contact Is	64.1*	45.8
3.5a Beneficial	87.2	82.4
3.5b Necessary	89.7	84.3
3.5c Good For Families	74.4	73.1
3.6 Encourage Visitation	82.1	82.6
3.7 Colleagues Think	61.5	67.3
Reunification		
4.1 Parents Capable	61.5*	40.7
4.2a Usual	53.8	54.2
4.2b Possible	81.6	73.1
4.2c Important	84.6*	73.1
4.2d Valuable	84.6	78.7
4.2e Good For Children	76.9	70.4
4.2f Desireable	87.2*	70.1
4.3 Recommend Reunification	64.1	67.5
4.4 Not Recommend Reunification**	38.1	45.2
4.5 Encourage Reunification	63.2	60.4
4.6 Colleagues Think	60.5	57.5

* Positive Responses >10% for Systemic Group

** In item 4.4, the lower the percentage the greater the positivity.

PERCENTAGE OF POSTIVE ATTITUDE RESPONSES FOR EACH ITEM
BY PRIMARY PRACTICE ORIENTATION

Items	Systemic Responses	Intrapsychic Responses
General Attitudes		
1.1 Parental Influence	17.9	21.1
1.2 Parental Importance	91.2*	80.0
1.3a Capable	34.0	38.4
1.3b Strong	16.1	19.3
1.3c Helpful	23.2	33.7
1.3d Useful	44.6	49.4
1.3e Stable	5.4	10.1
1.3f Nurturing	17.9	20.2
1.3g Essential	83.9	78.7
Decision Making		
2.1a Invite Re: Placement	94.7	96.6
2.1b Invite Re: Visitation	94.7	91.0
2.1c Invite Re: Return Home	94.7	92.1
2.1d Invite Re: Rights	87.7	86.5
2.1e Influence Placement	71.4	64.4
2.1f Influence Visitation	71.4	71.6
2.1g Influence Return Home	76.8*	65.2
2.1h Influence Rights	71.4*	56.2
2.2a Clarifying	86.0	81.8
2.2b Helpful	84.2	76.4
2.2c Stabilizing	47.4	53.9
2.3 Satisfied	40.4	34.8
2.4 Colleagues Think	64.9	74.2
2.5 Parents Think	89.5	86.4
Visitation		
3.1 Parents Want	61.4	57.8
3.2 Should Have	71.4	65.6
3.3 Frequent Contact Is	59.6*	41.6
3.4 Infrequent Contact Is	62.5*	43.8
3.5a Beneficial	86.0	82.0
3.5b Necessary	91.2	82.0
3.5c Good For Families	77.2	70.8
3.6 Encourage Visitation	87.7	78.9
3.7 Colleagues Think	63.2	67.0
Reunification		
4.1 Parents Capable	57.9*	38.2
4.2a Usual	61.4*	48.9
4.2b Possible	76.8	74.2
4.2c Important	84.2*	70.8
4.2d Valuable	86.0*	76.4
4.2e Good For Children	75.4	69.7
4.2f Desireable	82.5*	69.3
4.3 Recommend Reunification	80.7*	56.0
4.4 Not Recommend Reunification**	34.1*	48.6
4.5 Encourage Reunification	68.4*	55.8
4.6 Colleagues Think	66.7*	52.3

* Positive Responses >10% for Systemic Group

** In item 4.4, the lower the percentage the greater the positivity.

PERCENTAGE OF POSITIVE ATTITUDE RESPONSES FOR EACH ITEM
BY SECONDARY PRACTICE ORIENTATION

Items	Systemic Responses	Intrapsychic Responses
General Attitudes		
1.1 Parental Influence	30.4*	12.1
1.2 Parental Importance	84.8	81.8
1.3a Capable	44.2*	19.4
1.3b Strong	20.0	18.2
1.3c Helpful	44.4*	9.1
1.3d Useful	62.2*	36.4
1.3e Stable	6.7	3.0
1.3f Nurturing	20.0	15.2
1.3g Essential	86.7	84.8
Decision Making		
2.1a Invite Re: Placement	95.6	97.0
2.1b Invite Re: Visitation	88.9	90.9
2.1c Invite Re: Return Home	88.9	97.0
2.1d Invite Re: Rights	88.9	84.8
2.1e Influence Placement	73.9*	56.3
2.1f Influence Visitation	70.5	65.6
2.1g Influence Return Home	68.9	75.0
2.1h Influence Rights	68.9	65.6
2.2a Clarifying	84.4	84.8
2.2b Helpful	84.8	75.8
2.2c Stabilizing	60.9*	30.3
2.3 Satisfied	41.3*	27.3
2.4 Colleagues Think	69.6	72.7
2.5 Parents Think	95.6*	78.8
Visitation		
3.1 Parents Want	63.0	54.5
3.2 Should Have	64.4	66.7
3.3 Frequent Contact Is	47.8	48.4
3.4 Infrequent Contact Is	25.0	31.2
3.5a Beneficial	84.4	78.8
3.5b Necessary	84.4	84.8
3.5c Good For Families	71.1	66.7
3.6 Encourage Visitation	80.4	78.8
3.7 Colleagues Think	69.6	60.6
Reunification		
4.1 Parents Capable	46.7	45.5
4.2a Usual	57.8	51.5
4.2b Possible	77.8	75.8
4.2c Important	82.2	75.8
4.2d Valuable	82.2	84.8
4.2e Good For Children	77.8*	63.6
4.2f Desireable	77.3	75.8
4.3 Recommend Reunification	39.1	48.5
4.4 Not Recommend Reunification**	17.4	18.1
4.5 Encourage Reunification	55.8	57.6
4.6 Colleagues Think	58.1	54.5

* Positive Attitude Responses >10% for Systemic Group

** In item 4.4, the lower the percentage the greater the positivity.

PERCENTAGE OF POSITIVE ATTITUDE RESPONSES FOR EACH ITEM
BY POSTGRADUATE TRAINING ORIENTATION

Items	Systemic Responses	Intrapsychic Responses
General Attitudes		
1.1 Parental Influence	23.4	17.5
1.2 Parental Importance	87.5	82.8
1.3a Capable	41.0	33.9
1.3b Strong	19.4	19.0
1.3c Helpful	31.7	28.6
1.3d Useful	46.0	55.6
1.3e Stable	6.3	11.1
1.3f Nurturing	17.5	27.0
1.3g Essential	85.7	77.8
Decision Making		
2.1a Invite Re: Placement	96.8	95.3
2.1b Invite Re: Visitation	92.1	90.6
2.1c Invite Re: Return Home	93.7	90.6
2.1d Invite Re: Rights	85.7	84.4
2.1e Influence Placement	68.8	61.9
2.1f Influence Visitation	66.1	74.6
2.1g Influence Return Home	71.4	63.5
2.1h Influence Rights	63.5	55.6
2.2a Clarifying	87.3	79.7
2.2b Helpful	82.8	73.4
2.2c Stabilizing	51.6	48.4
2.3 Satisfied	34.4	39.1
2.4 Colleagues Think	62.5	76.6
2.5 Parents Think	92.1*	81.3
Visitation		
3.1 Parents Want	62.5	59.4
3.2 Should Have	71.4	64.1
3.3 Frequent Contact Is	53.1*	42.2
3.4 Infrequent Contact Is	57.1	48.5
3.5a Beneficial	88.9*	76.6
3.5b Necessary	90.5	82.8
3.5c Good For Families	79.4*	65.6
3.6 Encourage Visitation	85.9*	75.0
3.7 Colleagues Think	68.8	59.4
Reunification		
4.1 Parents Capable	50.0	44.4
4.2a Usual	67.2*	43.5
4.2b Possible	85.7*	65.1
4.2c Important	87.5*	65.1
4.2d Valuable	90.6*	71.4
4.2e Good For Children	79.7*	69.8
4.2f Desireable	84.1*	71.4
4.3 Recommend Reunification	59.4*	37.6
4.4 Not Recommend Reunification**	12.5*	28.2
4.5 Encourage Reunification	71.4*	54.8
4.6 Colleagues Think	69.8*	48.4

* Percentage of Positive Attitude Responses >10% for Systemic Group

** In item 4.4, the lower the percentage the greater the positivity.

PERCENTAGE OF POSITIVE ATTITUDE RESPONSES FOR EACH ITEM
BY SYSTEMIC SCORE

Items	Systemic Responses	Intrapsychic Responses
General Attitudes		
1.1 Parental Influence	20.7	15.9
1.2 Parental Importance	93.1*	79.7
1.3a Capable	39.3	35.4
1.3b Strong	20.7	17.6
1.3c Helpful	27.6	30.4
1.3d Useful	51.7	44.9
1.3e Stable	3.4	11.6
1.3f Nurturing	24.1	21.7
1.3g Essential	82.8	73.9
Decision Making		
2.1a Invite Re: Placement	93.1	95.7
2.1b Invite Re: Visitation	89.7	89.9
2.1c Invite Re: Return Home	89.7	91.3
2.1d Invite Re: Rights	79.3	82.6
2.1e Influence Placement	72.4*	60.9
2.1f Influence Visitation	65.5	73.9
2.1g Influence Return Home	65.5	63.8
2.1h Influence Rights	65.1*	52.2
2.2a Clarifying	86.2	80.9
2.2b Helpful	79.3	76.5
2.2c Stabilizing	44.8	51.5
2.3 Satisfied	37.9	33.8
2.4 Colleagues Think	51.7	73.5
2.5 Parents Think	96.6*	83.8
Visitation		
3.1 Parents Want	58.6	56.5
3.2 Should Have	67.9	65.2
3.3 Frequent Contact Is	55.2*	38.2
3.4 Infrequent Contact Is	64.2*	42.7
3.5a Beneficial	82.8	78.3
3.5b Necessary	86.2	78.3
3.5c Good For Families	72.4	69.6
3.6 Encourage Visitation	82.8	78.3
3.7 Colleagues Think	51.7	62.7
Reunification		
4.1 Parents Capable	55.2*	36.8
4.2a Usual	65.5*	46.3
4.2b Possible	82.1*	69.1
4.2c Important	93.1*	69.1
4.2d Valuable	93.1*	75.0
4.2e Good For Children	79.3*	67.6
4.2f Desireable	93.1*	66.2
4.3 Recommend Reunification	61.9*	33.2
4.4 Not Recommend Reunification**	24.0	31.7
4.5 Encourage Reunification	69.0*	53.7
4.6 Colleagues Think	69.0*	49.3

* Positive Responses >10% for Systemic Group

** In item 4.4, the lower the percentage the greater the positivity.

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