Parental substance abuse and child neglect: Development of a treatment manual

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PARENTAL SUBSTANCE ABUSE AND CHILD NEGLECT:
DEVELOPMENT OF A TREATMENT MANUAL

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ABSTRACT

Parental Substance Abuse and Child Neglect: Development of a Treatment Manual

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The maltreatment of children is a devastating social problem in the United States. Many researchers and child welfare workers believe the recent increase in child neglect is directly correlated to an increase in parental substance abuse. There is a strong relationship between child neglect and parental substance abuse, however there are limited treatments that address both issues simultaneously. The present study developed a Family Behavior Therapy treatment manual and preliminarily evaluated the credibility and client satisfaction of the interventions with a family referred by Clark County Family Services. The manual is based on existing published manuals, one of which is specific to drug abuse, and the other to child neglect. Manual development occurred in four phases including integration and modification of existing manuals, editing of developed drafts, role-plays, and finally implementation with a pilot case. This information will provide pilot support for a later controlled investigation of the treatment manual.
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CHAPTER 1

INTRODUCTION

*Child Maltreatment*

The maltreatment of children is a devastating problem in the United States. The annual number of reports of child maltreatment in America is approximately 3 million, or 40 cases per 1,000 children (McCurdy & Daro, 1993). Child maltreatment reports have maintained a steady growth for the past ten years, with the total number of reports of child maltreatment nationwide increasing 45% since 1987 (National Committee for the Prevention of Child Abuse, 2000). The number of children reported to be victims of child abuse and neglect in the United States has doubled from 1.4 million children in 1986 to 2.8 million in 1993 (Scdlack & Broadhurst, 1996).

There are multiple forms of child maltreatment, including physical abuse, sexual abuse, and child neglect. Unlike other forms of child maltreatment, child neglect involves an omission of behaviors that generally result in impairment to a child’s development or overall welfare. There are four main categories of neglect, physical neglect (e.g. inadequate supervision, lack of food, lack of safe housing), emotional neglect (e.g. failure to provide affection to child), educational neglect (e.g. not enforcing school truancy rules, failure to promote the child’s education), and medical neglect (e.g. not providing adequate medical care) (Scannapieco and Connell-Carrick, 2002).
A 1997 survey of child protective service agencies in the U.S. reported 2.3 million children were victims of child abuse and neglect, of which approximately half were neglected (Kaplan, Pelcovitz, & Labruna, 1999). According to the U.S. Department of Health and Human Services (1998), child neglect accounts for 60% of founded incidents of child maltreatment, with 57% of these cases being physical neglect, 29% being educational neglect, and 22% being emotional neglect.

**Negative Consequences of Child Neglect**

Unlike physical abuse, child neglect may not leave visible marks, but the effects are potentially more devastating. Indeed, the National Center on Child Abuse and Neglect reports child fatalities and serious injuries are more often associated with child neglect than child abuse (NCCAN, 2003). Studies have identified negative consequences for children who are victims of maltreatment, including long-term behavioral and emotional problems that often require psychological treatment. Long lasting consequences of being a child victim include feeling a loss of control over life, experiencing high stress, having poor self-esteem, feelings of hopelessness, and developmental delays (Erickson & Egeland, 2002).

A well-documented consequence of child maltreatment is impairments in language. Maltreated toddlers tend to show less developed expressive language about themselves and others, which may negatively affect their social interactions. For instance, Katz (1992) found abused and neglected children suffered from language delays. Harrington, Dubowitz, and Black (1995) found children from safer, cleaner, and more organized home environments had higher receptive language development than children in homes that were hazardous, untidy, and less organized.
Maltreated infants often form insecure attachments with their caregivers that are later associated with anxious and avoidant patterns of interaction with others (Schneider-Rosen & Cicchetti, 1984). Higgins and McCabe (2000) studied the relationship between different types of maltreatment during childhood and adjustment in adulthood. Retrospective reports of child maltreatment were used as well as family characteristics. Retrospective accounts of child neglect were associated with present low family cohesion and low family adaptability. Thus, having a history of child maltreatment resulted in the transmission of dysfunctional family patterns from the family of origin to the victim’s current family.

McCord (1983) studied a sample of 232 men who were boys between the ages 5 to 9 years old when selected to participate in the study and were followed into adulthood. Results showed that of the children found to be abused and neglected, one in five had a juvenile record that consisted of serious crimes and 40% were convicted of a crime as an adult. Moreover, approximately half became criminals, alcoholics, mentally ill, or died before reaching 35 years of age. Indeed, several studies have demonstrated a strong relationship between child maltreatment and the later development of juvenile delinquency (Grella, Stein, & Greenwell, 2005; Gover & MacKenzie, 2003, Widom, 1989).

Maltreated children appear to have significantly lower scores relative to non-maltreated youth on measures of intellectual functioning and academic achievement. The Minnesota Parent Child Project followed 267 newborns of mothers who were at high risk to commit child neglect (Egeland & Erickson, 1999). Of the children at risk those that were victims of child maltreatment in infancy were more anxious than those who were not maltreated in infancy. By the age of 2 years maltreated children lacked enthusiasm,
were easily frustrated, had issues with anger, had poor impulse control, and expressed
less happiness as compared to the non-maltreated children. By school age maltreated
children evidenced academic difficulties, and 95% of the maltreated children were
receiving some form of educational assistance in school.

Children who have been victims of child maltreatment often suffer from
psychological disorders. Victims of neglect, as well as other forms of child maltreatment,
have been identified as being at greater risk for developing psychiatric disorders than
non-maltreated children (Livingston, Lawson, & Jones, 1993). These disorders include
posttraumatic stress disorder, depression, personality disorders, conduct problems,
dissociation, panic disorders, anxiety disorders, and eating disorders (see Bernstein,
Stein, Newcomb, et al, 2003; Kaufman, 1991; Livingston, Lawson, & Jones, 1993; see
Werkerle & Wolfe, 2003). A disproportionately large number of adults who suffer from a
substance abuse disorder report that they were maltreated as children (Kelly, 2002). In
fact, childhood maltreatment has been found to double the risk of having a substance
abuse problem as an adult.

The most disturbing negative consequence of child neglect is death. Child neglect
accounts for approximately 45% of child fatality cases (Wang & Daro, 1998). Children
three years of age or younger are at greatest risk, and have higher fatality rates as a result
of being a victim of child neglect (Scannapieco & Connell-Carrick, 2002). In 78% of
child fatalities resulting from child maltreatment the victims were under the 3 years of
age (USDHHS, 1998). Child fatalities have also been identified to be associated with
parental substance abuse. Substance abuse has been found to be associated with
approximately two thirds of child maltreatment fatalities, with 44% of these deaths
involving child neglect (Reid, Macchetto, & Foster, 1999).
The negative consequences of child neglect extend beyond the victim and the victim’s family. For instance, direct monetary costs represent costs that are associated with the needs of abused or neglected children, and indirect costs are associated with the long-term effects of child maltreatment. Fromm (2001) estimates spending as a result of child abuse and neglect is 94 billion dollars annually. This cost includes hospitalization of children, chronic health problems, mental health services, spending by the child welfare system and law enforcement agencies, judicial system costs, special education, and loss of productivity as adults.

*Child Neglect and Substance Abuse*

The rate of child maltreatment, especially child neglect, appears to be increasing. Many researchers and child welfare workers believe the increase is directly correlated to an increase in parental substance abuse. Parental drug use may put a child at increased risk for child neglect because parents are likely to devote their time and resources to obtain drugs when they should be performing care taking behaviors (Harrington, Dubowitz, Black, & Binder, 1995). Along these lines, it is estimated that 9% or 6 million children in this country live with at least one parent who abuses alcohol or other drugs (NCCANCh, 2003).

Studies examining the relationship between parental substance abuse and child neglect have found that parental substance abuse occurs in approximately half of the families that have received services from family and welfare services (Murphy, Jellineck, Quinn, Smith, Poiric, Ooshko, 1991). Results of a 1999 national survey found 80% of 915 frontline professionals from child welfare agencies reported that parental substance abuse contributed to child maltreatment in their cases (Reid et al, 1999). In a large
community sample of approximately 11,000 parents, a lifetime DSM-III substance abuse
disorder has been indicated in slightly more than half of the parents who have self-
reported neglect of their children (Chaffin, et al., 1996; Kelleher, et al., 1994). In
addition, when the relationship between different types of child maltreatment (i.e.
eglect, physical abuse) and substance abuse disorders are examined, the strongest
association is between substance use and child neglect (Famularo, Kinscherff, & Fenton,

There is a particularly strong relationship between parental alcohol abuse and child
maltreatment. Famularo, Stone, Barnum, and Whalen (1986) found an increased
incidence of alcoholism in the parents of abused children who had been removed from
the home, and 50% of court-referred mothers were reportedly “alcoholic” compared to
30% in non-court referred cases. Alcoholism increased the likelihood of maltreatment,
which appeared to result in greater rates of aggression, stress, and decreased attention to
the basic needs of children within the home, decreased job performance, lower income,
and poor health. Similarly, Behling (1979) found 51% of patients in a naval hospital had
evidenced physically abusive behavior, 39% had evidenced neglect. “Alcoholism” was
reported in 69% of parents with a history of reported child maltreatment. Another study
compared the rate of alcoholism in parents whose children were removed from their
custody as a result of severe maltreatment with non-abusive parent control group
(Famularo, Stone, Barnum, & Wharton, 1986). The participants involved in child
maltreatment were found to have a higher incidence of alcoholism as compared with the
control group. Of the participants involving child maltreatment, 52% had at least one
parent who met their criteria for “alcoholism.”
Similar to alcohol, there is a strong association between parental drug use and the occurrence of child maltreatment, particularly child neglect (Famularo, Kinscherff, and Fenton, 1992). Indeed, 18% of substantiated reports of child abuse and neglect involved a caretaker that primarily abused an illicit drug (Magura & Laudet, 1996). Leif (1985) explained the difficulties of working with this population by stating in his experience there is no group more special than a drug-abusing parent. Drug-abusing mothers must cope with the consequences of drugs such as physical discomforts, including withdrawal symptoms, and they must often also cope with financial and psychological problems that place them at risk for parenting problems. Other problems that substance-using mothers may face include being a single mother, living in poverty, and being uneducated (Bernstein, Stein, Newcomb, et al, 2003).

**Purpose of the Present Study**

There is a strong relationship between child neglect and parental substance abuse. However, no standardized treatments have been developed to address both of these issues simultaneously. The present study employed a Family Behavior Therapy treatment manual and preliminarily evaluated the ease of administration of the manual with a family referred by Clark County Family Services (i.e. 1 case study). The study utilized a standardized method of manual development that involved reviewing and editing manual drafts, evaluating manual drafts during role-plays with staff members portraying the role of family members and therapists, and lastly implementation of the developed protocol in a case involving family members in which child neglect and parental drug abuse had occurred. Based on outcome results and clinical experiences with these cases, study revisions to the manual were conducted to assist in applicability and treatment feasibility.
The manual was based on two existing published manuals, one of which is specific to drug abuse, and the other child neglect. Protocol adherence measures corresponding to this manual were developed. It was hypothesized that the treatment manual would address both child neglect and substance abuse, and clients would find the interventions to be credible and satisfied that their treatment needs were met. Specifically, the implementation of the treatment is expected to increase positive behaviors such as abstaining from drugs and more appropriate parenting behaviors. It was also hypothesized that the manual would be successfully implemented with a family and based on experiences with this case study the treatment manual would require modification to increase the ease of administration. Implementation of the manual is expected to enhance treatment delivery as a result of providing specific guidelines for treatment implementation.
CHAPTER 2

LITERATURE REVIEW

The issue of child neglect is a fast growing problem in the United States. Presently, the literature on prevention, intervention, and other related topics provides great insight into the relevant antecedents and consequences of child neglect. Substance abuse, another major societal issue, has been studied vastly and a large body of research exists on the topic that informs researchers and clinicians about substance abuse disorders, characteristics associated with the initiation of drug use, and empirically validated treatment programs.

Characteristics of Perpetrators of Child Neglect

Researchers have identified several characteristics that are commonly evidenced in perpetrators of child maltreatment. In understanding the context in which these characteristics develop, it is important to acknowledge there is a strong intergenerational transmission of child maltreatment (Crouch, Milner, & Thomsen, 2001), although the majority of victims of child maltreatment do not victimize their children. A relationship between psychopathology and being a perpetrator of child maltreatment is well documented in the literature. For instance, abusive and neglectful parents are prone to develop Antisocial Personality Disorder, Major Depression, Dysthymia, and Substance Abuse (Kaplan et al, 1983). Interestingly, the latter study found other axis I disorders are
generally not risk factors for being a perpetrator of child maltreatment unless substance abuse is present. A recent Epidemiological Catchment Area study (1996) found more than half of parents who neglected their children had a lifetime prevalence rate for a DSM-III substance abuse disorder. Famularo, Kinschereff, and Fenton (1992) conducted a study to identify the DSM diagnosis of mothers who maltreated their children compared with mothers that did not maltreat their children. Based on results for a structured clinical interview, mothers who maltreated their children exhibited a significantly greater incidence of current mood disorders, alcohol abuse, personality disorders, and posttraumatic stress disorder.

According to Regan, Ehrlich, & Finnegan (1987) it is common for families in which child maltreatment has occurred to include one or both parents having been a victim of violence, having an unhappy childhood, being addicted to drugs or alcohol, being violent with the other caregiver, having abused or neglected multiple children, did not want or expect the pregnancy, did not bond with the child, and lived in poverty. Other factors include suffering from significant stressors such as health problems, economic problems, and family interaction problems (Bernstein, Stein, Newcomb, et al, 2003). In addition, perpetrators often have unrealistic expectations of a child’s development, are unaware of the child’s needs, and have strong beliefs in the value of physical punishment (English, Marshall, Brummel, & Orme, 1999).

Other risk factors of being a perpetrator of child neglect are the primary caregiver being a mother, especially a young mother (Fantuzzo, 1990; Regan, Ehrlich, & Finnegan, 1987; Zuravin, 1988). Approximately 80% of perpetrators of child neglect are the primary caregiver of the victim (Fantuzzo, 1990). An average of 33% of families reported for child maltreatment are single mothers, or single female-headed households (Fantuzzo,
People who become parents at a younger age, have more pregnancies, more unplanned children, larger families, or space the ages of their children closer together have a greater likelihood of becoming perpetrators of child neglect (Zuravin, 1988). This may result from the high stress levels that are associated with households comprised of the aforementioned characteristics.

In most cases perpetrators of child neglect are mothers, with teenage mothers being particularly at risk. Mothers under the age of 26 years have been found to neglect their children more often when compared to older mothers (Kienberger, Jaudes, Ekwo, & Van Voorhis, 1995). This is believed to be a result of younger mothers engaging in less appropriate parenting behaviors than older mothers possibly due to a lack of knowledge regarding parenting skills, having more unrealistic expectations of their children’s development, being unaware of children’s needs, and having a strong belief in physical punishment (Zurivan, 1996).

 Adolescent mothers, and mothers who had their first child when under the age of 18 years, comprise a high percentage of perpetrators of child maltreatment (Zuravin, 1988). Multiple studies that compare adolescent mothers with older have found younger mothers have a higher likelihood of maltreating their children. In a study that examined 24 adolescent and 24 adult single mothers, the infants of adolescent mothers, vocalized less, smiled less, and offered the infant toys less frequently (Barratt & Roach, 1995). Compared to the older mothers, the adolescent mothers were also rated less appropriate in their interactions, and less vocally responsive to their children. Along a slightly different vein, Zurivan (1996) examined child maltreatment in a group of 119 young mothers to identify the relationship of physical abuse and neglect among low-income female-headed households. Results of this study indicated that age of the mother was more likely to be
correlated significantly with neglect than abuse, and neglecting mothers were 5 times more likely to have had 2 or more children prior to the age of 18 years, as compared with abusing mothers. Neglecting mothers were also twice as likely to be depressed after the birth of the child than the other low-income mothers.

**Characteristics of Victims of Child Neglect**

There are certain characteristics that place children at an increased risk for being a victim of child maltreatment. For instance, a child's age can be a risk factor for being a victim, as child neglect occurs almost exclusively in children under the age of 8 years (Bernstein, Stein, Newcomb, et al, 2003). Indeed, children in this age range are highly dependent on their caregiver. Other child risk factors associated with being a victim of child abuse and neglect include being born prematurely, being viewed as less attractive by the parents, having a difficult temperaments, and having a physical or mental disability (Wolfe & McEachran, 1997) because these characteristics are believed to make the parenting role less rewarding. For example, babies born exposed to drugs in utero have physiological or developmental problems such as being easily agitated and often cry at relatively high rates, as compared with children who are not born in such circumstances (Kelly, 1992). When parental stress increases, the chances of children being perceived as troublesome also increase, thus escalating parental irritability and likelihood of child maltreatment.

**The Relationship Between Child Neglect and Substance Abuse**

Studies have found parental substance abuse plays a role in up to 70% of reported cases of child maltreatment (see Brown and Anderson, 1991). Approximately 375,000 of
the children born each year have been exposed to parental substance abuse resulting in Fetal Alcohol Syndrome and low birth rate and many other serious problems that can have short term and long-term effects on the child (Chasnoff, 1988). Jaudes, Ekwo, and Vorrhis (1995) compared the number of children born exposed to illicit drugs with Department of Family Services records of reported child abuse and neglect. Records showed that in total, 513 children were exposed to illicit substances in-utero, and of these children, 155 had been reported as victims of child abuse and neglect to child protective services. Indeed, children of substance abusing parents are more likely to experience emotional and physical neglect and abuse than those in non-substance abusing households (NCCANHC, 2003), exacerbating parenting and coping skills in the caregiver.

Kelly (1992) examined the relationship between parental stress, prenatal exposure to drugs, and the occurrence of child maltreatment. Participants included 24 infants prenatally exposed to drugs and a comparison group of infants not prenatally exposed. Demographics of the participants demonstrated that there were fewer fathers involved with the drug-exposed infant compared to the non-exposed infants. Drug exposed infants were more likely to be in the custody of child protective services and significantly more drug using mothers were found by child protective services to neglect their children. As expected, parents of drug exposed infants reported higher levels of parenting stress than the parents in the comparison group.

A 1998 survey of the 50 states showed 85% of child protection services caseworkers reported that substance abuse was one of the two leading problems in families that receive services from their agency (Kelly, 2002). The relationship between parental substance use and child maltreatment is very strong with some studies finding as much as
67% of child maltreatment cases involved parents who abused either alcohol, drugs, or both (Famularo, Kinscherff, and Fenton, 1992). In addition, caseworkers report that 65% of children who have substance-abusing parents were maltreated while their parents were under the influence of alcohol or drugs. A national survey in 1,991 indicated 24% of substantiated reports of child abuse and neglect involved a caretaker that primarily abused alcohol, and 18% involved a caretaker that primarily abused an illicit drug (Magura & Laudet, 1996). This survey also found that the most commonly abused substances by caregivers were alcohol (77%), followed by marijuana (32%), cocaine (20%), crack (17%), and with a small percentage-using heroin (4%).

Substance use by a caregiver of a child of any type increases the likelihood of child maltreatment (Kelly, 2002). Individuals who abuse substances tend to function worse as parents, as the substance use results in limited financial resources to purchase products necessary to effectively raise children, a significant amount of time spent seeking drugs, and time away from children prevents effective monitoring of, and engagement in, child activities (NCCANCh, 2003).

Ammerman et al (1999) hypothesized various ways that parental substance abuse negatively impacts parenting. Some of the common negative outcomes on parenting hypothesized included low frustration tolerance, increased anger reactivity, disinhibition of aggressive impulses, or interference with appropriate judgment. Indeed, substance use increases the chances of being reported to child protective services, and may result in a re-report after the initial report is documented (English, Marshall, Brummel, & Orme, 1999). For instance, Wolock and Magura (1996) found there was significantly more re-reports for the cases that involved parental substance abuse compared to those cases that did not involve parental substance abuse.
The relationship between parental substance use and child neglect is not necessarily a linear relationship, but is best thought of as interplay between many factors, including overall functioning in the family. Families with a substance abuse problem often experience a higher incidence of other problems, such as mental illness, unemployment, and stress (NCCANCh, 2003). Kelly (1998) compared parenting stress and coping mechanisms in 30 substance abusing and 30 non-substance abusing mothers. Ninety percent of substance abusing mothers self reported being referred to child protective services, as compared with 7% of non-substance abusing mothers. As compared with non-substance abusing mothers, substances abusing mothers had significantly greater levels of parenting stress, negative parent child interactions, and difficulties in child compliance.

Research has shown that common problems exist in homes where substance abuse occurs, including poor communication skills, high family conflict, and low levels of family competence (Moos and Moos, 1984). For instance, in a sample of families affected by child maltreatment, Dore, Doris, and Wright (1995) found families that included a substance abuser were more dysfunctional than families that did not involve a substance abuser. Murphy et al (1991) found parental substance abuse histories predicted various problem behaviors in parents. Parents with histories of substance abuse were more likely than other parents to have higher recidivism rates for child neglect and abuse, and had higher rates of failing to comply with court ordered treatment. In addition, parents with histories of substance abuse had a higher rate of children being removed from their custody than parents without a history of substance abuse. That is, substance abuse appears to negatively impact family functioning, which, in turn increases the likelihood of child neglect or abuse.
Existing Treatments for Child Neglect

Prior to the passage of the Child Abuse and Neglect Treatment Act in the 1970’s there were only a few interventions for child maltreatment (Cohn & Daro, 1987). However, there are now several treatments available for child abuse, and a few that target child neglect specifically. Some focus on child victims, some with perpetrating or non-perpetrating caregivers, and others involve the entire family utilizing comprehensive services. Few treatments have been developed specifically for child neglect, and of those that exist, most are not empirically validated.

Cohn and Daro (1987) reviewed 89 treatment programs targeting child abuse and neglect, and found treatment programs that provided parent education, household management, and vocational skills produced significant effects in increasing the likelihood that parents who received treatment would not maltreat their children in the future. In uncontrolled studies, evidence shows child-neglecting parents are responsive to skills training. Indeed, treatments aimed at reducing home hazards, improving home cleanliness, hygiene, nutrition, and child stimulation have been shown to be particularly effective in this population (Paget et al., 1993).

Child Focused Interventions

Several treatment programs for child victims of neglect have been developed, although outcome support for their efficacy is limited. Most treatment programs for child victims are day treatments that provide group activities combined with individual therapy (Wolfe & Wekerle, 1993). For instance, Culp, Richardson, and Heide (1987) demonstrated that child victims involved in a therapeutic day treatment program that received group and individual treatment in conjunction with similar services provided to their parents showed improvements in fine motor, cognitive, social, and language skills.
This study found positive pro-social responses increased in withdrawn maltreated children who engaged in peer and adult mediated play sessions. Thus, interventions that involve children can be beneficial to the child and to the family.

**Parent Focused Interventions**

Most parent-focused interventions for child maltreatment are of behavioral, cognitive, or cognitive-behaviorally oriented. Behaviorally oriented treatment programs for parents of neglected and abused children tend to involve skills training treatments, such as child management, anger management, and stress management. Child management skills training involves educating parents about differential reinforcement, contingency management for their children, modeling and role-playing relatively non-aversive disciplines (i.e., Hanf’s time out, Azrin’s positive practice), teaching problem solving skills, and providing feedback to parents about their behavior such as praising improvement (Wolfe & Wekerle, 1993).

Cognitive interventions focus on changing maladaptive thought patterns to more appropriate thought patterns to reduce the risk of engaging in child maltreatment. Self control and anger control techniques are employed to assist parents in controlling their arousal level. The components of these interventions are teaching parents to detect arousal changes, replacing anger producing thoughts with more appropriate thoughts, and teaching parents to use self-control in high risk situations or situations in the past that involved negative parenting practices. For example, a mother who is identified to neglect her infant by not changing dirty diapers would be taught to recognize maladaptive thought patterns pertinent to this behavior (i.e. the baby can wait to be changed until later) and adopt more appropriate thinking patterns (i.e. if I do not change the diaper now the baby may get a rash).
Cognitive-behavioral programs address treatment goals by increasing parenting skills and coping abilities simultaneously. Studies of cognitive behavioral treatments show that there is a high rate of success for caregivers to reduce behaviors and thoughts that predispose them to engage in child neglect or other forms of child maltreatment. Specifically, improvements in parenting skills are often evident, as well as an increased ability to positively interact with their children (Wolfe & Wekerle, 1993). Follow-up data also show newly established pro-social behaviors are maintained, and there is a low rate of recidivism.

Comprehensive treatment programs attempt to address multiple factors in child maltreatment, and provide a wide range of services. For example, comprehensive treatments may address family support, home safety, how to manage finances, job search skills, and enhancing family communication, (Brunk, Henggeler, Whelan, 1987; Hughes & Gottlieb, 2004; Barone, Greene & Lutzker, 1986; Lutzker, 1994). Family centered home-based intervention programs generally occur in families where child maltreatment is severe. Services provided to these families can include case management, self-control, problem solving, household management, and supportive counseling, but vary depending on the program.

Project 12 Ways answered the call made by researchers in the field for a comprehensive intervention that occurs in the home of the client. The recommendation for in home treatment is based on the belief that this would increase the likelihood of generalizability for the family since treatment would be occurring in their environment. Project 12 Ways espouses an eco-behavioral intervention approach to child maltreatment (Lutzker, 1994). Services are multifaceted and include parent training, stress reduction, problem solving, assertiveness training, social support, home safety, nutrition, leisure
skills, job finding, alcoholism treatment referral, and behavior management. In an uncontrolled outcome study (Lutzker, 1994), Project 12 Ways was shown to improve cleanliness of homes, improve emotional health of parents, and improve the parent’s child rearing skills.

Watson-Percel, Lutzker, Greene, and McGimpsey (1988) demonstrated improvements in a small sample of families who received home safety training. Improvements were objectively documented in regards to the family’s home cleanliness and safety. For example, one family, involved in the family services system due to child neglect, initially had a home environment that with a large amount of garbage, dirty clothes, spoiled food, and human feces on floor. In addition, the assessors of the home documented a foul odor, and infestation of pests in the home. The therapists utilized the Checklist for Living Environments to assess each room of the family’s home. For this family the initial treatment target was the bathroom because of its small size, which made it easier to clean, thus increasing the likelihood of the family being able to meet their treatment goal. The mother was given instructions about cleaning to ensure if there was a skill deficit, the mother had appropriate skills training for the task. The results for the family showed significant improvements in all rooms of the home. For the bathroom the total clean items averaged 13% at baseline, and rose to 95% during maintenance. Improvements were found for other rooms in the home that were almost as significant as demonstrated the improvements for the bathroom. Similar home cleanliness rates were demonstrated for the other participants of this study. Other uncontrolled studies of eco-behavioral interventions that include behavioral skill development with family members of the identified client have shown significant improvements from pre- to post-treatment (Lutzker, Campbell, & Watson-Perczel, 1984; Barone, Greene, & Luzker, 1986; Lutzker et
al., 1987). Improvements have been demonstrated in parents providing personal hygiene and dental care for their children (Lutzker, Campbell, & Watson-Perczel, 1984). In addition, other uncontrolled studies have demonstrated improvements in the responses of neglecting mothers (Lutzker et al., 1987).

Another treatment program, Project SafeCare, focuses on improving parenting skills and utilizes cognitive behavior interventions and social support with parents who are at risk for child maltreatment (Gershater-Molko, Lutzker, & Wesch, 2003). This project was a 4-year in home intervention for parents reported for, or at risk for, child abuse and neglect. This program includes 3 of the 12 intervention components found in Project 12 Ways including child health care, parent child interaction, and home safety skills to the families. The main goals of this intervention program are to improve parenting skills and reduce future occurrences of child maltreatment. In an uncontrolled study, 41 families received training in child health care, followed by the home safety intervention, and lastly received parenting training. Each intervention was found to be highly effective in improving parental functioning, and consumer satisfaction data showed parents were highly satisfied with services received.

Consistent with the eco-behavioral model is Multisystemic therapy, which was developed by Henggeler and his colleagues (Henggeler, Borduin et al., 1991) for maltreating mothers. Indeed, both interventions emphasize parent education, involve family members, initiate therapy in the home, and adjust standardized formats to be consistent with unique family needs. In their initial study (Henggeler et al., 1991), eight abusive, and 8 neglectful families were randomly assigned to receive 8 sessions of multisystemic therapy (MST), and ten abusive and seven neglectful families completed 8 sessions of parent training (Brunk, Henggeler, Whelan, 1987). MST included informal
parent education regarding child management strategies, appropriate expectations for child behavior, teaching neglectful parents to perform executive functions, improving the mothers' relations with extended family, serving as advocates for families that encountered difficulties with outside agencies, and attempts to enhance social perspective-taking abilities of family members. Results of this study indicated that the interventions improved both neglectful and abusive parents global psychiatric functioning and overall stress, however neither intervention resulted in significant improvement in family functioning. MST resulted in significantly enhanced parent-child interactions, as compared with parents who received parent training. Due to limitations of this study including a low number of neglect subjects, no definitive conclusions regarding the effectiveness of treatments can be made. Nevertheless, the results of this study, and the aforementioned studies by Lutzker and his colleagues, suggest home-based family interventions and parent training are worthy of further scientific exploration in the treatment of child neglecting parents.

Webster-Stratton’s parenting program (Hughes & Gottlieb, 2004) appears promising in child neglect. The intervention is a standardized video based modeling intervention that targets families with young children. The program involves teaching parents how to play with their children, assist their children to learn, to use praise and give reinforcement, set appropriate limits for their children, and how to handle undesired behavior displayed by their children. Parents work in groups that consisted of up to 8 people for a total of 8 - 2-hour sessions. A randomized clinical trial involving her program examined maltreating mothers’ ability to learn to provide three positive parenting conditions (i.e., involvement, autonomy-support, structure) and tested the effect of the parenting on child’s autonomy (Hughes & Gottlieb, 2004). Results indicated that
parents were significantly more involved with their children after the treatment, and mothers provided more autonomy support during free play. Of the mothers who received the treatment 30% showed clinically significant improvement, and these mothers tended to be older, better educated, and felt more satisfied with their social support than mothers who were in the wait list control group. The results of this study provide support for the success of behavioral-based interventions in high-risk populations, such as mothers who maltreat their children. However, the effects of this program in reducing child neglect are undetermined.

Existing Treatments for Drug Abuse

There are currently a number of treatments available for drug abuse and dependence that have demonstrated efficacy in treatment outcome studies of substance abuse. Treatment outcome research for substance abuse is far advanced when compared to child neglect. It appears that cognitive and behavioral approaches are most effective for substance use. Similar to the issue of child maltreatment interventions that include family members or significant others demonstrate promising results with substance abusers.

Addictive behavior is an acquired habit or pattern, which has been ameliorated for many individuals by utilizing learning based treatments (Finney & Moos, 2002). The focus of cognitive behavioral interventions is on altering the cognitive and behavioral processes that lead to substance use by identifying and modifying maladaptive patterns to reduce, or eliminate substance abuse. Cognitive Behavioral treatments have been rated as the most effective treatment in treatment reviews for substance abuse (see Rotgers, Morgenstern & Walter, 2003). Some basic assumptions of cognitive behavioral interventions are any behavior that is learned can be relearned, reshaped, or eliminated
through the same learning process, and the interaction between the person and the environment can be altered. The treatment goals are abstinence or reduction in the use of substances, as well as reduction in the frequency and severity of relapse (APA, 2002).

There are many forms of treatment for substance disorders that have cognitive and behavioral components. Cognitive therapy identifies and modifies maladaptive patterns that can reduce or eliminate negative feelings, and substance abuse (Beck, Wright, Newman, & Liese, 1993). Techniques vary and can include social skills training, coping strategies, and relapse prevention. Social skills training include identifying high-risk situations, and behavioral strategies to assist in coping with stressors. Coping strategies vary, but often involve the management of urges to use drugs, improvement of refusal skills, and teaching problem solving skills. Research has shown treatments that emphasize social skills training components are related to long-term positive outcomes (Rotgers, Morgenstern & Walter, 2003).

Relapse prevention is focused on the development of self control strategies aimed at avoiding relapse by identifying triggers of substance use and developing and practicing coping strategies (Chiauzzi, 1991). Factors for relapse include negative and positive emotional states, social pressure, testing of personal control, and interpersonal conflict. Relapse prevention may include teaching clients how to avoid and anticipate drug related cues through cognitive remediation (e.g. positive self-statements), lifestyle modification (e.g. time management), and skill building (e.g. self monitoring; George, 1990).

Family oriented treatments for drug use have demonstrated effectiveness in decreasing drug use (Santisteban et al., 2003; Latimer, Winters, D’zurilla, and Nichols, 2003). Behavioral family therapy includes empirically validated procedures such as behavioral contracting with effective components of family therapy such as involvement
of immediate family members. Controlled treatment outcome studies in adolescent drug abusers have indicated that therapies with family involvement are effective in reducing the use of drugs (see Myers, Brown, & Vik, 1999).

Brief Strategic Family Therapy (BSFT) has been empirically demonstrated to reduce drug use frequency, according to the results of urinalysis (Santisteban et al., 2003). In addition, improvements in family functioning have also been demonstrated. Multidimensional Family Therapy (MDFT) has been shown to be effective in several studies. In a recent study, MDFT reduced drug use up to 12-months at follow-up (Liddle et al., 2001). Similar improvements have resulted in Conjoint Family Therapy (CFT) (e.g., Szapocznik et al., 1983). Another intervention is Integrated Family and Cognitive-Behavioral Therapy (IFCBT), which is a new and well conceptualized family-based behavioral intervention that has led to improvements in several areas of family functioning including problem-solving, learning strategy skills, and reductions in drug use (Latimer, Winters, D’zurilla, and Nichols, 2003).

The Purdue Brief Family Therapy program is a behavioral family therapy treatment program for adolescents. Lewis, Peircy, Sprenkle, and Trepper (1990) examined the Purdue Brief Family Therapy program, which is a 12-session program that integrates the most effective elements of structural, strategic, functional, and behavioral family therapies. The goal of the program is to stop drug use in adolescents by helping the family understand their interpersonal dynamics and modify dynamics in ways that reduce adolescent substance abuse. Another goal is that by the end of treatment the family environment healthier and less likely to elicit drug use in the adolescent. Results found that 54.6% of the participants had significant decreases in drug use, or had abstained from drug use.
Waldron et al. (2001), conducted a study of 120 adolescents who met DSM-IV criteria for drug abuse and were randomly assigned to receive outpatient Psychoeducational Group Therapy, Family Functional Therapy (FFT), Individual Cognitive-Behavioral Therapy (ICBT), or Family Functional Therapy and Individual Cognitive-Behavioral Therapy (FFT +ICBT). Results showed significantly greater reductions in marijuana use at 4-month follow-up, according to time line follow-back self-report data, for individuals who received FFT and FFT+ICBT. Unfortunately at later follow ups the group differences in outcome were not maintained. Henggler et al. (1991) found home-based Multisystemic Therapy led to significantly lower rates of drug-related arrests at post-treatment assessment, as compared with individual counseling, in youth who were referred for drug use problems supporting the utilization of home-based family therapies in drug abusing and dependent adolescents. Thus, treatment outcome studies in adolescents have demonstrated family based interventions efficacy to reduce drug use.

There are several family-based interventions empirically validated with adults that have included interventions to address problem areas associated with substance use. For instance, in controlled trials Behavioral Couples Therapy (BCT) has consistently demonstrated increased family satisfaction, and reductions in drug abuse (Fals-Stewart et al., 1996, 2000, 2001). The developers of BCT have also recognized the unique needs of adult female substance abusers (e.g., focus on enhancing family support, depression, unemployment), and BCT has been shown to result in similar improvements in this population (Winters et al., 2001). BCT focuses on active recruitment of significant others to assist in the treatment of the identified substance abuser, employment of multiple behavioral/systems oriented therapies targeting the management of urges to use drugs, avoidance of exposure to drug related stimuli, emphasis on treatments within the program...
that appear particularly warranted (i.e., based on need), assistance in coping with relapse, drug refusal skills training, behavioral contracting, strategies to prevent violence, communication skills training, and standardized relationship enhancement exercises that focus on family support and cohesion that anecdotally appear to be particularly preferred in female substance abusers (Winters et al., 2001).

Presently, there are no published treatment outcome studies of mothers who abuse substances that have been substantiated for neglecting their children. Suggested interventions for this population include techniques that address parenting and family skills training such as addressing parental expectations and misconceptions about children, and programs that are home-based are preferred (Kienberger Jaudes, Ekwo, & Voorhis, 1995; Magura & Laudet, 1996; Wolfe, 1993). The proposed benefits for home-based interventions include the ability to incorporate children into treatment, elimination of the need for child care, and it allows the therapist to more effectively assist the family in acquiring and implementing home safety skills (Donohue, Ammerman, & Zelis, 1998). In addition, the home-based intervention program may increase the probability of the families generalizing the interventions. Many researchers believe that comprehensive home-based interventions are needed with at-risk families, such as mothers who abuse drugs and neglect their children. Olds & Kitzman (1993) suggest that parents are particularly responsive to home visitation programs, especially young mothers who are faced with an exceptional amount of stress.

*Family Behavior Therapy for Substance Abuse and Child Neglect*

Previous research has shown Family Behavior Therapy (FBT) to be effective in both substance abuse and child neglect. Multiple studies have demonstrated the efficacy of
Family Behavior Therapy in drug abusers. In addition, 93% of drug treatment programs indicated that family therapy was the treatment of choice with drug abusers (Coleman & Davis, 1978). Azrin, McMahon et al. (1994) examined FBT and Supportive Therapy in a controlled treatment outcome study in drug users. FBT included interventions to control urges to use drugs, communication skills training, stimulus control of drug associated stimuli, behavioral contracting, and job finding skills training. Supportive therapy consisted of discussion of drug abuse issues. Drug use was reduced to a greater extent for participants who received FBT compared to subjects who received Supportive Therapy, as measured in terms of number of days of use, and urinalysis results. The mean number of months of drug abstinence for all participants who received FBT was 6.36 months compared to 2.80 months for ST. Results of a 9 month follow up indicated that 71% of ST participants and 42% of FBT participants were using drugs at follow-up. Thus, long lasting positive effects were found for FBT in adult and adolescent drug abusers.

A second study with FBT and drug users consisted exclusively of adolescents (Azrin, Donohue et al., 1994). Results indicated that participants who were randomly assigned to receive FBT significantly decreased their drug use more than participants who received Supportive Therapy (ST) as measured by urinalysis, or days of drug use using urinalysis. Significant improvements were also found for FBT participants compared with ST participants, for depression, alcohol use, conduct problems, schoolwork attendance, parent satisfaction with youth, and youth satisfaction with parents. Thus, this pilot study suggested adolescents are particularly responsive to FBT compared with ST.

A third controlled treatment outcome study (Azrin, Donohue et al., 2001) examined the effectiveness of Family Behavior Therapy in comparison with an individualized cognitive problem-solving treatment in youths who were diagnosed with drug abuse.

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Participants were youth who were referred by individuals in the juvenile justice system (i.e. judges, probation officers, administrators). Of the 56 youths that participated, all had used marijuana at least once and most had used alcohol or illicit drugs. The two treatments were 6 months in duration, had an equal number of sessions, had an equal session length of 90 minutes, contained structured sessions that were guided by a treatment manual, and involved the use of praise for the client. Interventions used in the FBT program included behavioral contracting, stimulus control of drug stimuli, self control of urges to use drugs, and communication skills training. The Individual Cognitive Problem-Solving Therapy (ICPS) was based on theory, empirical research, and previously developed problem-solving methods that have been shown to improve self-control and problem-solving deficits in youths and adults evidencing aggressive and defiant behaviors (D'Zurilla, 1986; D'Zurilla & Goldfried, 1971; Kazdin et al., 1989; Kazdin, 1987; Richard & Dodge, 1982). The problem-solving treatment employed in this study was different from other problem solving therapies based on the fact that it was more reliant on cognition aspects and cognitive strategies that could be applied to a wide range of problems. Youth in both intervention conditions demonstrated significant decreases in their average number of self-reported days using illicit drugs per month, improved problem solving skills, increases in parents' satisfaction with their drug use, increases in youths' satisfaction with their parents, from the 6 months preceding treatment to the 6 months during treatment and the improvements were maintained at the follow up.

Donohue and Van Hasselt (1999) provide preliminary efficacy for Family Behavior Therapy in the treatment of caregivers of children who have been neglected. The study included 47 primary caregivers of maltreated children with half of these children reported for neglect. Family Behavior Therapy consisted of 16 home-based sessions.
scheduled on a weekly basis, and all family members living in the home were encouraged to participate. Interventions utilized included role-playing, behavioral rehearsal, and descriptive reinforcement strategies, with all therapies implemented sequentially and cumulatively. Child interventions focused on teaching children to identify early cues to violence, interpersonal safety skills, decrease risk of harm, and engage in escape or avoidance strategies, as needed (see Margolin, 1979). Concurrently, caregivers learned to identify early signs of abuse and were taught positive methods to reinforce desired behaviors and contingency management strategies. Therapists followed a treatment manual (see Donohue, Van Hasselt, Miller, and Hersen, 1997) and utilized prompting checklists. Caregivers demonstrated significant improvements in most measures, and at post-treatment, relative to pre-treatment, caregivers perceived their children as being significantly more adaptable and less demanding, perceived themselves as less depressed and socially isolated, were more satisfied with their children. The results of this study suggest the empirically derived Family Behavior Therapy components are promising in the treatment of neglecting mothers and their children.

There are currently no intervention studies that address both drug abuse and child neglect simultaneously. As described previously, Family Behavior Therapy has led to significant reduction in drug use and has demonstrated promise with caregivers and victims of child neglect, thus a treatment to address both issues with Family Behavior Therapy may be beneficial and produce significant improvements in both areas of dysfunction. However, at this time, no treatments, including treatment manuals, have been developed that targets the reduction of parental substance abuse and child neglect.
Manual Development

Treatment manuals were introduced to provide clinicians with specific guidelines for treatment implementation (Carroll & Nuro, 2002). Other reasons for the development of treatment manuals included a need for specific descriptions about treatment, to aid in training therapists in a particular treatment, and to standardize an individual approach (Strupp & Anderson, 1997). In the past treatments were often described in general terms, including vague descriptions of techniques to produce change in the client. However, manuals have resulted in the creation of detailed descriptions of treatments and step-by-step instructions about how to implement them. Therapy manuals are believed to have revolutionized psychotherapy research as evidenced by the major role manuals play in empirical research (Luborsky & DeRubies, 1984). Presently, the majority of efficacy research requires the utilization of treatment manuals.

Although many practitioners believe manuals interfere with the establishment of the therapist-client relationship, others see manuals as a tool to bring about focus and direction to treatment. Manuals help the therapist set appropriate treatment goals, time interventions, and guide the overall structure for the treatment process (Lock & Le Grange, 2001). Manuals permit consistent delivery of the intervention by different therapists in different settings because therapists may be trained to a common standard of treatment delivery (Morley, Shapiro, & Biggs, 2004).

Methods for Manual Development

Onken and colleges (1997) proposed a three-stage model of behavioral therapy research. The model begins with clinical ideas and innovation, and is culminated in controlled outcome research and dissemination of information to other therapists and researchers in the field. Stage I involves pilot and feasibility testing, manual writing,
training, program development, and adherence and protocol measure development for the newly developed treatment. Stage II consists of a randomized clinical trial that is conducted to evaluate the newly created manualized treatment that showed promise in earlier pilot testing in stage I. Lastly, in stage III treatment issues such as generalizability of the treatment (i.e. will this treatment be effective with different patients or settings), implementation issues (i.e. what kind of treatment is need for practitioners), cost effectiveness issues (i.e. what is the cost of implementing this treatment), and marketing issues (i.e. how acceptable is a new treatment to clients or practitioners) are addressed and clarified.

Rounsaville, Carroll, and Onken (2001) describe guidelines for completing stage I research, which can be separated into two phases titled stage Ia and stage Ib. Stage Ia, or the treatment development and manual writing stage, is similar to hypothesis generating in experimental research because the treatment can be based on completely novel ideas or modifications and improvements of existing treatments. Possibly because this stage requires the most creativity it often requires approximately 12 months to complete. Minimal requirements for this stage include having a theoretical rationale for the disorder, theoretical rationale for the new treatment’s change process, identification of a target population, and identification of what measures will be used to evaluate the treatment. Thus, the conclusion of this stage should result in a working version of the treatment manual.

Stage Ib is the stage in which the pilot trial of the treatment manual is conducted. The goal of this phase is to test the newly developed treatment manual to determine client’s acceptance of the treatment, the investigators ability to recruit members of the target population to participate, feasibility of treatment delivery, and whether or not there is
significant client improvement as a result of the treatment. If the therapy demonstrates efficacy at this stage the research can move forward to the next stage, and if not the investigator must determine if they should discontinue the research or make revisions.

Carroll and Nuro (2002) have proposed a parallel stage model for the explicit development of treatment manuals. This model consists of three stages starting with the development of the treatment manual (stage I), efficacy research utilizing the treatment manual (stage II), and implementation and effectiveness research with the treatment manual (stage III). The model proposes that the stages of manual development will evolve with the stages of the treatment development. It also recognizes that the development of the treatment manual often does not reach stage III, which may limit the use of the manual by clinicians who have broader populations to treat such as clinicians in community settings.

Stage I, the manual development phase, requires creativity and originality. The main goal of this stage is to specify the treatment, and determine its feasibility and efficacy. Basic structural elements that should also be addressed at this stage are duration of the treatment, format of the treatment (i.e. family versus individual), number of sessions, length of sessions, and level of manual flexibility. This stage lays the foundation for future controlled studies and requires client feedback regarding the manual from the uncontrolled pilot cases. Stage II is utilized to determine if the intervention in a standardized form is beneficial to individuals in the target population. Generally, at this point the manual has been examined in at least one pilot study. Indeed, the therapist experience with the treatment, review of session tapes, and analysis of outcome data can be used to improve the content areas and to address issues or problems that could not have been conceived of before the actual clinical implementation of the treatment.

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The manual should also address other commonly used approaches that can be used in conjunction with the specific treatment. For example, if there is a common comorbid diagnosis for the target population information about ways to integrate other treatment may be beneficial. Another critical component to a manual in this stage is the explanation of standards and procedures for therapists to follow. This includes therapist selection criteria, training, and supervision guidelines. It is during stage III that the manual is applied to diverse settings with a diverse group of individuals from the target population. At this point the treatment developer should have a clear understanding of how the treatment should and should not vary among diverse populations. The process and outcome data from earlier studies should inform the treatment developer of the limits of application of the treatment to diverse groups. A stage III manual should also include information regarding adaptations to the treatment that can be made for clients typically encountered in clinical settings to increase the likelihood that certain mental health providers will utilize the treatment manual.

Guidelines for Developing Therapist Friendly Manuals

Carroll and Nuro (2002) presented suggestions for manual developers to make their manual more “clinician friendly” by anticipating common criticisms. The first guideline is manuals are basically providing specific instructions for the implementation of a treatment. The more detailed, clear, and specific the instructions are, the more likely clinicians will implement the treatment the way the developers intended. Thus, it is important to clearly indicate the specific steps that would be needed to implement protocol without jargon and within a cumulative context.

Some have negatively critiqued manuals because they are written to address overly specified clients who do not evidence comorbid or complex problems. This is a critique
since over simplified clients are not the clients that clinicians are likely to encounter in "real world" clinical settings. This limits the clinical utility of the manual, and may also effect treatment adherence if a clinician is presented with a client who does not fit the specified prototype. Of course, it is necessary to restrict study populations during initial trials to determine if the specified populations are responsive to the intervention while excluding various confounding diversity factors. In later trials, however, the population parameters should be relaxed to permit examination of the effectiveness of the established treatment manuals for use in various diverse populations. Thus, manuals should evolve as the populations become more diverse throughout the stages of outcome research.

Some clinicians have the misconception that manuals overemphasize technique, and do not focus enough on the therapeutic alliance (i.e. rapport building), while others report some manuals do not point out how the manual can be implemented while still completing the important initial task of developing a therapeutic alliance. A clinician friendly manual should attempt to define therapist competence for the treatment, as well as to demonstrate when an individual may progress to later stages of treatment. Many treatment manuals provide little information to the clinician about when and which intervention to select at various points in treatment. Thus, a clinician friendly manual should provide this information to therapists. The different transition points and order of module implementation should be provided in a clear and specific way. If there were therapist choices in module implementation, then guidelines for selection would be beneficial. For example, a decision tree may be employed to assist in guiding the selection treatment protocols.
Lastly, summaries or outlines of the treatment are recommended. It is important to include outlines, or protocol checklists that may be utilized by therapists during treatment sessions to guide successful implementation of therapy procedures. Such outlines can be reviewed before the session to ensure the clinician is reminded of the key feature of the interventions. These outlines also serve as self-reports of treatment protocol adherence to monitor the essential components of treatments being implemented.

Examples of Manual Development

Lock and Le Grange (2001) provide a detailed description of the process that was utilized in developing a family-based treatment manual for anorexia nervosa. The first stage began with reviewing existing descriptions of the treatments available for anorexia nervosa, and strategies of family based interventions of anorexia. It was through this process that the main elements and the major phases of treatment were identified and outlined. The next step was consulting with clinicians trained in the techniques identified in the literature search. During this stage, a draft of the manual was created based on information obtained in the literature review, and clinicians evaluated the first draft of the manual. Feedback, such as clinician’s comments or criticisms, was incorporated into the draft. Then the structure of the model was developed with the final draft permitting easy reference and making important information readily available to the therapist.

The manual consists of three phases of treatment based on theory and clinical application with specific goals for each phase. In addition, goals for sessions within each phase were created, and a specific set of interventions were developed. Lastly, a description of each intervention was provided that included a short statement of the intervention, a description of how the intervention should be implemented, and the theoretical orientation and rationale for the intervention. A common difficulties section
was added which provides a description of problems therapist may encounter when implementing the intervention. After the manual was revised it was piloted with two adolescents and their families. Results of the pilot found that clients recovered from anorexia nervosa after receiving the manualized treatment. The final stage was training others in the use of the manual. Five therapists were trained by reading the manual, reviewing videotaped sessions, an in some cases observing in vivo sessions. After training, therapists videotaped their sessions with clients, which were reviewed by the manual developers to ensure adequate training had been accomplished.

Morely, Shapiro, and Biggs (2004) described the process for developing a cognitive behavior therapy manual to teach attention management in chronic pain. In the first stage of development the authors completed an extensive literature search for strategies of attention control. Based on the literature a draft of the treatment manual was completed. The complete manual included therapeutic aims, measures of treatment outcome, measures of treatment process, client exercises, client homework, examples of good practice of treatment implementation, possible problems in implementation with solution suggestions, and measures of therapist compliance and treatment adherence. In the next stage the manual was presented to six experts in the field who reviewed the manual. The expert's views on the draft were assessed utilizing a semi-structured interview. Experts were asked to provide alternatives to the treatment such as alternative exercises, methods for implementation of treatment, and solutions to problems that could arise. The final step was revisions to the manual based on feedback from the experts. The authors discussed the suggestions made by the experts and decided to implement most of the recommended changes. After the revisions were made the manual was again presented to the experts to ensure their recommendations had been properly addressed in the final version.
In both of the preceding examples, the investigators excluded on-going revisions of the manuals during case examples. Indeed, although Locke and LeGrange (2001) included a case implementation, the manuals were not said to be changed as a result of this process. Relatedly, Morely et al. (2004) relied upon expert critique, limiting their evaluation to expert testimony, and not empirical scrutiny. It may be that therapist feedback in response to case implementation of treatment should be utilized to guide protocol adjustments, thus potentially increasing generalizability and subsequent adoption of the developed manual by community therapists.

The content from one manual to another is quite varied. All existing manuals have aspects that increase the likelihood that a therapist will utilize the manual and do so in the way the developer intended. Although there are recommendations for treatment manual content, there is little information or suggestions regarding the layout and overall design of the treatment manual. The aesthetics of a manual are an important factor in its ease and utility of administration. For example, if a manual has clear and simple directions regarding how to implement a treatment that is presented in a disorganized layout, then this creates problems unrelated to the actual treatment. A treatment manual needs a format that enhances the ease of administration for the clinician. To assist in anecdotally determining ideal formatting methods, treatment manuals were identified, and subsequently reviewed.

Carroll (1998) authored a treatment manual entitled “A cognitive behavioral approach: treating cocaine addiction.” This manual begins with an introduction to the treatment modality of cognitive behavioral therapy. In addition, this section explains the rationale and effectiveness of cognitive behavioral therapy with substance abusing populations. This section is beneficial because it helps to ensure therapists have an
understanding of the rationale, which is important because it may ensure that there is therapist “by in” and also increases the therapist’s ability to explain the mechanism of expected therapeutic change to the client. A brief explanation of the treatment is provided, including the session format, session length, setting, target population, and suggestions for additional interventions that can be utilized in conjunction with this manual. This section is believed to be a helpful summary for those who wish to get a quick understanding of the treatment requirements. This would be helpful if therapists were unsure if this treatment fit into their own parameters and also serves as a quick reference section. This manual contains a section on treatment pace that provides guidelines about when to move forward in treatment, obviously acting as an aid to assist therapists in the effective delivery of intervention. This section also provides treatment delivery and stylistic recommendations for the therapist that are often lacking from manuals. Making suggestions on this topic increases the likelihood that the therapist does not leave out important factors, such as methods of establishing rapport. It also creates an increased confidence and understanding of what the delivery of the treatment should look like.

The next section of the manual focuses on describing the format of the treatment sessions, including how much time should be allocated to each procedure. For example, the first 20 minutes will be spent with the therapist getting an understanding of the client’s urges to use cocaine in the past week. The organization of information presented allows a clear understanding of the treatment, and enables the therapist to understand the specific steps involved in treatment implementation. Regarding layout, this manual is clear and “easy-to-follow.” The sections are broken into headings and subheadings with large font and a generous amount of white space to facilitate recognition during therapy.
Prompts to be utilized with clients are also provided, making it easy for therapists to ensure they are stating things clearly and at an appropriate language level for their clients. For each session the manual provides a short list of tasks to be completed in the session, session goals, and key interventions to be utilized.

Specific and detailed instructions of how to implement the key interventions are delineated with clear examples and simple worksheets. In addition to providing step-by-step information regarding implementation of regular sessions this manual also includes guidelines to be employed during the termination session, which is particularly valuable for inexperienced therapists who often find treatment termination difficult. Unique to most manuals, an appendices section includes information on how to train, assess, and supervise therapists. Along these lines, a therapist-prompting checklist is provided to permit treatment implementation.

Budney and Higgens (1998) also developed an outstanding treatment manual for cocaine addiction. The manual begins with an overview of psychosocial treatments for substance abuse and an overview of the specific treatment program. The program overview describes different components of the interventions, and when applicable provides some information about difficulties that can be expected when implementing treatment with cocaine addicted clients. This allows the therapist to be prepared for various obstacles that are likely to occur during treatment. There is a section entitled “counseling style,” which covers topics such as treatment flexibility, empathy, involvement, and how to use social reinforcement. For instance, therapists must be flexible when scheduling sessions and that the therapist’s attitude should reflect a desire to meet client needs. In addition there is a special issues section, which provides guidance on how to handle special circumstances such as client tardiness or clients needing extra
sessions. A unique aspect of this manual is that it provides information regarding case
documentation, such as how to document contact with the client and provided examples
of progress notes. This can be helpful to clinics to ensure ease of adaptability in
community settings that may be used to documentation in a very different way. Another
additional advantage to this manual is that it provides detailed information about
conducting an intake for clients that would like to receive this treatment, thus increasing
adoptability by a community agency.
CHAPTER 3

RESEARCH METHODS

Participating Research Team Members

A treatment team of approximately 12 undergraduate and graduate students, and a doctoral level research advisor were assembled. Team members were required to make a time commitment of at least 6 hours per week. Team member duties included attending a weekly meeting to review the manual modules, reviewing and editing modules, and active participation in role-play of the modules. The team was mainly comprised of members who are inexperienced in providing treatment services to the target populations. The researcher put forth a strong effort to ensure that the team members were diverse in terms of ethnicity, age, employment and clinical research/practice background.

The ethnic composition of the group included African American, Caucasian, Pacific Islander, Latino, and Middle Eastern students. Thus, any cultural issues or concerns that arose during the development process (i.e. adding ethnic names to examples) were discussed and addressed during meetings with a large amount of input from students from diverse backgrounds. The age range of the team was 18 to 40 years of age. The teams employment, clinical experience, and research experiences also fell into a wide range of experiences. The diverse composition of the team increases the likelihood that the resulting manual is culturally sensitive and applies to a more diverse population.
Participant Referral and Study Inclusionary Criteria

Approval for completing the single case study was given by the Social and Behavioral Sciences Committee on March 11, 2005. Prior to recruiting the participant for the case study, inclusionary/exclusionary criteria were established. Specifically, the mother needed to be a female at least 13 years old, and identified by Clark County Family Services to abuse illicit substances and neglect a child. Inclusionary criteria also included drug use occurring 4 months prior to baseline, no history of sexual abuse, no evidence of a psychotic episode, residing locally for at least 4 months with no plans to move, not receiving formal drug abuse counseling during the pre-treatment assessment to avoid confounds due to pre-existing treatment, and living with the neglected child at least at the beginning of the intervention.

Clark County Family Services referred 1 family to participate in this study. In this process, a case manager reviewed cases until one was deemed appropriate for the program, and met the study inclusionary criteria. Once a possible case was identified, the assigned caseworker informed the client about the opportunity to participate in the program. The therapist met with the mother, significant others who were going to be present during treatment (i.e., mother's boyfriend), and the mother's caseworker to complete informed consent. The therapist reviewed with the client potential risks and benefits for participation, the client's right to refuse participation or withdraw from the study at any time without prejudice, and guidelines concerning confidentiality.

The client was a 24-year-old African American female referred to child protective services for drug use during pregnancy. The mother's identified drug of choice was methyldioxymethamphetamine (MDMA). The client reported she believed she had been referred to child protective services because she had used drugs on the day her daughter
was born. The client has no prior history of reports to family services in the state of Nevada, however the client did admit one of her other children was also exposed to drugs in utero. The clinical picture for the client was complicated by unemployment, domestic violence, and problems with her primary support group. Child neglect behaviors included lack of food, an unclean and unsafe home, and inadequate supervision of her three children.

The client resided with her boyfriend and her three children that were 4 years old, 2 years old, and 1 month old at the onset of treatment. The client also lived in close proximity to her mother, stepfather, and cousins who often provided emotional support to the client. The client has a family history of substance abuse and domestic violence. The client had been the victim of domestic violence prior to treatment and once during treatment, however she denied any adult to child violence in her family. The client had resided locally for approximately 2 years, and reported limited social networks beyond her family. The client lived in a drug-infested neighborhood, which resulted in her limited peers also abusing illegal substances and created easy access for her habit. Her home was in need of a large amount of repair such as new carpet, screens in the windows, and repairs in the kitchen. The client had completed high school, however the client was unemployed at the time of the initial session. The client stated she had been unemployed for almost one year because she did not need to work as a result of receiving inheritance money. However by the initial session the majority of the inheritance had been spent to support her drug habit. The client evidenced no homicidal or suicidal ideations during treatment. The client was not taking any psychotropic medications.

When therapists met with the client at her apartment they were warmly greeted by the client and her children. For most of the sessions the client and her family were
appropriately dressed. As the sessions progressed, rapport was easy to establish with the client, and with her family. The client stated that her main goals for therapy were to “quit using drugs and be a better parent for her children.” She reportedly felt her current life circumstances were not “healthy” for her children, and she reported feeling it was important for her to change these circumstances (e.g., using drugs, having no food in the house, having a dirty home, etc). She also stated that she would like to join the workforce again to provide financial support for her family. She appeared motivated for abstinence; as she indicated learning ways to “stay clean” would help her improve the quality of her life. In addition, she seemed enthusiastic about learning child management strategies. The last goal the client had was to increase her communication with her family members including her boyfriend and her mother.

From the Stimulus Control module the mother identified a number of positive parenting behaviors that she wanted to set as goals for herself. These behaviors included feeding her children healthy unspoiled food, providing a more sanitary home environment, learning to manage overwhelming stress, supervise her children better, and get her children needed medical attention. The client also identified goals for drug incompatible behaviors that included finding more appropriate ways to deal with stress, avoid being around people who use drugs, and meeting new people who do not use drugs. For the necessities list her goals included keeping better track of her bills, keeping more food in the house, and keeping better contact with her caseworker.

Procedure

The proposed manual was developed according to a standardized method of manual development. The development of the treatment manual can be broken into four
phases: integration and modification of existing treatment manuals, review and edits of drafts of the treatment manual, role plays of the treatment manual, and implementation of the completed manual with a case study. In the first phase, the integration and modification of existing published Family Behavior Therapy manuals were combined and modified to form a treatment aimed at addressing both parental substance abuse and child neglect simultaneously. The manual was based on the integration of 2 empirically derived Family Behavior Therapy interventions. The drug abuse components were derived from a family-based behavioral treatment program that has demonstrated effectiveness in reducing adolescent drug use in controlled trials (Azrin, Acemo et al., 1996; Azrin, Donohue et al., 1994; Azrin, Donohue et al., 2001; Azrin, McMahon et al., 1994). The child neglect components were derived from a family-based treatment program that has demonstrated preliminary efficacy in a sample that included caregivers of neglected children (Donohue & Van Hasselt, 1999). The original manuals were read and aspects of each manual were integrated based on clinical experience and theory. Not all components of the original manuals were maintained because they were not all deemed relevant to the goals of the proposed treatment. Components that were utilized include Stimulus Control, Family Support, Self Control, Home Safety and Beautification Tours, Child Management, and Communication Skills Training. After the manuals were integrated modifications and additional components were added to some of the modules of the manual.

Once the manual was integrated and modified the researcher reviewed and edited the initial draft to ensure the manual was clear and simple to follow. After this initial review more specific instructions and clearer examples were added to the draft of the modules. The modules each include a brief overview of the intervention, rationale for the treatment
method, and specific steps for treatment implementation with examples. In addition, therapist-prompting lists were created for each intervention to serve as a therapist self report of treatment adherence. Information about treatment duration, treatment length, and order of implementation were also created.

Phase 2 involved reviewing and editing the manual with the team members. It is in this phase that a team of research assistances were asked to review each module of the manual, edit the module, and provide their feedback at the research team meeting. Each week research team members received drafts of the modules of the treatment manual. Team members then edited the content of the manual as well as other areas (i.e. grammar and punctuation). Then team members provided their edits to an editor who combined the edits and suggestions and provided a draft to the final editor who is the researcher of this project. The final editor then either accepted or rejected edits and suggestions made by the team members. In the weekly meetings team members reviewed the manual and determined if additional reviewing and editing was required (Appendix A). Based on the feedback edits to the manuals content and formatting were made until the team came to a consensus that the manual was ready to be initially evaluated in role-plays.

The next phase is role-plays, in which simulated treatment sessions. These were utilized to determine areas that required further modification. In the role-plays, members of the research team took turns playing the role of the therapist, and the role of the confederate. The clinical feasibility of the intervention was assessed through the role-play process. Aspects of the manual that did not meet the goal of the therapeutic intervention, or in which the therapist encountered difficulty in their attempts to implements the manual with the confederate were edited to eliminate these problems. The intervention protocol was also assessed and changes to the protocol for the same reasons.
were made. After each role-play, the research team discussed the ease of administration and potential revisions to protocol. Problems encountered during this process were brainstormed until a solution was identified.

The final phase was the implementation of the developed manual with 1 case study. The manual was implemented with a family referred by Clark County Family Services that met the studies inclusionary criteria. Protocol adherence methods and checklist were developed to assess inter-rater reliability, feasibility and clinical utility of the developed manual, and protocol adherence lists were assessed after the implementation of the manual with the family. The mother was also questioned regarding her perceptions about services provided. Therapists had audiotapes of sessions randomly listened to by Dr. Donohue, and met at the end of each week to review the therapy sessions, and address any issues that occurred with use of the treatment protocol. If issues did arise then possible solutions or improvements to the manual were brainstormed at the meeting. Therapists also received feedback regarding their adherence to protocol, as well as suggestions for ways to improve the delivery of treatment services.

Assessment Measures of Treatment Credibility

The client was asked to rate the perceived benefits of each intervention. The Client Satisfaction Questionnaire (CSQ-8), which contains 8 items to assess client's satisfaction with services received, was given to the client (Larsen, Atkinson, Hargreaves, & Nguyen, 1979). Scores range from 8 to 32, with higher scores indicating greater satisfaction with treatment services received. This questionnaire was administered to mothers at the conclusion of each intervention component to determine the mothers' satisfaction with the component. Participants were also provided with the Credibility Scale at the end of each module. This measure was designed to assess the clients
perceived credibility of the treatment (Borkovec & Costellow; 1993; Borkovec & Nau, 1972). This scale was also implemented to assist in determining acceptability of each treatment component. This scale consists of three items on a 9-point scale developed to identify differences in therapy expectancy with treatment plausibility.

Specific Interventions

An intervention schedule of 2 sessions per week for a total of 16 sessions was scheduled with the client. Spacing of sessions is used increase the likelihood that inventions techniques will be generalized. Actual session duration was 90 minutes for each session, however, some sessions required additional time. Interventions utilized in this study are Family Relationship Enhancement and Communication Skills Training, Home Safety and Beautification, Stimulus Control, Self Control, Family Support, and Child Management Skills Training. The order in which the interventions were administered, and emphasized, after initially being presented to the client was determined based on the outcome of the review of the stimulus control module for the week. For example, during the first session the Stimulus Control module was administered and behaviors considered high risk for substance use and child neglect were identified. If a high-risk behavior were the result of a lack of control the Self Control procedure would be implemented to help the mother develop this skill.

Family Relationship Enhancement and Communication Skills Training included three components Reciprocity Awareness, Positive Request, and Conflict Resolution Skills Training. The goal of Reciprocity Awareness is to make each family member aware of the reinforcers provided by other family members and ultimately increase the rate of positive verbal exchange. The increase in positive exchange assists in the reduction of
stimuli that trigger drug use and child neglect. Family members listed things others had done for them that they appreciated, and after the list was developed, all family members expressed appreciation to one another. The therapist provided feedback about the interactions, and taught family members how to utilize appreciation reminders by reading things on their lists that had been done for family members and asking if the other family members appreciated these things. The Positive Request procedure teaches family member to ask for reinforcers in a positive and appropriate manner. This skill is important because it increases the chances that requesting reinforcers will occur leading to the decrease in neglect (e.g. asking a family member to clean up dog feces so child does not crawl through the feces), and drug use behaviors (e.g. asking friends to go someplace other than a party). Conflict Resolution Skills Training was utilized to decrease negative interactions that are commonly present in families of neglecting and drug abusing mothers. Family members were taught when anger is identified to take a deep breath, relax, state the problem in a neutral, non-blaming way, blame something in the situation, and state something that may have been done to contribute to the annoying behavior.

Home Safety and Beautification Tours were conducted because there was a high probability that participant homes are likely to be unsafe for children. Many caregivers are unaware of potential home hazards and the home is often unclean. In addition, homes tend to be unstimulating such as not having pictures on the walls. This intervention involved the therapist touring the home and praising the mother for prevention of hazards, cleanliness, and creating a stimulating environment for children as well as prompting the family to identify hazards and implementing solutions. The Home Safety and Beautification list developed by Donohue and Van Hasselt (1999) was used as a
prompting and monitoring checklist. Items on this list include home and health hazards, home cleanliness and beautification, and having materials that facilitate personal and social growth for children in the home. During the tour the therapist prompted family members to recognize hazards (i.e., toys, books, clothing, home decorations).

Stimulus Control was implemented to assist mothers in decreasing their exposure to drugs and to increase the amount of time they spend engaging in healthy activities with their children. In particular, the mother was motivated to accomplish positive activities that involve the neglected child, that promote the prevention of neglect, and that are not compatible with drug use. Safe stimuli were also identified and the therapist encouraged the mother to spend more time with stimuli that are incompatible with drug use and parenting problems.

Self Control was implemented with the goal of assisting mothers to decrease their impulses to use drugs and/or engage in neglect associated behaviors. Mothers were taught how to interrupt their thoughts, urges, and physiological responses that are related to drug use and neglectful parenting behavior. The mother was taught to develop new thoughts and actions that are incompatible with drug use and neglect using a sequence of steps.

Family Support was included to increase the mothers' motivation to engage in drug-incompatible and non-neglect activities, and also to teach significant others how to monitor, supervise, and reinforce desired behaviors of the mothers. The mother-identified rewards desired for remaining abstinent from drugs and neglectful behavior, the significant other would provide identified rewards, and the contingency was reviewed in the first session and as needed. The child also identified ways he or she can be supportive of their mother and help the mother be the best parent she can be.
Child Management skills were taught because it was highly likely that the mothers would lack effective parenting skills. Mothers were taught to use differential reinforcement (i.e., Catching My Child Being Good) and Positive Practice with their children. In the latter procedure, neglecting mothers were taught to discipline undesired behavior by telling the child that the undesired behavior was at least partially the fault of some external influence (e.g., child didn't know dog would chew pillow if locked in bedroom), and instructing the child to practice the desired behavior (e.g., practicing letting the dog outside before playing).

Strategies were employed to ensure the integrity of treatment manuals utilized during session, which included written documentation by the therapist of techniques used during the session, audio taping of all sessions, on-going clinical supervision of treatment sessions, review of all audible audiotapes, corrective feedback to therapists, and detailed protocol checklists were utilized by therapists that indicate the materials needed for each session. These checklists were used to determine therapist adherence and competence. Therapists indicated on each protocol checklist whether each therapy task was performed. Then in supervision therapists were provided feedback regarding their ability to follow the protocol checklist. If any issues such as therapist drift occurred therapist received feedback from the supervisor regarding how to get back to the treatment protocol.
CHAPTER 4

RESULTS

The method of manual development resulted in the creation of a Family Behavior Therapy manual that addresses parental substance abuse and child neglect. The existing Family Behavior Therapy manuals for child neglect and drug abuse were initially combined into an outline of specific therapy steps based on theory and clinical experience, as outlined previously. A more detailed manual with examples was developed, and the research team reviewed and edited the manual on a weekly basis. The manual was utilized with members of a clinical research team during a series of role-play scenarios that attempted to simulate in vivo administration of the intervention protocol. Following each role-play the research team discussed ease of administration and clinical utility of the intervention protocol. After the modules were believed to be sufficient in role-play vignettes, the manual was implemented in an uncontrolled trial with a single case study. The manual development process required approximately 12 months, which is consistent with the timeline in the literature.

Implementation with a Pilot Case

The final step involved implementing the manual with the case referred by Clark County Family Services. The pilot study provided a wealth of knowledge regarding the
applicability of the treatment in a “real world” setting. The experiences from the pilot study assisted in determining that the manual required more revisions prior to conducting a randomized clinical trial.

In the first session with the client the therapist reviewed confidentiality, and completed the client enlistment questions. Once this was completed the other therapist and the client’s significant others were brought into the session to complete the I’ve Got a Great Family module. The exchanges were very positive as evidenced by the client’s daughter at one point spontaneously telling her mom she loved her and they both hugged. The client seemed to enjoy this module and the entire family fully participated. Thus, the first session ended on a very positive note and the client seemed eager for her next appointment.

The next session the therapist arrived and was informed by the client that the session would have to be canceled due to an emergency in the family. The emergency was that the power in the home had been shut off. Based on the immediacy of this issue the therapist decided not to complete the treatment protocol. Instead, the therapist assisted the mother in calling her caseworker and the electric company. The caseworker was able to get the client emergency funds to pay her power bill. In the following session the regular protocol was completed. For the next session the client attempted to cancel the session because she had been the victim of domestic violence. Her boyfriend was arrested the night before and the oldest daughter had witnessed him being arrested. Within 4 sessions half had involved an emergency. This was a consistent pattern with the client throughout the beginning of treatment.

Based on the loss of time resulting from unplanned emergencies and the seriousness of most of them the Basic Necessities and Safety Assurance module was developed.
Adding this component greatly reduced the occurrence of major emergencies occurring during treatment sessions. After working with the client through two major emergencies the therapist felt she had a strong trusting relationship with the client as evidenced by the clients openness and honesty regarding problem behaviors. For all the interventions except for Positive Practice the client put forth a great deal of effort each session to learn new skills. She also made attempts to practice the skills in between the session. Because the feedback was presented in a positive manner the client was very receptive to corrective feedback from the therapist. The client provided many positive statements regarding the helpfulness of the intervention and of her therapists throughout her treatment.

Changes to the Manual

There were a few unexpected situations that ultimately resulted in the creation of a module to assess and address emergency situations. For example, when the therapists arrived at the clients home for the second session the client informed the therapists that she would have to cancel the session because her power had just been shut off. The client then informed the therapists she had not paid her bill and she was unsure of her next step. The therapists in this situation worked with the client to generate solutions, including calling the power company to determine if an extension on the bill was possible and the caseworker was contacted to assess if she had knowledge of any other alternatives solutions. The problem was solved, but none of the program protocol was implemented. The therapist realized that for the family, getting the emergency situation under control was the priority and the safety issue needed immediate attention.

Another example, the therapists arrived for a session after the mother had just been the victim of domestic violence. In this situation there was not an immediate emergency,
although safety planning was needed for the prevention of future violence when the partner was released from jail. The therapists were able to work with the client to help her prepare and also suggested that interventions to address domestic could be added to her treatment program as reunification with her partner was likely to occur.

After the occurrence of the aforementioned emergencies and a few other situations that needed attention in the near future (e.g., bills were due, running low on baby formula), it was determined that there was a need to develop a standardized method to address these situations. The short module entitled Basic Necessities and Safety Assurance was created to assess the status of various situations the may require immediate attention. This module was implemented at the very beginning of each session and the mother completed an 8-item questionnaire by marking the status of certain situations (i.e. bills, food, adult to adult aggression, adult to child aggression, child to child aggression, medical attention, unclean conditions), as either not present, mild, or an emergency. For those situations the mother endorsed as an emergency the therapist canceled the regular session agenda, and worked with the mother to prevent future harm. Anything that the client endorsed as mild was added to the mothers at risk stimulus control list to be reviewed every week until the issue is resolved.

The order of the module implementation was changed based on the results of the pilot study. Because emergency situations often occurred, it took much longer than anticipated to implement various components of the manual. For example, it was expected that the completion of the Stimulus Control list would require two full sessions to develop (i.e., 4 hours). However, emergencies and extraordinary circumstances (e.g., domestic violence, power being turned off, eviction from apartment) necessitated three full sessions for the Stimulus Control list to be established. Similarly, the child management strategies were
expected to be initiated by session 5. However, in the pilot study these interventions were implemented in session 7. Because it is believed the child management strategies are of great importance the order of implementation for this intervention was rescheduled to occur earlier in the process (i.e., originally the child management modules were to be introduced to the mother 4th however as a result of the pilot case in the future they will be implemented 3rd).

The original session format proposed was a total of 16 sessions that would begin with 2 sessions a week and after approximately one month switch to a more traditional session format of 1 session a week. Based on the experiences with the case it was decided that scheduling would be 2 sessions for the duration of the treatment. The rationale for this change was due to the status of the family there were many unexpected circumstances that often interfered with the mother being able to keep her regularly scheduled appointment time, such as the power being turned off, having unexpected visitors, and a bodily injury resulting from a domestic dispute. It is believed that similar circumstances are likely to arise in other cases, therefore to ensure the client is able to complete the program within a reasonable amount of time, the 2 sessions a week format will be maintained for the entire duration of treatment.

In addition, a change was made to the actual session format. In the original format family members or significant others were asked to come to any session. This created an inconsistency in their participation. In some sessions there was no involvement while in others multiple parities were involved. To create more structure after session number 10 it was decided to schedule the first session of the week as a family session and the second session as an individual session. This created more structure for significant others to be clear on what days they should be involved in the therapy session.
Credibility and Client Satisfaction

The client rated all the interventions as extremely logical (M=9). The client also rated the interventions as something she would be extremely confident (M=9) in eliminating the issues she was receiving treatment for. Lastly, the client’s ratings after each intervention were that she would be extremely confident (M=9) in recommending this treatment to a friend. Although we were pleased to see such high ratings we noticed that the client selected a score of 9, on a scale ranging from 1 to 9, 100% of time. It is possible that this 100% rating was not the result of the intervention, but instead due to response reactivity resulting from a need to present oneself in a favorable light to impress the therapist. Along a different vein, the assessment tool provided a description for a score of “1” (i.e., extremely illogical), and a score of “9” (i.e., extremely logical). However, for the remaining numbers there was no description of the meaning of this value. It is possible the client was unclear as to what other values on the assessment would mean so she selected the highest score every time. Based on this finding, values for each number have been created.

The mean scores for each item on the Client Satisfaction Scale-8 were calculated with higher mean scores indicating higher levels of client satisfaction (Table 1). The highest possible score for each item was 4. The items that received the highest scores were item 1, which indicated the client viewed the services as high quality (M=3.25, SD=. 95), item 4 which indicated the client would generally recommend the program to a friend (M=3.25, SD.50), and item 7 that indicated the client overall had ratings of satisfaction with services she received (M=3.25, SD=. 50). The item with the lowest mean score was item 3, which assessed if the program met the clients needs. The scores indicate the client felt some of her needs, but not all of her needs had been met (M=2.5, SD=. 57). This was
consistent with our determination that child management skills training, a primary goal for the client was not addressed until much later in therapy than originally planned. An item of interest was item 8 which assessed if the client would seek help from the program in the future and the client indicated that she would (M=3, SD=.00).

Table 1
Means and Standard Deviations of Client Satisfaction Questionnaire

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: Quality of Services</td>
<td>3.25</td>
<td>.95</td>
</tr>
<tr>
<td>Item 2: Services Wanted</td>
<td>3.00</td>
<td>.00</td>
</tr>
<tr>
<td>Item 3: Met Goals</td>
<td>2.50</td>
<td>.58</td>
</tr>
<tr>
<td>Item 4: Recommend</td>
<td>3.25</td>
<td>.50</td>
</tr>
<tr>
<td>Item 5: Satisfied With Help</td>
<td>3.00</td>
<td>.81</td>
</tr>
<tr>
<td>Item 6: Effective</td>
<td>2.75</td>
<td>.50</td>
</tr>
<tr>
<td>Item 7: Satisfied Services</td>
<td>3.25</td>
<td>.50</td>
</tr>
<tr>
<td>Item 8: Come Back</td>
<td>3.00</td>
<td>.00</td>
</tr>
</tbody>
</table>

Final Version of the Family Behavior Therapy Manual

The final version of the manual includes a general program description (Appendix B), and contains various modules that address different skills. Formatting of each module is identical, and was selected based on administration ease and clarity. The modules all have a treatment rationale, therapist goals for the intervention, materials required to complete the module, an overview of the intervention, procedural steps, homework for the next session, how to review the homework in the following session, and a therapist prompting form.

Each module begins with a rationale for the treatment. This rationale is provided to the therapist and is not for use with the client. The rationale is the reasoning for the
particular module including how the intervention will likely result in behavioral change for the client. The goal of providing the rationale to the therapist is to enhance therapist understanding because if a therapist understands the reason the specific intervention is believed to benefit their client they may proceed with the implementation of the intervention with more confidence. In addition, providing a treatment rationale ensures the therapist has an understanding of the expected mechanism of change, and as a result is able to determine if the module is successful.

The therapist goals summarize the target behaviors of the therapist. The goals ensure that the therapist has a clear understanding of what is expected of them for this intervention. For example, if the goal is to teach a mother a new parenting skill then this will be clearly stated so the therapist knows that by the end of the session the client should have learned how to catch her child engaging in a desired behavior. This also ensures the therapist is able to communicate the intervention goals to the client.

The materials required for the intervention are also presented in a list. The therapist should review this list before beginning the session to ensure they have all the proper forms and material. Materials that are required in the manual include behavioral charts (i.e. Catching My Child Being Good), handouts for the client (Positive Request Handout), and any other assignments (i.e. Invitation for Family Fun). For each module the appendices are located after the specific intervention steps.

The module overview provides a brief summary of the process that will be utilized in the skills training. The therapist can review this section to ensure they have a clear understanding of the intervention steps. In the literature there was a recommendation that summaries allow for the therapist to get an overview without needing to review the entire manual.
The procedural steps provide the specific instructions that differentiate manualized therapy from non-manualized therapy. This portion of the manual provides step-by-step specific instructions for the module, and includes the treatment rationale given to the client and the steps the therapist completes. In addition to giving instructions the procedural component also provides detailed narrative examples of the treatment implementation. For example, the specific topics that should be address when providing the rationale are given and there is a narrative example of a therapist presenting the rationale to a client.

Almost every intervention requires that the client complete an activity during the week to ensure they are practicing the new skill. Any homework that the client must complete will be presented at the end of the procedural steps. Once the therapist reaches this point in the manual the skill has been introduced and work to practice the skill is assigned. The steps for future implementation follow the procedural steps. This part of the manual informs the therapist how to review the homework from this session in future sessions. It also informs the therapist if any other homework is required of the client in the future. The first time the module is implemented this section is skipped and is returned to in the subsequent sessions.

Lastly, there is a therapist prompting form, which is an outline that the therapist follows to ensure the steps of the treatment module are completed. This is a tool the that can be used in session. The format allows the therapist to check off each step completed to ensure a step is not missed. It is not as detailed as the manual, but is provides enough information for the therapist to be able to complete the intervention and the specific steps. The therapist prompting forms also serves as a self-report of the therapist's protocol adherence. This can also be used as summary of the intervention for therapist.
The final version of the manual contains seven main treatment areas. The main treatment interventions are Stimulus Control, Communication Skills, Child Management, Self Control, Safety Assurance, Home Safety and Beatification, and Family Support. The manual encompasses individual modules with each module addressing one of the aforementioned treatment areas. Communication Skills and Child Management are the two treatment interventions that contain more than one module. For Communication Skills there are 3 modules, I’ve Got a Great Family, Positive Request, and Arousal Management, all of which address common communication problems in mothers who abuse drugs and engage in behaviors associated with neglect. Child Management includes both Catching My Child Being Good and Positive Practice, which teach parenting skills to the mothers.

The Stimulus Control procedure (Appendix C) was implemented to assist the mother in decreasing her exposure to drugs and to increase the amount of time spent engaging in healthy activities with her children. The rationale for this procedure is that when people spend time in at risk situations or around at risk people there is a high likelihood that they will continue to engage in a negative pattern of behavior. For the mother in this program the negative behaviors included using drugs and engaging in behaviors consistent with child neglect. Therefore, it was critical to determine the places, people, and situations that the mother previously used drugs or neglected her children with, so those situations may be avoided in the future. The main goal of this procedure was to increase the amount of time the mother spends with safe associations and decrease the amount of time she spends with at risk associations. For those at risk situations that cannot be eliminated another goal of this procedure was to provide individuals with skills to remain clean and engage in positive parenting behaviors in at risk situations.
The first part of the module required the therapist meet with the mother alone and creates a comprehensive list of safe and at risk situations. The therapist asked the mother to share the people, places, and situations she spends time in where she has never used drugs, and that benefit her children in some way (i.e. they learn, they have fun, they are safe). Then the mother was asked to share people, places, and situations that place her at risk to use drugs, or engage in behaviors associated with child neglect. The therapist, with the mother’s permission, then reviewed the safe list with an adult significant other. The significant other was asked to provide additional safe situations for the mother, and to verify that the safe situations the mother provided were actually safe.

Mothers then monitored these behaviors in future sessions on a daily recording form by placing a check mark next to the people they have spent time with, places they have been, and activities in which they have engaged. Therapists praised the mother when she spent time with safe associations, and assisted the mother in identifying methods of spending more time with safe associations. When the mother spent time in risky situations the therapist assessed if drug use or child neglect occurred. If neither behavior occurred in the risky situation the therapist praised the mothers efforts to meet her goals.

If the mother did engage in either child neglect or drug use the therapist worked with the mother to identify what she could have done differently then either role played this with the mother or implemented a different module that addressed the skill deficit displayed in the at risk situation. For example, if going to a friend’s house is a risky situation and the mother endorsed spending time at her friend’s house the therapist would have worked with the mother to assess if child neglect occurred. If the mother said yes she did not change her baby’s diaper because she was busy the therapist would have implemented the self-control procedure to teach the mother to control her behavior in this
situation. Another example was for the client fighting with her boyfriend was a risk factor for her drug use. When reviewing the mother's stimulus control list the mother checked off spending time fighting with her boyfriend and when queried about her ability to stay clean in this situation the client stated she did, but only because she had no money. The therapist realized the mother had a skill deficit in self-control so the self-control procedure was implemented.

In this module the mother completed a comprehensive assessment of drug use behaviors, neglect associated behaviors, and basic necessities for the family. For each of these areas the therapist provided the mother with a list of behaviors that other people have said are important to engage in and that the therapist would like to know the mother's opinion about them. The therapist asked the mother if any of the behaviors are goals she would like to set for herself and her family. In addition to being an important assessment and goal-setting tool, this section also served to build rapport with the client. Because we are asking the client for information in a positive non-judgmental way it increases the likelihood that the mother will answer these and future questions honestly. It also demonstrated for the client that the therapist-client relationship is a collaborative relationship. The mother is setting goals that the therapist and client will work to accomplish together. This section of Stimulus Control looked more like a relaxed conversation than an assessment. The therapist and the mother were going back and forth discussing the items, which also appeared to make the client feel more comfortable.

For the child neglect assessment mothers were asked why it is important for parents to engage in various positive parenting behaviors (i.e. feed the children regularly), why she thinks parents may not always engage in these behaviors, how difficult engaging in these behaviors has been, and if the behavior is something she would like to set as a goal.
The therapist provided reasons other parents have provided for why it may be an important parenting behavior. By providing the information in this format the client is learning information in a way that may feel less judgmental to the client than perhaps by simply providing the reason directly. For everything the mother says has been difficult for her and she would like to set as a goal the therapist added it to the mothers safe association list. A similar process occurred for the Drug Incompatible List and the Family Necessities List. For the Drug Incompatible list, behaviors that are associated with sobriety were presented to the mother and goals were established. For the Family Necessities list, behaviors such a staying safe from domestic violence, having food in the house, getting social services such as welfare if needed, and staying in contact with social serves were assessed and goals for this behaviors were established.

The final task the therapist and the client completed for the stimulus control module is to schedule the next 24 hours with a pleasant safe activity. After the mother identified a situation she determined the time to complete the activity and who will be involved. In future sessions the therapist assessed if the activity occurred and if the mother benefited from spending time in a safe pleasant activity by remaining clean from drugs or by spending time with her children. This task is designed to increase the time the mother spends in safe activities by scheduling a set time to be with safe associations, thus reducing the amount of time she spend with at risk associations. For example, the first safe activity the client schedule was to take her children to the neighborhood park. When the therapist reviewed this safe activity with the mother in the next session the client stated that going to the park prevented her from feeling bored, which was usually a precursor to her drug use. The client also stated that the activity helped her to focus on her children, and that her family really enjoyed their time together.
The Home Safety and Beautification procedure (Appendix D) involved the therapist conducting a tour of the client's home and then providing feedback about the home safety and cleanliness to the client. This intervention is part of the treatment protocol because often caregivers of neglected children are unaware of potential home hazards that may create an unsafe environment for their children. The homes are often messy and may have household items that need to be replaced or repaired, and basic items that make the home a stimulating environment may be lacking such as age appropriate toys, books, and home decorations. The primary goal of this intervention was to increase the mother's ability to recognize the importance of maintaining a safe, clean, and stimulating home environment for their family.

This intervention involved a tour of the home to descriptively praise family members for their efforts to prevent home hazards and maintain a clean, stimulating and beautiful home. The therapist utilized the Home Safety and Beautification Checklist as a prompt, and for each room the therapist determined if any of the hazardous items on the list were present. The first 9 items on this checklist are pertinent to home and health hazards (i.e., toxins, electrical hazards, adequate food/nutrition, etc.), item 10 pertains to home cleanliness and beautification, and items 11 to 15 consist of home equipment and materials that facilitate personal and social growth for children (i.e., toys, clothing, etc). The therapist began this intervention by explaining to the mother and any significant others the rationale for conducting the tour. The therapist received permission from the mother to tour every room of the house. With the mother and significant others the therapist goes from room to room reviewing the items on the checklist. For each room the family was praised for preventing possible hazards, for the room being clean, or for providing children with a stimulating home environment.
If a hazard, cleanliness issue, or possibility for improvement in stimulation in the home environment was identified during the tour the therapist worked with the family to generate and implement solutions. In some instances the solution generated on the spot was a temporary solution and the therapist assigned the family to implement a more permanent solution by the next session when a review of all assignments from the home tour would be completed. For example, in the pilot case a hazard of exposed electrical outlets in the children's bedroom was identified. The therapist, the mother, and the oldest child worked together to brainstorm solutions. A temporary solution of moving furniture to cover the exposed outlets was implemented. A more permanent solution of buying outlet covers was assigned to the mother and reviewed the following week.

The Self Control procedure (Appendix E) was designed to assist mothers in decreasing their impulses to use drugs or engage in behaviors consistent with child neglect. For many individuals it is difficult to be fully aware of the urges to use drugs and the behaviors that may not benefit their children. As a result of the lack of awareness the mothers may have developed habits that lead to drug use and behaviors associated with child neglect. The main goal of this module is to create awareness about the triggers to the aforementioned behaviors by teaching the mothers to interrupt thoughts, urges, and physical sensations related to drug use and behaviors consistent with child neglect. Mothers were taught to replace these thoughts and actions with competing thoughts and actions.

The mothers were taught to utilize various steps for problem situations by having the therapist first model the steps then the client performed the steps. Steps for this intervention include: (a) identify initial antecedent stimuli to neglectful behavior (e.g., mother walking away from dog feces on kitchen floor where infant walks) or drug use
situation (offer to use cocaine at a party), (b) detect the earliest thought, feeling, action, or image related to the drug use or neglectful behavior, (c) interrupt the association by shouting, “Stop and Think!” (d) state at least two negative consequences for self, and two negative consequences for others, that could occur from the drug use or neglectful behavior, (e) relax by scanning and relaxing her muscles, and taking a few deep breaths, (f) state four prosocial alternatives to the drug use or neglectful behavior in that situation, (g) pick one of the generated alternatives, and imagine out loud engaging in those behaviors, (h) imagine telling someone important to the mother how the mother was able to avoid drug use or neglectful behavior, and imagine the person responding positively, and (i) state at least 2 positive consequences of having avoided drug use, or neglectful behavior, in that situation.

The therapist provided descriptive feedback, including praise and suggestions for future improvement. In addition, the client provided feedback on her performance including a self-report of her perceived correctness, her pre and post likelihood ratings (i.e. pre trial ratings to of desire to use drugs and post trial ratings of desire to use drugs), and the step she felt was the most helpful. At a minimum two trials per session were completed, one for drug use behavior and one for neglectful behavior. Additional trials depended on the extent of problem behavior evidenced during the week. For instance, if drug use was indicated during the week more trials were performed to assist the mothers in avoidance of similar drug use situations.

In the pilot case the client appeared to enjoy this procedure and did very well with the role-play. She thought of a great amount of detail when she was imagining herself engaging in prosocial activity and telling others she stayed clean. She also did a good job imagining what it would sound like to tell someone she stayed clean and how this would

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make her feel. For example, one week she marked off that she had a fight with her boyfriend, which was a risky situation for her. In this situation she wanted to use, but due to limited finances was able to stay clean so the therapist implemented the Self Control procedure with the client. Then in future sessions when reviewing the stimulus control list the client stated she was able to stay clean by utilizing the steps from this procedure for the at risk situation of fighting with her boyfriend. When the therapist asked how the client stated what she had found helpful was the step where she relaxed and took deep breaths and the step where you think of negative consequences of using drugs. She said that the procedure calmed her down after the fight and made her feel more in control. She said she was able to remain calm and this calm feeling eliminated her desire to use drugs.

The Child Management modules are designed to teach the mother new effective parenting skills. Many mothers found for child neglect are lacking parenting skills and find that learning new skills is very helpful. Often time’s children who have experienced maltreatment are not able to perform behaviors that parents find preferable as a result of insufficient or inconsistent learning. Mother’s tend to assume that their children are choosing to perform undesired behaviors, and do not understand the possibility that their children are unaware of what behaviors their parents may view as desirable and continue repeating the undesirable behaviors. In this manual there are two child management procedures: Positive Practice and Catching My Child Being Good.

Positive Practice (Appendix F) is a disciplinary method that may be utilized to non-aversively punish undesired behaviors by having children practice target behaviors using a method that relies on acceptance, patience, and support from the mother to the child. The first part of this module was to explain to mother that children need to be taught what
behaviors are undesired, and in addition children need to be taught a desired behavior to replace it with. The therapist explained to the mother that positive practice involves having the child perform a desired behavior multiple times after an undesired behavior occurs. The therapists then provided the mother with examples of behaviors that would be appropriate for this procedure and probed the mother to provide examples she believed would be appropriate.

Then the therapist modeled the steps for positive practice, which are making an excuse that blames the situation not the child, state what the desired behavior is, state that this desired behavior is difficult, use a calm voice, and have the child practice the behavior an appropriate number of times (i.e. based on severity of the undesired behavior). After the therapist modeled the steps for the mother the mother practiced implementing the procedure, and the therapist provided feedback and suggestions for actual implementations with the children. The mother was then asked to implement this procedure at least once by the next session. In future sessions the therapist reviewed the mother’s progress with this intervention.

Another parenting strategy is teaching a child to behave in a more desired way by positively reinforcing the child when engaging in desired behavior while ignoring the children as much as possible when undesired behaviors occur. The “Catching My Child Being Good” procedure (Appendix G) is a standardized method to accomplish this task via instruction, role-playing, feedback, and therapy assignments. The therapist explained to the mother that parents often focus their attention on stopping the child from engaging in undesired behaviors, but often parents do not reinforce the desired behaviors. The therapist explained to the mother that this procedure is useful for behaviors that do not put the child’s safety at risk or cause damage to property.
The therapist first modeled for the mother different types of reinforcement she can provide to the children though a role-play. The therapist pretended to be the mother and the mother took on the role of her child. Through this interaction the therapist demonstrated appropriate reinforcement such as attending to the child, praising the child, and incidental teaching. Then the therapist and the mother switched roles and the mother practices providing reinforcement to the therapist. In a similar manner the therapist taught the mother how to ignore undesired behaviors.

The final step of this procedure involved the mother conducting an in vivo trial with her child. The therapist instructed the mother to implement these newly learned techniques while providing feedback to the mother. During the in vivo trial the therapist praised the mother for what she was doing well and provided suggestions for additional reinforcement to give to the child. The mother was then assigned to practice catching her child or children being good and her attempts were reviewed in future sessions.

The Family Support module (Appendix H) was designed to increase the mothers motivation to engage in drug incompatible behaviors, and positive parenting behaviors by providing her needed support from the significant others in her life. The goal was to increase the amount of support significant others provide to the mother, which will likely increase the mother’s ability to stay clean from drugs and engage in behaviors that benefit her children. The mother’s adult significant others identified things they could do that they thought would decrease the stress the mother was under because stress is likely a trigger for her substance use, which then results in behavior associated with child neglect. The significant others created a list of ways they would support the mother for the following week. Then her children over the age of three identified ways to be supportive of their mother, and help the mother be the best parent she can be. This could have been
as simple as giving the client a hug in the morning or as complex as helping the client prepare dinner. Finally, if the mother remained clean then a bonus reward was provided by the significant others. A brief assessment was conducted to ensure that significant others could identify the signs of drug use in their loved one before the bonus reward could be provided. This intervention is important because the significant others are likely to be a big influence in the mother's life, thus their involvement in therapy will be beneficial to the entire family. In future sessions support that was provided to the mother was reviewed and new forms of support were identified. In addition to the support, future sessions involved the determination of if the mother was clean and what reward her significant others would provide her.

The Communication Skill Training modules were added to the manual because for many people poor communication is an antecedent for drug use and child neglect. Families with dysfunctional communication patterns tend to have high rates of drug use and child neglect. The goal of this intervention was to improve the mother’s ability to communicate with others in order to increase the rate of positive exchange between family members. Improved communication patterns were likely to result in the prevention of antecedent stimuli that often elicit drug use (e.g., anger, depression, guilt) and neglect (e.g., lack of concern and empathy). The manual contains three communication skills training modules including Reciprocity Awareness, Positive Request, and Annoyance Prevention.

Reciprocity Awareness procedures, also know as I’ve Got a Great Family, (Appendix I) was designed to create awareness of the reinforcers the mother and significant others provide to each other, and increase the rate of positive exchanges. The goal of this technique is to enhance positive interactions that will be a buffer against stressors. The

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mother and significant others take time to identify things that the other family members do for them that they appreciate. The mother and her significant others were taught to share things that they like, appreciate, and respect about other. Each family member stated things that other family members have done that were appreciated. The family member who was receiving the statement of appreciation then expressed how it felt to hear the appreciation statements.

The Positive Request procedure (Appendix J) involved teaching family members to ask others for reinforces or actions in a positive manner. The therapist modeled for the client how to request a specific action by stating when the behavior is desired, stating benefits for the other person if the request was completed, stating why the action would be good for the person making the request, stating why the requested action might be difficult or inconvenient to perform, offering help to make the action easier to perform, offering to do something nice for the person being asked to perform the request, and suggesting alternative actions. After the therapist demonstrated the steps the mother and significant others were asked what they liked, what they did not like, and how they would change it to fit their style. Then the mother and significant others attempted to implement the steps while the therapist provided feedback. Practice continued in additional sessions.

The Arousal Management procedure (Appendix K) was implemented to decrease negative interactions and assist in the prevention of emotional neglect. The therapist modeled the techniques to decrease the level of anger. Techniques were used when anger is first identified, include: taking a deep breath and relaxing, stating the problem in a neutral way, blaming something in the situation, and stating something that may have been done to contribute to the undesired behavior. After the therapist modeled the
procedure the mothers and significant others were instructed to completed the steps for a recent anger-provoking situation. Individuals were given feedback regarding their compliance with these steps and were encouraged to use the steps during future disagreements that are accompanied by anger.

The Assurance of Basic Necessities and Safety (Appendix L) was the final intervention developed and was created after working with the initial case study. This procedure begins with an assessment of emergency situations that were presently occurring or may occur in the near future. The client was asked to provide the current status of situation as either not present, mild, or severe (an emergency). Examples of items on the list are loss of power, the possibility of loss of residence such as an eviction, upcoming bills, and domestic violence. If the client endorsed an item as an emergency then the session becomes an emergency session in which the therapist worked with the client to identify a solution for the emergency and whenever possible help the mother implement the solution. If there were situations the client endorsed as mild the therapist added the item to the clients stimulus control list to be reviewed in future sessions.
CHAPTER 5

DISCUSSION

Summary of Results

This study resulted in the culmination of a stage 1 manual. The Family Behavior Therapy manual is based on existing family behavior treatments, and is aimed to concurrently treat substance abuse and child neglect in mothers. The treatment consists of several family based interventions, most of which address drug use and child neglect. There are modules that are more specific to either drug abuse or child neglect, such as the child management interventions. However, the implementation in the child neglect or drug specific modules can result in reduction of the other undesired behavior due to the reciprocal relationship between drug abuse and child neglect.

Each module of the Family Behavior Therapy attempts to teach the mother a new skill that will enable her to stay clean from drugs and engage in behavior that benefits her children. Based on the pilot case an average of 30 minutes is required to implement each module with the exception of stimulus control. Because stimulus control also included an assessment component it required two sessions in the case study. This time may be decreased depending on situation in the home. Each module has a treatment rationale, therapist goals for the intervention, materials required, an overview of the intervention, procedural steps for implementation, homework, requirements for future sessions, and a therapist prompting list. The rationale is the reasoning for the particular module.
including how the intervention will likely result in behavioral change for the client. The therapist goals summarize the target behaviors of the therapist for outcome of the module. The overview provides a brief summary of the process that will be utilized in the skills training. The procedural steps give step-by-step specific instructions for the module. Included in this portion are narrative examples of the treatment implementation. Any homework that the client must complete will be presented at the end of the procedural steps. The steps for future implementation follow the procedural steps. The first time the module is implemented this section is skipped and is returned to in the subsequent sessions. Lastly, there is a therapist promoting form, which can serves as a self-report of the therapist’s protocol adherence. This form is an outline that the therapist can follow to ensure the main steps of the treatment are completed.

Critique of the Interventions

The Stimulus Control Procedure is designed to help mothers increase the amount of time spent in situation in which they are safe from drug use and engaging in behavior that do not benefit their children. This module provides a wealth of information regarding the client’s triggers for drug use and behaviors consistent with neglect. However, one critique of this section is the length. As it currently stands it requires approximately two sessions to complete this module. Because the initial sessions are so important a client may be unable to see the direct benefits of the initial portion of this module. Thus, before implementing with future cases the length of this module may need to be reviewed and areas may be shortened.
The Self Control Procedure is designed to assist mothers in decreasing their impulses to use drugs or engage in behaviors consistent with child neglect by helping mothers become fully aware of the urges to use drugs and the behaviors that may not benefit their children. This procedure appeared to be the one that the client felt she benefited the most from as evidenced by the high credibility scores given and praise she gave to the therapist about the intervention. This intervention appeared to provide the client with skills she felt were extremely helpful. In future cases it may be beneficial to attempt to introduce this intervention much earlier than it was implemented in the pilot case.

The Family Support Procedure is designed to increase the mothers' motivation to engage in drug incompatible behaviors, and positive parenting behaviors by increasing the support she is receiving from her significant others. In the beginning of this pilot case the therapist did not utilize the benefits of the support from the family nearly enough. This was a result of the sequence that the intervention modules were presented. Thus, in future cases it is highly recommended that this intervention be presented much earlier to increase the support that the client is receiving from the very beginning.

The Communication Skill Training Procedures is designed to increase the communication in between the mother and her significant others. The rationale to increase communication in families is that poor communication may be antecedent for drug use and child neglect for the mother. There are three modules for designed to increase the communication in families consisting of Reciprocity Awareness, Positive Request, and Arousal Management. At the present time these modules appear to be meeting the objectives.

The Child Management Procedure involves Positive Practice and Catching My Child Being Good. The client seemed to prefer the Catching My Child Being Good procedure
as evidenced by her higher score in participation from her therapist. This may have resulted from the client not having a clear understanding of the goal of the Positive Practice intervention. The therapist felt the instructions were somewhat unclear and modifications were made as a result of feedback from the therapist. In future cases the clarity of instructions will have to be assessed and if participation is still low other changes to the manual may be needed.

The Home Safety and Beautification Procedure is the procedure in which the mothers and her family are taught about potential home hazards and the benefits of home beautification. The client appeared to benefit from this intervention as evidence by an increase in the cleanliness and a reduction in hazards in her home. In fact, after implementing this procedure the therapist noticed an increase in the care the client took in her and her children’s physical appearance. The one issue that did arise was dealing with hazards that required the attention of the client’s landlord. In this case there were hazards (i.e. no screens on windows, broken garbage disposal) that the client herself could not eliminate, and landlord was not very responsive to her attempts to request the landlord eliminate these issues. In supervision it was decided the therapists could go to the landlords office with the client and be there with her to discuss these issues with the landlord. If issues similar to this occur in future cases a more standardized approach to how to address this problem may need to be developed.

The final intervention was created after working with the initial case and is the Assurance of Basic Necessities and Safety Procedure. This procedure is begins with an assessment of emergency situations that are presently occurring or may occur in the near future. This module is expected to ensure that therapists are able to work with the client to address emergency issues. It is expected that the population is likely to require an
intervention to reinforce appropriate planning skills for basic life events. In some cases, such as the pilot case, clients may have reached a point where ensuring basic necessities such as food and power may be a difficult task. These cases may require some work to eliminate emergencies before some intervention protocol can be implemented.

Innovations of the Developed Treatment Manual

Overall the Family Behavior Therapy treatment manual consists of many innovations to the treatment of substance abuse and child neglect. For example, this treatment manual adopted treatments that were previously utilized for drug abuse (i.e. stimulus control and self control) and modified them to make the interventions also applicable to child neglect. This increases the likelihood that the client will learn to generalize the techniques to other problem situations such as domestic violence or anger.

Another innovation of the manual is that we created a module that will assess and if needed implement solutions to basic emergencies that the clients may encounter. This module was developed based on the occurrence of emergency issues that the client encountered during our treatment with her. This module is innovative because it allows the therapist to work with the mother to manage real world problems that may be creating stress.

The family support module is also innovative because we are increasing the family support the mother receives not only from her adult significant others, but also from her children. Including the children was an important component of this intervention because it was another method utilized to strengthen the family unit. This module is also innovative because in addition to family members providing support to the mother we added a spontaneous reward. The mother can earn a reward from adult significant others.
if she was clean and engaged in behaviors that benefited her children. The reward serves
as a reinforcer to the mother to remain clean from drugs and be the best parent she can
be. This also allows for the entire family to be involved in the positive aspects of the
treatment such as enjoying a reward together.

The stimulus control module has many of the standard features from the original
version. However, the research team created an innovative assessment and goal setting
measure. We created lists of positive behaviors including positive parenting behaviors,
drug incompatible behaviors, and safety and necessity assurance behaviors. We decided
that our treatment was going to be positive and strength based so instead of creating an
assessment of the undesirable behaviors the clients may engage in we chose to assess
what desirable behaviors they would like to set as a goal for themselves. Although in
essence we are arriving at the same information we are doing it in a more positive way
than it is often currently done in treatment settings.

*Advantages of this Method of Manual Development*

There are many advantages to the method of manual development that were
employed for this study. One advantage is that those team members who contributed to
the development in the manual also received training in how to implement the treatment
protocol. To edit the modules of the manual, team members had to read the protocol and
have a clear understanding of what steps the therapist must complete for the
implementation of the intervention. The role-plays were another avenue of training that
occurred during this process. Because team members were required to role-play as the
therapist and as the client they received a clear understanding of what treatment delivery
should be. Before each role-play the research advisor conducted a role-play thus
modeling for the team what the treatment delivery should be like. Through modeling and receiving corrective feedback from someone experienced in the treatment implementation, team members learned how to be the therapist without direct training.

Another advantage is that members on the treatment development team were also likely to be therapists for the final stage; they tended to view the treatment as a whole and rationales for individual modules as highly credible. Because of the contribution they made such as feedback and edits, the therapists were more inclined to believe in the treatment. This seemed to result from their clear understanding of the rationale and information about how the treatment was designed. This also increased the therapist confidence in the implementation of the manual.

The team was comprised of a diverse group of students. Although the team was predominantly female, male students also contributed. The ethnic composition was also diverse with many members of various ethnic backgrounds including African American, Middle Eastern, and Latino. The age range also varied ranging from 18 years to 40 years of age. Having diverse contributors increases chances of the treatment manual being applicable with diverse groups.

Future Directions for the Family Behavior Therapy Manual

The results from the uncontrolled trial of the treatment manual are promising. The client found the treatment credible and endorsed she would refer others to the treatment. The client also endorsed that she felt the interventions were helpful. Based on the preliminary evidence a more controlled trial should be conducted with the treatment manual. The pilot study provided evidence to suggest that the treatment manual is likely to show a decrease in parental drug use and child neglect when examined in a more controlled design.
Future versions of the manual should address how to handle co-morbid disorders that may occur in this population. One issue that arose in the pilot study was the need to address domestic violence. Based on the experience with the pilot study is it likely that domestic violence and other mental health issues such as depression and anxiety may occur in future cases within the target population. As suggested in the literature on manual development, adding information on ways to handle co-morbid disorders makes the manual more therapists friendly. This may also increase the acceptability of the treatment manual by therapists in community settings. One of the reasons treatment manuals are difficult for therapist in these settings to adopt is that they provide little or no guidance on supplemental treatments for the co-morbid disorders that are common or expected to occur in the target population.

One goal of the program is to utilize the benefits of the family support. However, due to the scheduling of interventions we relied more heavily on family support in some sessions than in others, which led to family attendance having a large degree of variability. To create more structure after session number 10, it was decided to schedule the first session of the week as a family session and the second session as an individual session. This created more structure for significant others to be clear on what days they should be involved in the therapy session.

Based on the client's credibility and satisfaction scores there are a few changes that should occur in the future. First, the new credibility scale that provides a description for each value on the assessment will be used in order to elicit a more accurate picture of the client's views about the treatment credibility. Based on the satisfaction scale future areas of improvement include taking steps to ensure we are meeting the needs of the client. One possible change to increase the likelihood that the client feels their needs are being
met is to change the review of the stimulus control. As it is now the therapist selects items on the safe and at risk list to review. In the future, this process could involve asking the client to select items and review the items the client selected first. It would be important for the therapist to continue to select items to review to ensure the client is not selecting items of low importance or avoiding the more salient issue of drug use and child neglect.

Training programs for the manual also need to be developed. Some possibilities include using video or audiotapes as models for training therapists. The video or audiotapes could depict ideal and problematic sessions and models of how to handle the problematic situations. This has been a recommendation in the literature on manual development in order to increase the probability that therapists are delivering the treatment the way the developers intended. These examples would be helpful in training therapists in the interventions.

Communication procedures with child protective services need to be firmly established. At the time of the pilot study coordination with the caseworker to share information was sometimes problematic. In addition, there was not a set method of providing the caseworker with updates about the client such as monthly progress reports. Although there was a great amount of contact between the caseworker and the therapist a more standardized schedule and method of contact would benefit all involved parties.

Child specific interventions would enhance the benefits for the families we are targeting. The manual currently makes great efforts to include significant others including the children of the mother. However, more child specific interventions may enhance the effectiveness of the intervention and improve the overall family functioning. Some ideas for child interventions include working with the child utilizing methods such
as positive practice to increase their desired behaviors (e.g., cleaning up a mess or to reduce child-to-child violence). Also working with the child to identify ways they can be helpful and provide support to their mother such as helping to change a sibling’s diaper.

Concluding Remarks

This study set out to develop a treatment manual for a family based therapy that simultaneously targets parental substance abuse and child neglect. After 12 months of extensive manual development and an implementation of the manual with a pilot study the results for the effectiveness of the manual are promising. The recommendations for the manual will enhance the acceptability and likelihood that other clinicians will utilize this newly developed manual. Lastly, the results from a future more controlled trial will determine the effectiveness of the developed manualized intervention within the target population.
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