

12-1-2012

The Initial Development of Child-Focused Interventions in the Treatment of Maternal Substance Abuse and Child Neglect

Kendra Tracy

University of Nevada, Las Vegas, tracyk6@unlv.nevada.edu

Follow this and additional works at: <https://digitalscholarship.unlv.edu/thesesdissertations>

Repository Citation

Tracy, Kendra, "The Initial Development of Child-Focused Interventions in the Treatment of Maternal Substance Abuse and Child Neglect" (2012). *UNLV Theses, Dissertations, Professional Papers, and Capstones*. 1527.

<https://digitalscholarship.unlv.edu/thesesdissertations/1527>

This Thesis is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Thesis in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Thesis has been accepted for inclusion in UNLV Theses, Dissertations, Professional Papers, and Capstones by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

THE INITIAL DEVELOPMENT OF CHILD-FOCUSED INTERVENTIONS IN THE
TREATMENT OF MATERNAL SUBSTANCE ABUSE AND CHILD NEGLECT

By

Kendra Tracy

Bachelor of Arts
San Diego State University
2002

A thesis submitted in partial fulfillment of
the requirements for the

Master of Art in Psychology

**Department of Psychology
College of Liberal Arts
Graduate College**

**University of Nevada, Las Vegas
May 2012**

Copyright by Kendra Tracy 2012
All Rights Reserved



THE GRADUATE COLLEGE

We recommend the thesis prepared under our supervision by

Kendra Tracy

entitled

The Initial Development of Child-Focused Interventions in the Treatment of Maternal Substance Abuse and Child Neglect

be accepted in partial fulfillment of the requirements for the degree of

Master of Art in Psychology
Department of Psychology

Brad Donahue, Committee Chair

Daniel Allen, Committee Member

Jennifer Rennels, Committee Member

Chad Cross, Graduate College Representative

Ronald Smith, Ph. D., Vice President for Research and Graduate Studies
and Dean of the Graduate College

May 2012

ABSTRACT

The Initial Development of Child-Focused Interventions in the Treatment of Maternal Substance Abuse and Child Neglect

by

Kendra Tracy

Dr. Brad Donohue, Thesis Committee Chair
Professor of Psychology
University of Nevada, Las Vegas

This single case study focuses on the development and evaluation of child-focused interventions for the treatment of child neglect and concurrent maternal substance abuse that were incorporated into Family Behavior Therapy (FBT). The participants were a mother referred by the Department of Family Services and her child. The child participated in three child-focused interventions that were developed to decrease child behavior problems, increase support and communication, and prevent future neglect by strengthening the mother-child relationship. Although not a focus in this study, the mother participated in traditional FBT adult-focused intervention components. The chief aim of the present study was to examine the feasibility of incorporating these child-focused interventions into FBT, while the second aim was to evaluate the effect of these interventions on measures of parenting. Treatment fidelity, feasibility, and consumer satisfaction were assessed and found to be adequate for two of the proposed interventions. Implications and limitations of the present study are discussed.

TABLE OF CONTENTS

ABSTRACT	iii
LIST OF TABLES.....	vi
CHAPTER 1 INTRODUCTION.....	1
The Present Study.....	3
CHAPTER 2 LITERATURE REVIEW.....	5
Characteristics of Neglectful Families	5
Characteristics of Neglected Children.....	13
Review of Treatments for Substance Abuse	20
Review of Adult-Focused Treatments for Neglect	22
Review of Child-Focused Treatments for Neglect.....	24
Review of Treatments for Correlates of Neglect	27
The Proposed Study	31
Hypotheses	35
CHAPTER 3 METHODS.....	36
Participants	36
Measures Related to the Interventions' Feasibility	37
Measures Related to Outcome.....	38
Procedures	42
Experimental Design	43
Process of Developing the Experimental Child-Focused Interventions.....	43
Adult-Focused Interventions	44
Child-Focused Interventions	46
CHAPTER 4 RESULTS.....	49
Course of Treatment.....	49
Results Related to Feasibility.....	67
Results Related to Outcome	71
CHAPTER 5 DISCUSSION	76
Feasibility	76
Outcome	78
Limitations	78
Future Directions.....	80
APPENDIX A WHY I'M SPECIAL	84
APPENDIX B HELPING PARENTS.....	88
APPENDIX C CATCH MY PARENTS BEING GOOD	93
APPENDIX D ACTIVITY LIST	96

APPENDIX E SMILEY FACE SCALE.....	111
REFERENCES.....	120
VITA.....	139

LIST OF TABLES

Table 1	Session 2 Feasibility Data.....	110
Table 2	Session 3 Feasibility Data.....	111
Table 3	Session 5 Feasibility Data.....	112
Table 4	Session 6 Feasibility Data.....	113
Table 5	Session 7 Feasibility Data.....	114
Table 6	Session 8 Feasibility Data.....	115
Table 7	Scores on Outcome Data Measures.....	116
Table 8	Parent Satisfaction with Child Scale Results.....	117

CHAPTER 1

INTRODUCTION

Child neglect is the most commonly reported form of child maltreatment (USDHHS, 2009). The US Department of Health and Human Services (2009) indicated that among the types of child maltreatment, physical abuse accounts for 16.6% of reports, sexual abuse accounts for 9.3%, psychological abuse accounts for 7.1%, while neglect accounts for more than all other types of maltreatment combined at 62.8% of reports. Younger children, particularly children under the age of 4 years, are at the highest risk of neglect; however, neglect affects children of all ages (USDHHS, 2009). Although the prevalence of neglect reports is alarmingly high, these numbers are most likely an underrepresentation of the actual scope of the problem. Estimates suggest only 50% of maltreatment cases are reported to child protective services (Sedlak & Broadhurst, 1996).

Legal definitions of child neglect vary between states; however, researchers have identified the following categories of neglect (Child Welfare Information Gateway, 2008). Physical neglect is the most commonly reported subtype (DePanfilis & Salus, 1992). Child neglect involves a failure to provide basic necessities to children, the lack of which may endanger the physical well-being, health, psychological growth, or development of children. Child neglect also includes behaviors such as lack of supervision, abandonment, and failure to provide for food or shelter. Educational neglect is a failure to address academic needs of children. Indicators of educational neglect include a failure to enroll children in school, chronic truancy, failure to provide, or refusal of, necessary special education. Emotional neglect incorporates the failure to attend to a child's emotional needs. This includes behaviors such as engaging in physical

violence in front of a child and allowing a child to use drugs or alcohol. Lastly, medical neglect is the failure to provide appropriate health care to children, including physical and mental health needs.

Professionals often disagree as to the “basic needs” of children and what constitutes “appropriate care,” so that researchers attempting to identify neglect use variable criteria (Tyler, Allison, & Winsler, 2006). Assessment of child neglect is further complicated because failure to provide basic necessities sometimes does not constitute neglect. If, for example, a parent has a sick child, but has no access to medical care, failure to provide health care cannot be considered medical neglect. However, if assistance or resources are available, and parents fail to use them, neglect may be indicated.

Oftentimes, parents who are found to neglect their children are not aware of proper parenting practices (Brown, Cohen, Johnson, & Salzinger, 1998; Pears & Capaldi, 1999). They may blame their children for difficulties experienced in parenting, or view their children as burdens or trouble-makers (Sullivan & Knuston, 2000; Zirpoli & Bell, 1987). Negative perceptions of their children may inhibit the attachment process, leading to problems in the overall tone of the relationship and subsequent avoidance behavior (Bugental & Happeney, 2004; De Paul & Guibert, 2008). These problems are often compounded by substance abuse and dependence. Indeed, parents who use illicit substances are two to four times more likely to be reported for neglect than non-substance abusing parents (Carter & Myers, 2007). Although parents may use substances to reduce negative feelings associated with difficulties in raising children, the effects of substance use often exacerbate problems associated with inadequate childcare.

Child neglect has devastating consequences. For instance, a recent national survey found that 34% of child fatalities are due to neglect (USDHHS, 2009). Malnourishment, failure-to-thrive, and other health problems are commonly experienced in neglected children (Block, Krebs, Hibbard, Jenny, Kellogg, & Spivak, et al., 2005). In addition to physical consequences, neglect often causes psychological, social, and emotional problems in affected youth. Indeed, victims of neglect evidence a myriad of deficits in social skills, self-regulation, and cognitive and academic abilities (Crozier & Barth, 2005; Fantuzzo, Weiss, Atkins, Meyers, & Noone, 1998; Maughan & Cicchetti, 2002). These children display higher rates of mental illness than their non-maltreated counterparts (McCauley, Kern, Kolodner, Dill, Schroeder, DeChant, et al., 1997), putting them at greater risk of suicide, victimization, incarceration, and substance abuse or dependence (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Gilbert, Widom, Browne, Fergusson, Webb, & Janson, 2009; Tyler, Johnson, & Brownridge, 2008). Many neglectful mothers use illicit substances during pregnancy (Ondersma, Simpson, Brestan, & Ward, 2000). Drug exposed infants are at risk for problems associated with low birth weight, cognitive deficiencies, behavior problems, inattention, and impulsivity (Liu, Bann, Lester, Tronick, Das, Lagasse, et al., 2010; Ornoy, 2002; Pulsifer, Butz, Foran, & Belcher, 2008; Williams & Ross, 2007).

The Present Study

There are few evidence-based treatments for child neglect and the few that exist are primarily adult-focused (Cohen, Mannarino, Murray, & Igleman, 2006). Therefore, the present study was focused on the development of child-focused interventions for victims of child neglect. In this first line of research, these intervention components were

systematically developed, and their feasibility was examined within the context of a single case trial involving a parent who was concurrently treated for child neglect and drug abuse utilizing a family behavior therapy. The child-focused interventions were designed to strengthen family bonds and assist parents in perceiving their children as more reinforcing. Along these lines, it was hypothesized that family bonds are positively related to perceptions of parental satisfaction, and this relationship is enhanced through the elimination of risk factors for child neglect (i.e., drug abuse, parenting skill deficits).

The proposed interventions were developed within the Family Behavior Therapy (FBT) framework as applied to adults who have been indicated to neglect their children and abuse illicit substances. A standardized manual development procedure was utilized in designing the child-focused interventions. The development of the interventions themselves consisted of five phases: 1) identification of treatment targets in victims of neglect, 2) identification of existing evidence-based child-focused interventions that are consistent with the FBT approach, 3) adaptation of these child-focused interventions to address the needs of victims of neglect, 4) examination of the feasibility of the developed child-focused treatments, 5) preliminary evaluation of child-focused interventions for victims of neglect in an uncontrolled, single case trial.

CHAPTER 2

LITERATURE REVIEW

Child neglect accounts for the majority of child welfare reports (USDHHS, 2009); however, it receives the least attention from researchers compared to other types of maltreatment. Few investigators have examined neglect alone, as the majority of research is focused on multiple types of maltreatment together, such as both child neglect and physical abuse (Black, 2000). Nevertheless, researchers have identified many characteristics and factors associated with child neglect, particularly characteristics of neglected children. These characteristics are important to note as they may be utilized to assist in the identification of children at risk for maltreatment.

Characteristics of Neglectful Families

One of the strongest correlates of child neglect is poverty (Glaser, 2008). Poverty is associated with environmental risks and parental characteristics associated with child maltreatment (Carter & Myers, 2007). Impoverished families have difficulty obtaining consistent medical and dental care, such as vaccinations and check-ups (Guendelman, Wyn, & Tsai, 2000; Klevens & Luman, 2001). Poor housing conditions are common in cases of poverty and neglect (Farrel, Britner, Guzzardo, & Goodrich, 2010), and impoverished neighborhoods are notable for having higher crime rates, availability of drugs and alcohol, and lower cohesion (Kohen, Leventhal, Dahinten, & McIntosh, 2008). These neighborhood characteristics can negatively impact caregivers' mental health, which in turn negatively impacts their parenting skills. It has been noted that families in impoverished areas spend less time engaged in activities with their children. Kohen et al. (2008) found that parents in poor neighborhoods spend less time reading to their children,

and suggested that this lack of interaction may be related to employment conditions.

Parents working long hours have reduced time to engage in family activities.

Additionally, working long hours can lead to stress, which could cause the parent to want to spend more time alone. On the other end of the employment spectrum, Kohen suggested unemployed parents may develop depression that causes them to be fatigued and reduces motivation, which leads to less time spent with their children.

Interestingly, the severity of poverty is less related to child maltreatment than the perceived hardship associated with poverty (Kohen et al., 2008; Slack, Holl, McDaniel, Yoo, Bolger, 2004). That is, as parents perceive greater hardships, they are more likely to experience child maltreatment regardless of the actual hardship encountered. For instance, stress may interfere with appropriate care-taking activities (Guterman, Lee, Taylor, & Rathouz, 2009), leading parents to use inefficient coping strategies, such as substance use (Kelly, 2002). Stress or poor mental health is related to inconsistent and punitive parenting, which in turn is related to increased child behavior problems (Kohen et al., 2008). Increased child behavior problems lead to increased parental stress, which increases the likelihood of child maltreatment, thus creating a vicious cycle of stress and maltreatment.

Financial stress is associated with child maltreatment, and is often influenced by being a teenage or single parent, or having several young children that are near the same age (Chaffin, Kelleher and Hollenberg, 1996; Haveman, Wolfe, & Peterson, 1997). For instance, single parents report more mental health problems and lower self-esteem than married mothers (Ceballo & McLoyd, 2002). Mental health problems affect parenting ability in a variety of ways. For example, depression may lead to less affect and having

fewer interactions with offspring, while parents with borderline personality disorder are likely to foster unstable environments. In addition to evidencing more mental health problems, young parents may feel that they are unable to parent effectively (Rodriguez, 2008). Teenage parents in particular are likely to feel unprepared for parenthood. Indeed, two-thirds of pregnancies occurring in children under the age of 18 years are unintended pregnancies (Chandra, Martinez, Mosher, Abma, & Jones, 2005). Teen parents are more likely to have a history of sexual or physical abuse or exposure to domestic violence that negatively impacts their parenting ability (Boyer & Fine, 1990). Teen parents are also more likely to be single parents (Hoffman, 2008). Parental self-efficacy is related to parental competence, child monitoring, positive parenting, positive parent-child interactions, parental warmth, and discipline style across children of all ages (see Jones & Prinze, 2005 for a review). In fact, several researchers claim that parental self-efficacy accounts for the improvements made in family-based treatment (Gross, Fogg, & Tucker, 1995; Hoza et al., 2000)

Young and single parents have fewer resources to help them manage parental duties and related stressors. Young parents are likely to have fewer friends with children they can rely on for support and advice while single parents bear the brunt of the childrearing responsibility alone, which is a correlate of child neglect (Williamson, Borduin, & Howe, 1991). Parents who report having more sources of support report better personal well-being than parents with less support. They also report spending more time playing a variety of games with their children, indicating that social support relieves stress and improves parents' ability to care for their children (Dunst, Trivette, & Cross, 2002). For parents who lack such support there are agencies within the community that

can provide assistance, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This agency provides food to low-income women with children. However, not all parents are aware of these resources or what they need to do in order to receive them. Young parents in particular may be unaware of the sources of support available in the community.

Neglectful parents lack the basic educational background that many non-neglectful parents possess (Mersky, Berger, Reynolds, & Gromoske, 2009). Teens who become pregnant are more likely to drop out of school, leading to educational deficits (Hoffman, 2008). These educational deficits can make it more difficult to find adequate employment, thus leading to financial difficulties which increase stress, which in turn increases the likelihood of child maltreatment. In addition to the skill sets acquired in school, neglectful parents lack education about other basic skills. Neglectful parents are often raised in poor family environments where proper parenting skills were not consistently or appropriately modeled. Effective discipline strategies, health care routines, and communication skills are just some of the behaviors that some parents may have never had an opportunity to learn. Individuals from these backgrounds may reenact their own neglect because they do not know of another way to parent. Victims of neglect are almost three times more likely to become neglectful parents than non-neglected children (Kim, 2009).

Neglectful parents often have unrealistic developmental expectations of their children, which may be related to the parent's lack of education or parenting skills (Dubowitz, 1999; Erickson & Egeland, 2002). Parents may expect too much from their children, such as expecting a two year old to have impulse control, which can lead to

frustration (Peterson, Gable, Doyle, Ewigman, 1997). Other parents may attribute their child's failure to perform certain behaviors as being motivated by spite. For example, a two year-old who eats a cookie when left unattended will be seen as having intentionally made a choice to break a rule and upset the parent, rather than as a child who was left alone in a highly tempting situation.

Neglectful parents tend to have more negative views of their children than non-neglecting parents and are more likely to describe their children as having behavior problems (Dubowitz, 1999; Erickson & Egeland, 2002). During play interactions neglectful parents have been observed to make more harsh and critical statements to their children, particularly during play scenarios in which children are in charge of the activities (Aragona & Eyberg, 1981). Indeed, some researchers have found neglectful parents are significantly less likely to comply with their children's requests and issue more commands during play (Burgess & Conger, 1978). Recent reviews show that, compared to non-maltreating parents, neglectful parents interact less with their children (including both verbal and nonverbal behavior) and display less positivity and warmth in their interactions with children (Schumacher, Slep, & Heyman, 2001; Wilson, Rack, Shi, & Norris, 2008).

Hildyard and Wolfe (2007) found neglectful mothers were less accurate than non-neglectful mothers in labeling emotions when shown pictures of one-year-old infants. The neglectful mothers were more likely than the non-neglecting mothers to label the infants as displaying negative emotions. They also made an increased number of atypical responses, such as saying the infants were "judging," being "sneaky," or giving the "death stare." The neglectful parents also gave more internal attributions to the behavior

of their children than non-neglecting parents. Neglectful parents were more likely to see negative behavior (e.g., crying) as being a result of a bad temperament rather than the result of external stimuli (e.g., being scared by a sudden movement). Hildyard and Wolfe also found neglectful parents were less able to identify interest in children. Parents who are unable to see when their children are interested in something may be less likely to provide opportunities for their children to engage in activities, which may result in fewer positive, fun interactions between parents and children. Parents who are unable to correctly identify emotional states in their infants are at increased risk to miss out on certain signals of infant needs, such as hunger or the need to change dirty diapers. These parents may misinterpret an infant's crying due to hunger as crying because the child is being difficult, or wishes to punish the parent.

It has been suggested that parents' cognitive schemata of relationships affects their ability to accurately label emotions. A mother's attachment status affects her ability to identify infant emotions. Mothers with secure attachments were better able to identify infant emotions when shown photos or videos of infants displaying different emotions, as compared with mothers who evidenced insecure attachments, or mothers who experienced inconsistent or invalidating experiences, with their parents (DeOliveira, Moran, & Pederson, 2005). The mothers' experience with their own parents affected their ability to perceive emotion in others, providing an example of how neglect can be transmitted between generations. Mothers with insecure attachments used fewer emotion labels and were more likely to see emotions as either completely positive or negative, suggesting they were unaware of, or less empathic to, the complexity of emotions.

Parents may lack awareness of the needs of their children, in general. This is consistent with the presumption that some parents are unprepared for parenthood and/or never experienced appropriate parental responses to their own needs as children. Some parents may lack awareness of the need that the child is attempting to communicate in the moment, reflecting an error in social information processing (Wilson, Rack, Shi, & Norris, 2008). Parents may misinterpret the needs of their children, and thus be unable to satisfy their need, which is more likely in unplanned pregnancies, young parents, parents with psychopathology, and parents who were maltreated themselves (Wilson, et al., 2008). Crittenden (1999) suggests that a parent's response to a child's cue can break down in several areas of the response chain (attention, interpretation, response selection, and response initiation) resulting in an ineffective response. Parents may not notice the signals of their children, or they may not think these signals require responses from them. They may choose inappropriate responses to perceived needs, or they may choose good responses, but experience difficulty initiating them. For example, a parent may decide to monitor a child playing in the front yard, which is an appropriate response to the child's request to play. However, if the parent is under the influence of a sedative or narcotic, they may experience difficulty concentrating on this task, such as falling asleep which leaves the child unattended.

To cope with child behavior problems, stress, and perceived life difficulties, parents may engage in unhealthy behaviors that further impair their parenting ability. Carter and Myers (2007) found that parents who used illicit substances were two to four times more likely to be reported for child neglect. Estimates of the number of child welfare cases in which substance use is also a problem range from 40%-80% (Young,

Boles, & Otero, 2007). Substance use can affect parenting ability in a variety of ways. Parents may use their money to purchase drugs or drug paraphernalia rather than spending money on basic life necessities, such as food, clothing, etc. In addition, the effects of the particular substance can affect parenting ability. Sedatives and narcotics cause impairments in motor ability and attention and cause drowsiness and mood swings. During mood swings, drug-using parents may become depressed, impairing their ability to attend to the needs of their children. Individuals often become less aware of their surroundings when under the effect of these types of substances. Parents who use sedatives when around their children are likely to go through periods where they are unaware of their children's needs or even whereabouts. Research with adolescent mothers has demonstrated that mothers who abuse drugs show impaired interactions with their infants as compared to non-drug-using mothers (Field, Scafidi, Pickens, Prodromidis, Pelaez-Norgueras, Torquati, et al., 1998).

Stimulant use can also negatively impact parenting ability. Stimulants increase alertness, energy level, and can lead to psychomotor agitation. However, parents who abuse stimulant drugs may become irritable and lash out at their children or other household members due to the effects of these drugs. Among couples, physical aggression is up to three times more likely on days of drug use (Fals-Stewart, Golden, & Schumacher, 2003; O'Leary & Schumacher, 2003). Sprang, Clark, & Bass (2005) found the severity of drug use was predictive of the severity of child neglect, and more severe use was positively associated with severe neglect.

Characteristics of Neglected Children

Many neglectful parents evidence substance abuse and dependence. Indeed, some estimates of the prevalence of co-occurring substance abuse and neglect have been as high as 70% among child welfare cases (Carter & Myers, 2007; Young, Boles, & Otero, 2007). In a large community sample, over 50% of the mothers who qualified for a diagnosis of substance abuse self-reported neglect of their children (Chaffin, Kelleher, & Hollenberg, 1996; Kelleher, Chaffin, Hollenberg, & Fischer, 1994).

In utero drug exposure can lead to a variety of health and social problems for the developing child. Prenatal exposure to cocaine is related to premature birth, and preterm cocaine exposed infants have been shown to demonstrate poor self-regulation and increased agitation (Scafidi et al., 1996). Mothers with polydrug abuse bear infants with decreased regulatory capacity who cry more, sleep less, and are more irritable than non-drug exposed infants (Field et al., 1998). Infants born to mothers dependent on heroin and cocaine show psychomotor delays. By the time these children reach school age, many show intellectual impairment (Ornoy, 2002). For instance, school age children who experienced prenatal drug exposure have evidenced delays in language development, school readiness skills, impulse control, planning, attention, and visual attention than non-drug exposed children matched for age and SES (Pulsifer, Butz, Foran, & Belcher, 2008).

Children living with parents who use substances are at risk to develop an array of problems, as well. Velleman and Templeton (2007) outline the ways substance use can impact family functions. They note that substance use affects family rituals, roles, routines, communication, social life, finances, and relationships. Disruptions in these

areas can lead to specific problems in the child's functioning. Inconsistent family rituals, roles, and routines affect the child's perception of security and safety. Drug use often causes parents to be less reliable. They may forget to pick the child up from school, take him to a doctor's appointment, or may forget his birthday. The parent's behavior may be markedly different when under the use of drugs, such that the child never knows what to expect from their parent. Children may become angry at their parent, leading to outbursts, or may come to feel that their needs, and by extension, the child himself, is unimportant. Discipline may be inconsistent, leading to an increase in child behavior problems. Indeed, children of drug users are at increased risk for internalizing and externalizing disorders such as depression, aggression, and anxiety (Kelley & Fals-Stewart, 2004; Kelley & Fals-Stewart, 2008; Osborne & Berger, 2009; Stanger et al., 1999).

Disruptions in communication, relationships, and social activities in the family affect the children's socialization. When a family member uses substances, the family itself tends to become more isolated. Extended family is often pushed away as the user attempts to hide their drug use. In the case of young children, parents may not make an effort to get the children involved in social activities. In the case of older children, they may be embarrassed by the parent's substance use and refrain from inviting friends over. Maltreated children often show impairment in social skills (Fantuzzo, Weiss, Atkins, Meyers, & Noone, 1998; Levendosky, Okun, & Parker, 1995; Shonk & Cicchetti, 2001). Maltreatment is associated with lower levels of social competence in children, which is related to greater internalizing and externalizing behaviors (Kim & Cicchetti, 2004). Thus, there is a cyclical relationship in which the social skills deficits of neglected children may lead to feelings of incompetence, which in turn may influence the children

to withdraw or become aggressive, leading to greater difficulty establishing positive relationships.

When under the influence of substances, parents may become angry, irritable, or violent. They may curse, lash out, or be unreasonable. Their children may learn to perform these inappropriate communication styles modeled by the parent. Children may be a victim of, or witness to, domestic violence or abuse. Children with substance abusing parents are more likely to experience a host of negative emotions, such as shame, embarrassment, guilt, fear, and anger. These children may become less able to regulate their emotional responses, more likely to be hypervigilant and reactive to ambiguous stimuli, or become depressed. Indeed, maltreated children are more likely to exhibit emotional dysregulation than non-maltreated children, with 80% of maltreated children demonstrating dysregulation as opposed to 37% of non-maltreated controls (Maughan & Cicchetti, 2002). Emotional dysregulation leads to behavior problems such as inattention, hyperactivity, impulsivity, and antisocial behaviors that are often exhibited by neglected children (Schatz, Smith, Borkowski, Whitman, & Keogh, 2008).

Longitudinal analyses reveal that neglect is associated with subsequent school engagement, delinquency, well being, and for females, victimization (Tyler, Johnson, Brownridge, 2008). Prior research has shown that neglectful families often show lower levels of positive parenting (Burgess & Conger, 1978). Thus, to account for the aforementioned consequences of neglect, this study included a measure of positive parenting, defined as containing three constructs: parental monitoring, closeness (i.e., the adolescent's perception of how close they are with their primary caregiver and how much the caregiver cares about them), and relationship (i.e., how supportive/helpful the

caregiver is). Tyler et al. (2008), found that low levels of positive parenting was associated with running away, which predicted delinquency. Teen runaways are at increased risk to engage in delinquent behaviors because they spend more time on the streets where they come into contact with delinquent peers (Whitbeck & Simons, 1990). Runaways are also exposed to potential victimizers when on the street (Tyler, Hoyt, Whitbeck, & Cauce, 2001b), leading to the documented higher victimization rates.

Given that neglected children are noted to have difficulty with emotional and behavioral regulation, and are prone to act out in ways such as being aggressive, using drugs, and running away, it is reasonable to assume that the relationship between neglectful parents and their children is affected by these behaviors. We do not wish to suggest that children are responsible for their own neglect, but that the consequences of neglect make future neglect more likely by causing a larger rift in family relationships. For example, substance-abusing parents may not monitor their child's whereabouts because a great deal of their time is spent using, or under the influence of, drugs. Their child may make friends with other unmonitored children. These children begin to engage in deviant behaviors, such as stealing and fighting. When the children's parents notice this delinquent behavior, they may become verbally abusive and threatening. These children may feel that their parents are too controlling or do not care about them, so they may run away, which may cause their parents to label their child as "bad" or to feel like their child does not love them. When their child returns home, both parent and child feel disconnected from each other, and feel the other does not understand them. This may cause parents to use drugs to avoid the negative feelings, and children to bond more

strongly with their deviant peers because they provide validation and support that is lacking at home.

Positive relationships between family members are a protective factor for children (Saewyc & Tonkin, 2008). Kim and Cicchetti (2004) used structural equation modeling to demonstrate that children with secure attachment to their mother, regardless of maltreatment status, showed less internalizing and externalizing behavior than children with insecure attachments. Secure attachment in maltreated children is associated with having a supportive family member in the home and a less chaotic household (Egeland & Sroufe, 1981). Thus, when children perceive they are being consistently supported, they show improved behavior and mental health. Importantly, this relationship was mediated by self-esteem, indicating that the child's self-esteem can also be a protective factor. Consistent, supportive parenting leads children to develop a sense of self worth, which directly contributes to reduced rates of behavior problems.

Related to self-esteem is self-efficacy, which is a person's perception of their ability to effectively complete tasks. Maltreated children often report lower levels of competence or efficacy (Sagy & Dotan, 2001). However, Sagy and Dotan found that strong family coherence moderated the relationship between perceived competence and maltreatment, such that high coherence was associated with greater perceived competence. It was also found that an increased sense of competence was related to lower levels of reported distress among maltreated children, indicating that children who have a high sense of self-efficacy experience less suffering. Families with low coherence tend to be less predictable; the rules are inconsistent and applied unfairly, and there is no consistent involvement between family members. In this chaotic environment where

many things are out of the child's control, the maltreated child may show a kind of learned helplessness and be more passive and dependent, and therefore, feel less competent. Thus, families that share strong bonds between members lead children to develop higher self-esteem and competence, which protect against maladjustment, even in maltreating families

One way family members can support each other is through helping one another when they perceive there is a need. Eberly & Montemayor (1998) propose a relational model of helping, in which helping behavior within families is determined, in part, by the attachment status between parents and children. They concluded that secure attachment is characterized by an interdependent relationship, whereby the caregiver and child respond to each other's needs. Children with secure attachments showed greater levels of interdependence and prosocial behavior within the family. Parents who withdraw from or reject their children's emotional needs, or provide inconsistent care (as do many neglectful parents) often raise children who display low levels of empathy (Kestenbaum, Farber, and Sroufe 1989).

Prosocial behavior is often related to empathy (Eisenberg & Fabes, 1991; McMahon, Wernsman, Parnes, 2006). Negativity, particularly anger, has been associated with less prosocial behavior and low levels of empathy (Knafo & Plomin, 2006). Thus, it stands to reason that children exposed to chronic negativity by their parents have had relatively few prosocial models, and may have adopted their parents' negative communication style. These children may be less likely to give help to family members, possibly due to limited perspective taking, a skill linked to empathy (FitzGerald & White, 2003). Indeed, maltreated children and adolescents show impaired perspective taking

skills and tend to be more egocentric (Burack, Flanagan, Peleg, Sutton, Zygmuntowicz, & Manly, 2006).

Yet another way of increasing empathy and prosocial behavior is through increasing positive feelings in others. Gratitude has been identified as a predictor of helping/prosocial behavior (McCullough, Kimeldorf, & Cohen, 2008). In a study involving college students, when an individual felt grateful to another person they were more likely to invest more energy into helping that person (Bartlett & DeSteno, 2006). In this study, the amount and type of interaction was controlled so that gratitude could not be attributed to having had more positive interactions with the individual. That is, the presence of a positive relationship between the individuals was not enough to account for the helping behavior. Tsang (2006) found that people who received a favor felt grateful and were more likely to provide help in return. It has been suggested that gratitude fosters social support and can protect against stress and depression (Wood, Maltby, Gillet, Linley, & Joseph, 2008). This finding may be of use to neglectful parents and their children. Neglected children may have the ability to engage their parents in performing supportive and helpful behaviors if they are able to create a sense of gratitude in their parents. Feeling grateful may also enable neglectful parents to elicit more social support, which can reduce their stress level.

It appears that relationship quality affects children in a variety of ways. Kim and Cicchetti (2004) demonstrated that child maltreatment was related to poor attachment to caregivers, and resulted in low levels of self-efficacy in maltreated children. Neglectful parents are more negative and critical of their children, which may cause their children to develop a sense of being ineffective, that in turn may be related to lower levels of helping

behavior. Research on non-maltreated preschoolers indicates that perceived competence has an effect on prosocial behavior, such as helping others (Lupinetti, 1999). For instance, if children are raised in an environment that causes them to doubt their self-efficacy, they may be less willing to provide assistance to others due to fears associated with potential for being criticized or demonstrating failure.

Resiliency factors discussed earlier, such as attachment status, self-esteem, and self-efficacy can mediate the relationship between neglect and these negative outcomes and result in more positive outcomes in maltreating families. By enhancing cohesion between parents and children, and providing opportunities for positive interaction, we may see an increase in prosocial behavior because the children will feel supported by their parents, and therefore, more competent to help them or others. Through helping others, the child has the opportunity to build self-esteem and self-efficacy, which are demonstrated protective factors. In addition, when parents see their children being helpful, their satisfaction with their children may increase, and higher levels of parental satisfaction are associated with lower levels of maltreatment (Downing-Tsushima, 2006).

Review of Treatments for Substance Abuse

Substance abuse is indicated in the majority of cases of child neglect (see Donohue, Romero, & Hill, 2006 for a review). Successful treatment of parental substance use results in some benefits to family and child functioning (Andreas, O'Farrell, & Fals-Stewart, 2006). Behavioral Couples Therapy (BCT; O'Farrell & Fals-Stewart, 2006) is an evidence-based substance abuse treatment designed to engage the substance user's significant other in treatment. The treatment is founded on the principles of reinforcement wherein a partner is rewarded for abstinence. The couple learns communication and

problem-solving skills to reduce the likelihood of future arguments, which in turn reduces stress that often leads to substance use. Couples are instructed to practice communication skills at home, and are encouraged to make daily expressions of affection for their partner in order to enhance their relationship. Controlled trials have shown that BCT is effective in reducing substance use and conflict between partners (Fals-Stewart, Birchler, & O'Farrell, 1996; O'Farrell & Fals-Stewart, 2006; Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002). A pilot study assessed the benefit of including a parent training component to BCT to address the deficits in parenting found in families in which parents abuse alcohol or drugs. Incorporating parenting skills resulted in increased parental monitoring, decreased parental overreactivity, and reduced amounts of CPS involvement in the cases compared to individual treatment or BCT alone (Lam, Fals-Stewart, & Kelley, 2009).

Behavioral Family Counseling (BFC; O'Farrell, Murphy, Alter, & Fals-Stewart) is a modification of BCT that allows for incorporation of other family members (besides spouses) into treatment. The treatment approach is similar to BCT; the goal is to increase support for abstinence, although there is less emphasis on shared rewards and less emphasis on in-home practice of communication and expressions of affection. In a treatment outcome study comparing BFC to individual cognitive behavioral treatment for substance abuse, 29 participants were assessed at baseline, post-treatment, and at 3-6 month follow-up. Participants in the BFC condition engaged in 24 treatment sessions over 12 weeks. Participants in the individual treatment condition attended one session per week for 12 weeks. Participants in the BFC condition showed less attrition than those receiving individual treatment. Participants in the BFC condition showed decreases in

substance use and increases in abstinence, with greater effect sizes than the individual treatment condition. Both treatment conditions showed similar significant reductions in negative consequences associated with drug use and greater satisfaction with relationships.

Family Behavior Therapy (FBT) is an approach that attempts to engage the entire family in the treatment of substance use. FBT has been used successfully with substance abusing youth and parents (Azrin, Donohue, Besalel, Kogan, & Acierno, 1994; Azrin, MacMahon, Donohue, Besalel, Lapinski, & Kogan, et al., 1994; Azrin, Acierno, Kogan, Donohue, Besalel, & MacMahon, 1996). FBT reduces substance use by targeting various antecedents to stress, and therefore, substance use. Treatment components include stimulus control, development of behavioral goals, problem-solving, urge control, non-aversive parenting techniques, home safety, communication training, financial management, and job-getting skills training. Family members learn to increase positive communication and reward each other for completing goals and providing support to each other. FBT has recently been adapted to meet the needs of substance abusing mothers founded for child neglect. A randomized controlled trial is currently underway to assess the efficacy of FBT compared to typical community treatments for mothers found to abuse illicit substances and neglect their children (NIDA R01DA02054801A1).

Review of Adult-Focused Treatments for Neglect

Treatments that have been developed for child neglect usually focus on parents rather than the neglected children, probably because parents are conceptualized as the potential change agents and most children who have been neglected are less than 5 years old, and therefore, poor candidates for treatment. Thus, the parents are conceptualized to

be responsible for the neglect, and consequently are the change agents capable of eliminating child neglect and its ill effects. In this conceptualization, parents need to alter their parenting practices to bring about change. Described below are treatments that focus primarily on parents and parenting practices in an attempt to prevent or eliminate neglect.

Project SafeCare is an ecobehavioral approach for the treatment and prevention of child abuse and neglect (Lutzker, Bigelow, Doctor, & Kessler, 1998). Treatment focuses on home safety, child healthcare, and parent-child bonding. Treatment lasts 15 weeks, with five weeks devoted to each component. Parents learn to prevent illness, use reference materials to identify and treat illness, and develop a plan to either self-treat or obtain medical care if an illness is present. In the home safety component, parents are taught to identify and remove home hazards. The bonding component focuses on helping parents develop skills to plan and engage in stimulating activities with their children. Psychoeducation, modeling, and role-plays are used to assist parents in developing these skills. A treatment outcome study demonstrated that both maltreating families and families at risk for maltreatment involved in Project SafeCare had large reductions in the number of home hazards, and improvements in parenting and child healthcare (Gershater-Molko, Lutzker, & Wesch, 2003). When compared to maltreating families who received standard community treatment, families who completed Project SafeCare showed fewer CPS reports throughout treatment and at 24 months follow-up (Gershater-Molko, Lutzker, & Wesch, 2002).

Multisystemic therapy (MST) is a family treatment approach that varies by family, but typically involves parent training, providing support, and psychoeducation (Brunk, Henggeller, & Whelan, 1987). As the name suggests, MST is a systemic

approach that conceptualizes problems as multidetermined, so interventions may focus on one or more systems (i.e., parents, extended family, children, etc.). Relevant to child maltreatment, a randomized, controlled trial compared parent training alone to MST (Brunk et al., 1987). Of the families in the MST condition, psychoeducation regarding developmental expectations and discipline strategies was conducted with 88% of the families. Restructuring of family relationships to assist abusive parents in becoming more flexible and assist neglectful parents in becoming more proactive was conducted with 88% of the families. Twenty-five percent of families participated in marital counseling and another 25% focused on relationships with extended family members. Perspective taking skills training was conducted with 38% of the families. While both parent training and MST showed positive effects, MST demonstrated greater effectiveness at restructuring relationships; neglectful parents were more involved with their children and were better able to manage their children's behavior. Therapists reported that participants who received MST showed fewer family problems post-treatment than parents who received parent training.

Review of Child-Focused Treatments for Neglect

Allin, Wathen, & MacMillan (2005) identified five child-focused treatments for child maltreatment in their review of the literature, all of which focused on child physical abuse and neglect. Of these five treatments, two treatments were classified as “good,” indicating they had a strong evidence base, and 3 treatments were classified as “fair.” The two evidence-based treatments, Resilient Peer Treatment and Imaginative Play Training will be reviewed first, followed by the “fair” treatments.

Resilient Peer Treatment (RPT) is a child-focused treatment that targets neglected children from a developmental-ecological approach (Fantuzzo, Sutton-Smith, Atkins, Meyers, Stevenson, & Coolahan, et al., 1996). The authors assert that neglect disrupts normal development, such that developmental tasks are not successfully completed. With young children the primary task is to develop social relationships, which is often done through play. Thus, Fantuzzo et al. identify play as a relevant treatment target. In RPT, a form of play therapy, a neglected child is paired with a resilient peer (one who shows good social and play skills) while a trained adult supervises the interaction. The goal of the treatment is to increase social skills and enhance imaginative play skills. In a randomized controlled trial with 46 neglected and abused children who received 15 sessions of RPT, the children participating in RPT showed increases in peer interaction, social skills, and self-control, and decreases in internalizing and externalizing problems (Fantuzzo et al., 1996). These gains were maintained at an 8-week follow-up assessment.

Imaginative Play Training (IPT) has also demonstrated effectiveness in the treatment of child neglect and is considered to have a good evidence base (Allin, Wathen, & MacMillan (2005). Udwin (1983) conducted a randomized, controlled trial assessing the effectiveness of IPT with abused and neglected preschool-age children. These children were identified as emotionally deprived and had been removed from their homes. Children were assigned to IPT or a control group that participated in play sessions without a focus on imagination. Each group received ten 30-minute sessions. Children in the experimental group showed increased imagination, cooperation, positive affect, and interactive play, and less aggression than children in the control group.

A third randomized, controlled trial comparing a combination of play and milieu therapy to milieu therapy alone was judged to be “fair.” Milieu therapy is used in residential and inpatient programs and is a group therapy designed to target personality traits that result in interpersonal problems. The goals of the play therapy were to improve safety, increase expressivity, and teach coping skills to abused and neglected children (Reams & Friedrich, 1994). Therapy occurred in a specialized nursery setting where children participated in hour-long weekly sessions for 15 weeks. Results did not indicate large differences between the groups, except that the experimental group showed less isolated play than the control group. However, this effect was not maintained at the two-month follow-up. This approach is considered a “fair” treatment for child neglect, although the effects may be short-lived (Allin, et al., 2005).

Culp, Little, Letts, & Lawrence (1991) evaluated a therapeutic day treatment program for maltreated preschoolers removed from their parents’ care. This treatment was judged to be “fair” (Allin, et al., 2005). The study was conducted using a prospective cohort design. Children participated in various types of therapy for six hours per day, five days a week, for a period of nine months. Children received play, physical, and speech therapies, and participated in milieu therapy. Children’s parents received counseling and education, participated in support groups, and were offered emergency crisis services and financial aid. The entire family participated in family therapy. Post-treatment results show improvements in children’s perceived competence and peer and maternal acceptance compared to no-treatment controls.

MST targets children as well as parents. MST was identified as a “fair” treatment for child neglect (Allin et al., 2005). As described in the adult-focused treatments section,

the techniques used in MST vary according to the needs of the family. For example, aggressive children may receive problem-solving skills training while withdrawn children may receive social skills training. In their randomized controlled trial of MST with maltreating families (Brunk et al., 1987), children participated in eight weekly 90-minute therapy sessions with their parents. Social perspective taking exercises and emotional support and coaching were implemented to address difficulties with peer relationships. The results demonstrated a greater reduction in family problems, an increase in child compliance, and improved parent-child relationships in MST than in parent training alone. This intervention's rating was influenced by the lack of a follow-up to verify that treatment effects were maintained and pre-treatment differences between the groups.

Review of Treatments for Correlates of Neglect

There is a dearth of child-focused treatments for child neglect; a comprehensive literature review identified five treatments for neglect, of which only two were substantiated by adequate support. Research on other types of maltreatment and child behavior problems shows that incorporating parents and children in treatment together is more effective than treating either group alone, which may explain the lack of treatments focused on children (Brinkmeyer & Eyberg, 2003; Henggeler & Lee, 2003; Kazdin et al., 1992; Webster-Stratton & Hammond, 1997). Due to the presence of so few treatments for neglect, relatively few methods for treating the consequences of neglect (i.e., low self-efficacy, defiance, etc.) were identified. In order to address the needs of neglected children, it is necessary to consult the literature for treatments of the problems associated with neglect.

Behavior problems are common among maltreated children (Hildyard & Wolfe, 2002; Schatz, Smith, Borkowski, Whitman, & Keogh, 2008). Parent Child Interaction Therapy (PCIT) is an intervention commonly used for the treatment of conduct disorders and has also been successfully used with physically abusive families (Foote, Schuhmann, Jones, & Eyberg, 1998; Urquiza & McNeil, 1996). PCIT involves parent training, but also focuses on the parent/child relationship, involving aspects of play therapy. The parent is the primary focus in PCIT, which has shown to be effective in reducing child behavior problems in maltreating families (Timmer, Urquiza, Zebell, & McGrath, 2005). Wolfe (1994) hypothesized that focusing on parents in maltreatment prevention is effective because it is more face valid (i.e., the parent is responsible for neglect, so they are the likely treatment target to reduce neglect), thus parents have a greater “buy-in” to treatment, which leads to greater motivation and thus greater effectiveness in altering parent behavior than child-focused treatment.

There are two main components in PCIT: child-directed interaction (CDI) and parent-directed interaction (PDI). The primary goal in CDI is to increase the bond between parents and their children. Parents learn to allow their children to control play sessions, which leads to less oppositional behavior. Parents also learn specific skills to use during these play sessions, such as giving praise, avoiding criticism and questions, and differential reinforcement. Therapists model the skills and parents practice the skills in role-plays. Once parents are able to perform the skills, they practice with their children in session. Therapists coach parents throughout the training. Parents are instructed to practice CDI with their children for 5 minutes every day, and to record the session on a homework sheet. Therapists review the homework and observe interactions with the

parent and children to ensure the skills are being properly applied. Once a parent attains mastery of CDI they move on to PDI.

In PDI, parents learn how to make effective commands to their children and how to apply consequences. Parents lead the play session and direct their child to perform certain activities. The child is rewarded for compliance and given time-out for non-compliance. Parents are coached through the PDI sessions and are not instructed to use the technique at home until competence has been demonstrated in session. Once parents achieve mastery of PDI in a play setting, the principles are generalized to “house rules,” such as no hitting, no yelling, and so on, that apply outside of play sessions.

Several treatment outcome studies show that PCIT is effective for reducing deviant behavior, and increasing compliance and positivity in children diagnosed with behavior problems (i.e., conduct disorder, oppositional defiance disorder, and ADHD) (Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001). In fact, treatment effects have been shown to persist up to six years after treatment completion, albeit at a somewhat reduced level (Hood & Eyberg, 2003). A randomized trial involving 64 families demonstrated that PCIT significantly improved parent-child interactions and increased child compliance compared to wait-list controls (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998).

Parent training programs are typically used to treat child behavior problems. However, these approaches have some limitations. Parents are sometimes unwilling to change their parenting techniques (Webster-Stratton, 1990c). They may not see any reason to change, they may not believe the new technique will be effective, or they may simply lack motivation. Other parents have difficulty applying the techniques, leading to

unsuccessful results. Lastly, effective parent training may lead to decreases in behavior problems when the child is at home or with the parent, but these changes may not occur in other areas, such as at school (Webster-Stratton, 1990b). In order to address these limitations, child-focused treatments have been developed.

The Dina Dinosaur Social, Emotional and Problem-Solving Child Training Program is a group treatment for behavior problems for children aged 4-8 years (Webster-Stratton & Reid, 2003). Children participate in two-hour sessions over the course of 18-22 weeks. The first stage of treatment focuses on the importance of rules. Children learn the rules of treatment, such as no hitting or shouting. Rewards are given for compliance with rules and time-out is administered for non-compliance. The second stage of treatment focuses on developing emotional literacy. Children learn to identify emotions by watching videos, looking at photos of people, and making faces themselves. Children learn perspective-taking skills and empathy through role-plays in which they assume the role of another person who has a problem. The next stage of treatment focuses on problem-solving and anger management. Children participate in problem-solving skills training and learn to use relaxation techniques such as deep breathing or imagery. The last stage of treatment focuses on social skills, such as sharing, taking turns, asking and making suggestions (as opposed to demanding), giving compliments, and entering a group of children already in play.

Two randomized controlled trials have shown the Dina Dinosaur program is effective in reducing child behavior problems, increasing positive interactions with family and peers, and improving problem-solving skills among children referred for conduct problems (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, &

Hammond, 2001). These positive outcomes were maintained at a one-year follow-up. In each of these trials, 97-99 participants were assigned to either the dinosaur program (child training) alone, parent training alone, combined parent and child training, or a wait-list control. In all of the experimental conditions significant improvements were made. However, treatment effects were greatest when parents were treated concurrently.

The Proposed Study

The proposed study aims to develop child-focused interventions specific to neglect. These interventions will be implemented along with adult-focused interventions designed for the treatment of maternal substance abuse and child neglect, and will integrate the child and parent's treatment. In this way, both the child and mother will participate in the other's treatment, which has been shown to lead to more positive outcomes than treating either person individually (Brinkmeyer & Eyberg, 2003; Henggeler & Lee, 2003; Kazdin et al., 1992; Webster-Stratton and Hammond, 1997). The child-focused interventions will extend the scope of available treatments for neglect to encompass the broad range of problems evidenced by victims of neglect.

The goals of the proposed child-focused interventions are to prevent future episodes of neglect in parents who have been found to abuse drugs and neglect their children. The proposed interventions are based on the assumption that relationship difficulties between parents and their children, parental factors that distract from appropriate parenting (e.g., substance use, lack of attention and affection), and negative parental perceptions of children, are factors that contribute to child neglect in parents. Addressing parental factors that interfere with parenting, such as substance use, in adult-focused interventions, will enable the parent to begin working on relational issues with

their children. By repairing the parent/child relationship and teaching children activities that will help them be more reinforcing to parents, it is hypothesized that parents will be more likely to support their children with attention and engage their children in activities that are incompatible with child neglect. In turn, children will be more likely to evidence fewer behavior problems and subsequently achieve greater self-esteem.

While neglected children are indeed victims, the proposed interventions are conceptualized from a systemic perspective. That is, the system is perceived to be faulty and in need of repair. The researchers believe neglectful parents' behavior creates child behavior problems that disrupt family relationships, leading to greater parental dissatisfaction, which leads parents to disengage from their children. The neglectful family has learned certain patterns of behavior, and the entire family needs to learn how to interact in a more positive way. Changing parents' behavior can lead to some positive change; however, children need assistance in changing their maladaptive behaviors as well.

Along these lines, three interventions are proposed to accommodate the aforementioned needs. In the first intervention, children will demonstrate skills or perform activities for parents, and parents are encouraged to engage in these activities and reinforce the efforts of the children. Parents have the opportunity to learn what activities their children are interested in so that they can engage in similar activities in the future, which may serve to reduce child behavior problems. Children have the opportunity to lead the play with their parents, creating an environment that is conducive to positive interactions. Parents learn to permit their child to direct the play and withhold criticism, which also helps create a positive, fun environment. An added benefit to this

intervention is that it allows neglected children to build a sense of self-efficacy and competence as they complete activities and are reinforced for their efforts. Neglected children have few opportunities to engage in activities that build skills, such as imaginative play, language, or fine-motor skills (Scannapieco & Connell-Carrick, 2005). They are also more likely to receive criticism than praise from their parents (Aragona & Eyberg, 1981). These criticisms and skill deficits may contribute to the sense of low self-esteem and competence reported by neglected children (Sagy & Dotan, 2001). By building these skills and earning praise, children may evidence increases in self-esteem and efficacy. Both of these constructs are related to reduced child behavior problems (Donnelan, Trzesniewski, Robins, Moffitt, & Caspi, 2005; Shonk & Cicchetti, 2001), which may assist in creating a more positive, less stressful environment at home. High stress levels are positively correlated with maltreatment risk, so a decrease in stress may aid in the elimination or prevention of future neglect (Curenton, McWey, & Bolen, 2009; Guterman, Lee, Taylor, & Rathouz, 2009).

Many neglectful parents feel burdened by their children. This feeling may stem from neglectful parents' expectations of their children, which are often developmentally inappropriate (Peterson, Gable, Doyle, & Ewigman, 1997). Such parents may feel overwhelmed by parenting or household duties because they do not permit anyone to help them complete these tasks. In order to provide more learning opportunities for children and to enable therapists to correct parents' inappropriate developmental expectations, an intervention is proposed in which children are taught to identify developmentally appropriate activities they can perform to help or support family members, and how to initiate those activities. Parents are taught to monitor and reward helpful activities

completed by their children. This reciprocity may lead to increased support in both parents and children.

Many victims of neglect show impaired empathy, which is associated with less helping behavior (FitzGerald & White, 2003; Kestenbaum, Farber, & Sroufe 1989). Empathy awareness training is conducted as part of this intervention. Building children's perspective-taking skills enables them to see the value of helping others and alerts children to situations in which providing help may be warranted, and increased empathy may serve to increase their desire to help others. As children help others, they may begin to see themselves in a more positive way. They may see themselves as being more useful and capable, constructs that are related to decreases in negative behavior in children.

Neglectful families are characterized by a focus on negativity and poor communication. In order to build positivity and communication skills, a third component to child-focused FBT has been proposed in which children are taught to identify and reinforce positive parenting behavior. This serves a two-fold purpose; the first is to increase positive communication. Many neglected children are not given compliments, thus they may not give compliments to others, as they have not been exposed to adults who model this behavior. By learning how to effectively reinforce others, children should find it easier to build positive relationships. The second purpose is to reinforce parents for engaging in positive behaviors, which will increase the likelihood of the parent engaging in the behaviors in the future, which will hopefully serve to prevent future neglect.

The present study seeks to evaluate the feasibility of child-focused interventions designed to complement FBT in adults, including examination of the efficacy of these interventions in a single case trial involving a child who has been neglected. Feasibility

will be measured along several parameters, including (1) establishing protocol adherence, or the ability of therapists to apply the interventions consistently and with fidelity, (2) demonstrating participant compliance, which is the participants' ability to perform the interventions, and (3) demonstrating participant satisfaction, or the degree to which the participants finds the intervention helpful.

Hypotheses

1. The child-focused treatments can be implemented with adequate fidelity. In this study, completion of at least 85% of the procedures will be considered adequate. Reliability of the treatment fidelity ratings will be adequate, as measured by Cronbach's alpha greater than .70 across interventions.
2. The participants' satisfaction with the child-focused treatments will indicate they find the treatments beneficial, as indicated by helpfulness ratings of 5 or greater on a 7-point Likert scale measuring parent and child satisfaction.
3. The participants are able and willing to follow the child-focused treatment protocols to an acceptable degree. Therapists rate participant compliance on a 7-point Likert scale. Factors that contribute to this score are the completion of homework and performance in session. Likert scale scores of 5 or greater indicate adequate compliance.

CHAPTER 3

METHODS

Participants

The participant, Denise, was a Caucasian, 25-year old adult female. She was referred by the Clark County Department of Family Services for having been identified as a perpetrator of child neglect and concurrent abuse of drugs. To be referred to this study, Denise had to meet the following criteria: a documented report of child neglect and use of an illicit drug occurring within the past four months, the presence of a significant other who was willing to participate in treatment, at least one child living in the home over the age of five years-old, and the referral was not primarily due to domestic violence or child sexual abuse.

Denise lived with her three children and their father, Bob (i.e., her live-in boyfriend). At the time of referral, her daughter, Kayla, was six-years old, and her sons, Mike and John were four- and two-years old, respectively. As the oldest child, Kayla was the focus of the experimental child-focused intervention.

Denise was a “stay-at-home” mother. She dropped out of high school in the 10th grade. Bob was employed in the field of construction. His employment hours were steady, although the hours he worked fluctuated (thus, income was inconsistent). The family received \$600 in food stamps per month. Denise’s family lived in an apartment. Kayla attended kindergarten and Mike attended half-day pre-school.

Measures Related to the Interventions' Feasibility

Consumer Satisfaction.

To evaluate the degree to which Denise and Kayla were satisfied with the child-focused interventions that were examined in this study, helpfulness ratings were solicited from each of them separately upon completion of each intervention in each session. The mother rated how helpful she believed the intervention to be on a 7-point Likert scale, where higher scores indicate greater perceived helpfulness (i.e., 1 = extremely unhelpful and 7 = extremely helpful). The scale for Kayla contained visual descriptors of seven faces ranging from “sad” to “happy,” as suggested by Hopkins and Stanley (1981; see Appendix E).

Protocol Adherence.

Treatment manuals were developed for each of the experimental child-focused interventions. The manuals were summarized in protocol checklists (see appendix A-C). The protocol checklists include detailed step-by-step instructions used by therapists during intervention sessions to assist in maintaining treatment fidelity. These checklists are also utilized to measure treatment fidelity. Along these lines, the therapist records the number of protocol steps completed and the number of protocol steps possible. The number of steps possible is the number of steps that would be completed if the therapist achieved perfect adherence. The percentage of steps completed refers to treatment integrity.

An independent reviewer also rated the sessions for protocol adherence to assist in the assessment of treatment integrity. This rater independently listened to audiotapes of each of the intervention sessions, completing protocol checklists for each of the

interventions according to the method conducted by the therapist. Thus, an estimate of treatment integrity (percentage of therapy steps completed) was obtained from both the therapist and independent rater for each experimental intervention that was implemented during each treatment session.

Compliance.

To assess the compliance of family members, therapists rated the participant's compliance each time the experimental interventions were implemented. The mother's compliance was evaluated according to the extent to which she supported Kayla in completing practice assignments, participated with her during the experimental interventions, and ensured her attendance to session. The mother's compliance was rated on a 7-point Likert scale with higher scores indicating greater compliance (1 = extremely noncompliant, 7 = extremely compliant). The child's compliance (participation during session) was also rated on a 7-point scale with higher scores indicating greater compliance. The mother was provided her compliance score at the end of each intervention. Kayla was not told her compliance score, and instead was given qualitative feedback such as "Good job! You tried really hard!" or "Try harder next time" At the end of each intervention, participants were provided feedback as to the factors that contributed to their compliance rating, with particular focus on what could be done to raise the rating.

Measures Related to Outcome

The following measures were administered at the pre- and post-treatment assessments.

Structured Clinical Interview for DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 2002).

The SCID-IV is a structured diagnostic interview designed to assess for the presence of disorders that are listed in the DSM-IV. The SCID-IV has demonstrated good reliability and validity across administrations (Spitzer, Williams, Gibbon, & First, 1992), and it has been found useful in clinical controlled outcome studies with substance users (Azrin et al., 2001). In this study, only the sections on drug and alcohol use were administered to determine if there was existing drug or alcohol abuse or dependence.

Time-Line Follow-Back Interview (TLFB; Sobell, Sobell, Klajner, Paven, & Basian, 1986).

The TLFB is a self-report measure in which a calendar is used to elicit and record pertinent events over a period of several months. Self-reports of the participant's frequency of illicit drug and alcohol use were obtained via the TLFB. A month-by-month calendar for the time period of interest was shown to the participant. Significant events (e.g., birthdays and holidays) are marked on the calendar and are intended to facilitate recall of the days in which substances were used. After calendars were constructed, the participant was asked to indicate on the calendar which days she used illicit drugs or alcohol, including the specific substances that were used. The TLFB was used to assess drug use over the previous 120 days. The TLFB method has been shown to be relatively consistent with official records and collateral reports up to 6 months prior to intake, and shows good test-retest reliability (Donohue et al., 2004; Sobell et al., 1986).

Urine Drug Screens.

Urine samples were obtained to serve as an objective measure of drug use. A panel-dip drug screen test utilizing conventional cutoffs was used to determine use of THC (marijuana), cocaine, amphetamines, barbiturates, benzodiazepines, opiates, phencyclidine (PCP), and methamphetamine.

Parenting Stress Index–Short Form (PSI-SF; Abidin, 1995).

The PSI-SF is a 36-item measure of stress in the parent–child system. It includes three scales (i.e., Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child) with a 5-point Likert-type scale response format (i.e., *strongly agree*, *strongly disagree*). Higher scores indicate higher levels of perceived parenting stress. The clinical cutoff for total stress is above 90, and a defensive responding score of 24 or less indicates the individual may be responding in a defensive manner.

The Child Abuse Potential Inventory (CAPI; Milner, 1986).

The CAPI consists of 160-items designed to assess an individual’s risk to engage in physical abuse of a child. The CAPI factors include the following subscales: Abuse, Lie, Random Responding, Distress, Rigidity, Unhappiness, Loneliness, and Problems With Others, Problems With Child And Self, and Problems With Family. The clinical cutoff score for the Abuse Potential Scale is 215 and the cutoff used for the Lie Scale was eight. The CAPI is a widely used instrument, and has been shown to have good reliability and validity (Milner, 1986).

The Family Environment Scale (FES; Moos & Moos, 1984).

The FES is a scale containing 90 True/False items designed to measure the social environment of the family. The FES contains 10 subscales, of which only the Conflict

and Family Cohesion scales were administered in this study, as recommended by others in substance abuse (Santisteban et al., 2003). These scales measure the extent to which family members support each other (higher scores = higher cohesion) and the amount of openly expressed anger or conflict in the family (higher scores = higher levels of expressed anger).

Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999).

The ECBI is a 36-item checklist of commonly occurring child behavior problems. The ECBI contains an Intensity scale, where the frequency of the behavior is rated from “never happens” to “always happens”, in addition to a Problem scale, where the parent notes whether or not the behavior is problematic. The ECBI shows good internal consistency among children of differing age and ethnicity (Colvin, Eyberg, & Adams, 1999), and has been shown to be reliable across informants and over time (Eyberg & Pincus, 1999).

The following assessments were administered at the beginning of each treatment session.

Parent Satisfaction with Child Scale (PSCS; modified from Donohue, DeCato, Azrin, & Teichner, 2001).

The PSCS is a self-report 11-item scale in which parents rate their satisfaction with an identified child in various contexts (i.e., their communication, relationship, the child’s reaction to praise and attention, compliance, reaction to redirection or punishment, extent to which they follow household rules, level of family involvement, safety skills, performance of household chores, school performance, and overall happiness with the

child). Satisfaction among the domains assessed is measured on a 0 to 100% satisfaction scale with 10% response increments (i.e., 0%, 10%, ... 100%).

Activity Time Monitoring Log.

A time monitoring log was utilized to record how much time the participant spent engaging in fun or educational activities with her children. The participant is able to record, for each day of the week, the amount of time spent engaging in fun or educational activities with each child in the household. The participant was instructed to record the activity times as soon as the events occurred. A new activity time monitoring log was administered each week.

Procedures

This study was approved by the Institutional Review Board of UNLV. Upon first contact with the treatment center, the participating mother was scheduled to complete the pre-treatment assessment measures specific to child neglect and drug abuse to ensure she met study in/exclusionary criteria. At this point the participant signed an informed consent form stating the requirements of study participation and the limits of confidentiality (e.g., indications of sexual abuse, suicidal intentions, etc.). This assessment was conducted in the mother's home and required approximately 3 hours.

One week after the pre-treatment assessment, the mother and her family initiated the adult-focused intervention components of Family Behavior Therapy (see Adult-Focused Treatments below). Two graduate-level, trained FBT therapists provided treatment. A third individual attended the sessions with the therapists to assist in managing the younger children during times when they were unable to participate in the child-focused activities. Treatment sessions were scheduled to last 90-120 minutes. In the

second treatment session, therapists initiated the child-focused interventions (see Child-Focused Interventions section below). One therapist continued working on the adult-focused treatments with the mother and her boyfriend, while the second therapist began the child-focused interventions with Kayla.

Experimental Design

An A/B experimental design was employed, such that the participant participated in a pre-treatment assessment session, followed by treatment, and concluding with a post-treatment assessment session. At the beginning of each session, she was asked to complete the PSCS regarding Kayla and to turn in or complete the Activity Time Monitoring Log. At the end of every month, the mother completed the Eyberg Child Behavior Inventory. Immediately after each of the experimental intervention components was implemented during each treatment session, consumer satisfaction and compliance ratings were conducted.

Process of Developing the Experimental Child-Focused Interventions

The child-focused module consists of three interventions: Why I'm Special, Helping Parents, and Catch My Parent Being Good. In the origination of these interventions, treatment targets were initially identified in a scientific literature review and interviews with several Family Behavior Therapists who had treated child neglect and substance abuse utilizing FBT in uncontrolled case studies (Donohue et al., 2010; LaPota, Donohue, Warren, & Allen, 2011; Romero, Donohue, & Allen, 2010; Romero, Donohue, Hill, Powell, Van Hasselt, Azrin, & Allen, 2010). Therapists noted that when asked to schedule a family activity as a treatment assignment, parents and their children frequently evidenced difficulty thinking of activities that were fun and interactive.

Indeed, they often chose sedentary, passive activities, such as watching television or movies. It was also noted that when families engaged in events, there was often little interaction between family members. It became apparent that parents needed to develop a larger repertoire of activities to keep their children engaged in positive interactions. In particular, it was hypothesized that it would be important to encourage educational activities that were interesting to children to spark their interest in learning.

From the literature review, evidence based child-focused treatments were identified, and subsequently adapted to fit the needs of victims of child neglect. The resulting child-focused treatments were manualized, and step-by-step protocol checklists were developed that outlined the therapeutic actions required by therapists to implement the interventions (see Child-Focused Interventions section below). The protocol checklists served a dual purpose; they provided a detailed set of prompts for the therapist to reference in session to ensure treatment fidelity, and they provided a means of assessing treatment fidelity. The treatments were distributed to FBT therapists who attempted to deliver the treatment in role-plays during training sessions. The role-plays allowed therapists to discover potential problems in delivering the treatment to participants. When problems were noted, the manuals and protocols were modified to address the respective problems. The resulting experimental child-focused intervention module is described below after the well-established adult-focused family behavior therapies are delineated.

Adult-Focused Interventions

The parent-focused interventions in FBT consist of 7 modules that address child management, communication, home safety, problem-solving, goal-setting, stimulus

control, job skills and finance management. Denise participated in the following five interventions.

Catch My Child Being Good.

Participants learn to use differential reinforcement with their children. Through role-play and supervised behavior rehearsal, participants learn to reinforce desired behaviors performed by their children and to ignore minor undesired behaviors.

I've Got a Great Family.

In this intervention, each family member is instructed to share “things” that are loved, admired or respected about all other family members. Family members are also encouraged to express statements of appreciation, while the therapist provides feedback about these interactions.

Positive Request.

Participants learn to make requests of others in a socially acceptable manner.

Arousal Management.

Participants learn to identify antecedents to anger and other negative emotional states, conduct a brief relaxation exercise, and communicate their feelings in a proactive, neutral manner.

Self Control.

The Self Control intervention is a behavioral skill set that assists in the management of antecedent stimuli to drug use, HIV risk, and child neglect. Participants learn to manage arousal associated with triggers, and to generate appropriate incompatible behaviors.

Child-Focused Interventions

Why I'm Special (Appendix A).

In this intervention, children engage in fun, educational activities that showcase their positive qualities to their parent. Therapists support children's interests by engaging in activities of the child's choice. Each session, the target child chooses an activity from a list (see Appendix D). The activities range from games to crafts and drama to fun science experiments. For instance, the child may choose to make a homemade lava lamp (using a water bottle, vegetable oil, water, and food coloring) and incidentally learn about properties of oil and water, or the child may choose to act out a scene from a favorite story. The child engages in the respective activity with the therapist. The child and therapist then show the activity to the mother. The therapist models positive reinforcement to the mother by providing praise to the child. If needed, the therapist solicits the mother's appraisal of the activity, thereby providing an opportunity for the mother to provide positive feedback to the child. The mother is encouraged to support the child by participating in the activity that was performed, or a related activity, later in the week. Unlike traditional play therapy, in which a child plays with a therapist with the goal of expressing unvoiced emotions, this intervention is more focused on play and building positive experiences between the parent and child.

This intervention is intended to have beneficial effects for parents and children. In regards to parents, this intervention demonstrates fun, educational, and low cost ways to engage their children in activities. During the initial construction of this intervention, FBT therapists reported that parents typically chose passive activities to do with their

children, such as watching television. This intervention thus serves to provide examples of activities that facilitate interaction between parents and their children.

Neglectful parents may be unaware of activities in which their children show interest (Hildyard & Wolfe, 2007). Thus, in this intervention the parent has opportunities to identify activities the child enjoys by observing the types of activities the child chooses to perform. This enables the parent to select future activities outside of treatment that are likely to be successful with the child, setting the stage for the parent to have positive experiences with the child. As the parent becomes associated with fun, positive activities, the child's perception of the parent is likely to become more positive.

Neglectful parents tend to be more negative and hostile in their interactions with their children (Wilson, Rack, Shi, & Norris, 2008), and they are directive and resistant to allowing their children to lead interactions (Aragona & Eyberg, 1981). Therapist modeling of interactions with children demonstrates warmth and models a less directive approach where the child is permitted to take charge in the activity. As the child begins to see the parent as being more fun, less critical, and more interested in sharing the child's interests, the child is likely to exhibit fewer negative behaviors, such as defiance and hostility toward the parent. Lastly, the frequency of positive interactions is conceptualized to increase once the child and parent begin to respond positively to each other.

Helping Parents (Appendix B).

Given that neglected children evidence difficulty comprehending the emotions of others (FitzGerald & White, 2003), children begin this intervention by engaging in perspective-taking exercises that are relevant to learning to identify when persons need

assistance. They are queried to indicate how they feel when they are provided help from others, and how their assistance might affect the feelings of others. Children brainstorm ways to support their parents, creating a list of their ideas in the process. This list is reviewed with the parents who are instructed to monitor and praise their children when their children perform these behaviors. Thus, children are encouraged to conduct specific behaviors that are supportive to parents (e.g., making their bed, helping take care of siblings). Instructing parents to reward their children for performance of helping behaviors also provides therapists opportunities to provide parents feedback that is relevant to identifying appropriate expectations of children (see Erikson & Egeland, 2002). Modeling and role-playing are used to enhance these assistance skills.

Catch My Parent Being Good (Appendix C).

This intervention is conducted to assist in altering negative communication style that is often seen in neglectful families, and to increase the rate of positive parenting behavior. Through modeling and role-playing, children are taught to positively reinforce their parents for desired behaviors (e.g., saying “thank you” when positive parenting occurs, providing hugs), which in turn is conceptualized to increase the likelihood parents will continue to perform these target behaviors (McCullough, Kimeldorf, & Cohen, 1998; Tsang 2006). Children are assigned homework in which they “catch their parents being good” at home between therapy sessions.

CHAPTER 4

RESULTS

The therapeutic content reviewed in each of the treatment sessions is described in the Course of Treatment section below. Lessons were learned during the administration of the child-focused interventions, and these lessons resulted in systematic modifications to protocol that are also reported in this section. For each session, the participants' helpfulness and the therapist compliance scores are provided for each child-focused intervention. Lastly, the percentage of protocol steps that were assessed by the therapist and independent rater for each of the intervention components is provided. For each session, the specific adult-focused interventions that were implemented are reported to provide a context in which to interpret the experimental child-focused interventions. However, the therapeutic content of the adult-focused interventions is not reported.

Course of Treatment

The participant and her family completed eight treatment sessions rather than the proposed 16 sessions. She chose to terminate treatment early, stating that her primary motivation for becoming involved in treatment was to obtain the free cell phone incentive and that once she had obtained the phone and learned it could not be taken away she was no longer interested in continuing treatment.

Session 1.

Adult-Focused Components.

In the first treatment session the participant was introduced to the program policies, she chose her family's treatment plan, and the family participated in the adult-focused I've Got A Great Family intervention. She completed the PSCS, then the

Activity Time Monitoring Log retrospectively for the prior week. She was given a new Activity Time Monitoring Log and was asked to complete it during the week as she engaged in activities with her children. Child-Focused interventions were scheduled to begin the following session.

Session 2.

Adult-Focused Components:

Consistent with their treatment plan, Arousal Management was the first active adult-focused intervention component implemented with Denise and Bob. Both parties were engaged in role-plays and they appeared to enjoy learning the techniques. Next, they participated in Positive Request. Again, both parties participated in role-plays and each took turns making positive requests. At the conclusion of these interventions, both parties indicated they looked forward to using these techniques at home.

The PSCS was completed. Denise did not complete the Activity Time Monitoring Log and could not find the blank form to complete retrospectively. She was provided a new log to be completed during the next week.

Child-Focused Components:

The experimental child-focused interventions were initiated. During this treatment session, Why I'm Special was implemented. Kayla was presented with several choices of activities and chose to play "Memory." Game pieces were created by the child and therapist; pairs of pictures were drawn on paper and cut into squares. The pictures were turned face down on the table, and Kayla and the therapist alternated turning over two cards at a time, looking for a match. The person who found the most "matches" won the game. The therapist and child played the Memory game twice, and then the child's

parents were brought in to participate. Kayla enjoyed drawing the pairs of pictures and discussed why she chose to draw them. The game itself interested her, and she appeared to like the competitive component.

When her parents were brought in to participate, Kayla explained the rules of the game and watched her parents play each other while she kept score. She initially wanted to watch her parents play the game, rather than play one of her parents. Consistent with pre-established protocols designed for parent/child interactions (Foote, Schuman, Jones, & Eyberg, 1998), the play in this intervention is driven by the child, so Kayla was permitted to establish the rules and watch her parents play. She appeared to enjoy being the “expert” on the game and often gave instructions to her parents while they were playing. Her parents spontaneously gave her positive feedback about the game and her drawings, and no prompting to do so was required by therapists. Therapists praised the family for positive interactions throughout the activity. When it came time for session to end, Kayla wanted to keep playing. Her parents stated that they would play again after the therapists left. The intervention lasted approximately 90 minutes. Feasibility data are presented in Table 1.

Lessons Learned:

The child was compliant and appeared to enjoy the activity. The household was lacking in art supplies and the game was constructed with notebook paper, writing pens, and a highlighter. It was noted to come prepared with more supplies for activities in future sessions.

It was decided that if Denise did not complete the Activity Time Monitoring Log, that she would complete it retrospectively at the beginning of the session. However, in this case, she could not find the form to complete.

Session 3.

Adult-Focused Components:

This session occurred two weeks after session two due to scheduling conflicts. The participant completed the PSCS and the ECBI. She turned in a completed activity time monitoring log, which appeared to have been completed all at once, rather than each day as requested (i.e., writing was sloppy, appeared that the form had been filled out quickly, appeared the same pen was used throughout the week).

Arousal Management and Positive Request were reviewed this session. The participant had not completed homework assigned in the prior session although she stated that she used the techniques.

Child-Focused Components:

In this treatment session, Helping Parents was implemented in addition to Why I'm Special. The Helping Parents intervention lasted approximately 30 minutes. Kayla was compliant and participated in the role-play. In the empathy awareness training section of this intervention, Kayla was provided with a fictional story about a child who encountered some difficulties, and she was asked questions about this child's feelings and needs. She was told a hypothetical situation involving a child at school who dropped a big pile of papers. She demonstrated good perspective-taking skills in this intervention, as she was quick to respond to questions about this fictional child's feelings and potential needs. She was able to identify emotions someone in this situation might experience

(e.g., embarrassment, sadness). She was also able to identify how the child would feel if help was provided (e.g., happy).

During the brainstorming session in Helping Parents, Kayla generated activities already on the list, in addition to novel activities such as helping to make dinner or fold laundry. The list was reviewed with Denise, in addition to reviewing how to complete the homework. Denise reported that she thought that Kayla would respond positively to having her helpful activities monitored, so she wanted to identify more ways Kayla could perform these behaviors. Denise stated that Kayla's only chore was to clean her room, but that now she would consider other chores or activities that Kayla could help with.

In the Why I'm Special intervention, the children made tambourines out of paper plates, dried beans, and crepe paper. They learned a song to sing while shaking their tambourines and performed for their parents at the end of session. This activity was very engaging to the children. They enjoyed decorating their tambourines and carefully selected materials with which to decorate them. There were many opportunities for both the therapists and parents to reinforce the children for hard work, creativity, and skill. During the children's performance, the parents laughed and clapped, and the children appeared to enjoy the attention and praise, as indicated by their big smiles. Both parents demonstrated good skills in praising the children and required no prompting from the therapists. The therapists reinforced the parents for their skills in noticing and praising positive behaviors. Due to time constraints, the parents were unable to perform a related activity with the children in session; however, they were instructed to do so for homework. The Why I'm Special intervention lasted approximately one hour. Feasibility data are presented in Table 2.

Lessons Learned:

The Helping Parents intervention was easily implemented and the child was compliant and attentive. The therapist was to discuss the child's homework with the parents after the child completed a practice activity. However, rather than complete the child's Helping Parents homework protocol immediately upon completion of the practice activity for this intervention component (homework in the adult-focused interventions is typically reviewed at the end of the treatment session) and interrupt the parent's session, it was decided by the therapist to review the homework sections of both protocols with the parents at the same time. Thus, the homework for Helping Parents was reviewed with the parents after the Why I'm Special activity was complete. This change in timing entailed no changes to the protocol itself. There was concern that this practice could negatively affect protocol adherence, as the blind reviewer listening to the session audiotape for protocol adherence might think the homework section to the first intervention was not performed. However, the reviewer was able to identify that both interventions were reviewed, but outside the prescribed order, thus there was no negative effect on adherence.

The activity completed in Why I'm Special took a lot of time to finish, thus it was decided to do more prep work (e.g., cutting papers, gluing things together) prior to future sessions even though it would deprive the children of practicing skills such as using scissors or working with glue. As mentioned earlier, these children did not have access to many art supplies at home, so they had little practice working with these items. One of the goals of this intervention is to increase the child's sense of competency, so learning practical skills such as these were seen as useful. However, it was decided that it was

more important to allow sufficient time for the children to engage in the activity with their parents at the end of session. The major goal of this intervention is to increase parent/child bonding, so allowing the parents and children time to play and bond was deemed more important.

Session 4.

Procedures:

The family was unable to attend the fourth treatment session due to one of the children being sick and Bob not being at home to help take care of him. However, a brief telephone call was conducted with the mother. The mother completed the PSCS and discussed her progress on the homework from the prior sessions. She had not completed the activity time monitoring log and claimed she could not remember how much quality time she spent with her children over the past week. The participant noted that she was experiencing difficulty finding time to complete the homework. The participant and therapist brainstormed ways to make homework completion easier, and the participant concluded that she would complete the homework while the children worked on their schoolwork.

Lessons Learned:

The participant had not completed her homework. During the discussion with the participant regarding homework, it seemed like she was trying to convince the therapist that she was too busy to complete it so that she could be exempt from completing homework.

Session 5.

Adult-Focused Components:

The participant completed the PSCS. She had not completed the activity time monitoring log and could not find it to complete it retrospectively. She was given a new form to fill out for the upcoming week.

Self Control was initiated this session. Both Bob and Denise participated in role-plays and practiced the technique. The intervention was not completed in session, so no homework was assigned.

Child-Focused Components:

In the fifth treatment session, Catch My Parent Being Good was initiated along with the prior two interventions. Catch My Parent Being Good and Helping Parents each took approximately 15 minutes to complete.

Catch My Parent Being Good was implemented first. Kayla was presented a hypothetical situation where her mother made Kayla's favorite food. The therapist modeled ways in which Kayla could catch her parent being good. The therapist smiled, said, "Thanks for making my favorite breakfast!" and said, "You're the best!" Kayla was asked to identify the behaviors that showed appreciation. She was able to identify these behaviors. Next, Kayla was asked to engage in a role-play for the same situation. She completed the role-play, but needed to be prompted continuously throughout. She showed distractibility during the homework review and needed to be refocused.

Helping Parents was reviewed next. However, Kayla and her mother had not completed the homework and could not locate it to be completed retrospectively. When asked if Kayla had performed any items in the list, Denise stated that she did not think

Kayla could help make dinner because it was “too dangerous.” In particular, she was concerned about the presence of knives in the kitchen. Consistent with the protocol, the therapist and Denise came up with activities that Kayla could complete that would be safe, but that would also enable her to help. Denise stated that Kayla could help set the table (without knives) and stir things that required mixing (at the kitchen table, not at the stove).

A new situation was presented for Kayla to role-play, that of her mother bringing in many bags of groceries. Kayla was able to identify her mother’s feelings in this hypothetical situation (e.g., tired) and was able to identify her needs (e.g., wished someone would help), and was able to make an offer to help her mother (i.e., “What can I do?). She was given a new homework form to complete.

Why I’m Special lasted approximately 45 minutes. For their activity, the children wrote and illustrated brief books about their parents that were developmentally consistent with their age. Blank pages of paper were stapled together to create a booklet. The children were asked to describe their parents. One sentence was put on each page. The children stated things like “My mom is beautiful” and “My dad like to play with me.” Kayla wrote her own sentences, while Mike dictated and the therapist wrote the sentence. The children enjoyed coming up with descriptions of their parents. Kayla was reinforced for writing her own sentences and responded positively to the attention.

The activity was not complete by the end of session, so the children did not show their parents this project as the books were intended to be a surprise. The books were scheduled to be completed in the following session. Feasibility data are presented in Table 3.

Lessons Learned:

No problems were noted in the implementation of Helping Parents, although the participant had not helped her daughter complete the homework assignment, despite the fact that she previously stated that she thought monitoring her child's behavior would be useful. It appeared Denise might have told therapists what she thought they wanted to hear.

No problems inherent to the protocol were noted during Catch My Parents Being Good. However, the child's interest seemed to wane as the intervention proceeded. She was distractible and asked to begin Why I'm Special rather than complete the intervention. Despite this, she rated this intervention highly on the smiley face scale used to assess consumer satisfaction. This inconsistency cast doubt on the validity of that measure and raised the question of whether a different assessment should be used.

Protocol adherence was low for Why I'm Special this session because the activity was not completed in session, thus steps such as showing parents the projects and assigning homework wherein the family completes a similar activity could not be performed. There was no way of accounting for an incomplete activity on the protocol, so many steps were marked as missed. It appeared that changes would have to be made to the protocol that would enable therapists to signal if an activity was not yet complete and would be completed in the following session. This would reduce the number of protocol steps missed in cases where an activity took a long time to implement and needed to be completed in a following session. Another solution would be to alter the activity selections, only including activities that could be completed in 30 minutes or less. In this way, therapists would not encounter the problem of incomplete activities.

Session 6.

Adult-Focused Components:

The participant completed the PSCS and filled out an activity time monitoring log retrospectively. Denise and Bob continued to practice Self Control this session. Denise and Bob completed the intervention and were assigned homework to practice the technique.

Child-Focused Components

This session was an abbreviated session that lasted one hour. The family had plans to go out for one of the children's birthdays, so session was completed early to allow the family enough time to go out. Why I'm Special was conducted and the activity from the prior session was completed. The children illustrated the books they initiated last session. Mike wanted to write in his book, so he asked the therapist how to spell the words, which she spelled for him one letter at a time, and he wrote the letters. The children read their books to their parents at the end of session. Their mother complimented their artwork and laughed at the descriptions the children came up with (e.g., My mom likes sausage.) She let the children know she was appreciative of their efforts and the nice things they wrote about her. She hugged and kissed Kayla, whose final page of the book read, "I love my mom because she is beautiful." Feasibility data are presented in Table 4.

Lessons Learned:

The modification made to the child consumer satisfaction measure elicited an appropriate response; Kayla's rating of the intervention was consistent with her behavior during the intervention in that she expressed pleasure with the activity (i.e., smiling,

paying attention), and also gave it a high rating. This indicated that the new measure may have elicited a valid assessment of satisfaction with the intervention. However, Kayla always expressed excitement to begin Why I'm Special and always gave it a high rating, so it is unclear if the new measure will work under different conditions, such as when she does not like the intervention. She may simply have a tendency to give positive ratings, despite her feelings about the interventions. In support of the idea that Kayla has a tendency to give positive ratings, Kayla asked to see the smiley face scale again and also rated the intervention that way (she gave it a very happy face). She liked the smiley face scale and enjoyed looking at the range of faces.

Denise noted that Kayla was excited to see the therapists and appeared to be benefitting from the attention given her in Why I'm Special. Denise stated that Kayla responded very well to the therapists and that she wished she could have the same impact on her daughter. It was explained to Denise that the homework outside of session was designed to shape Kayla into reacting as positively toward her mother as she was to the therapists. Denise stated that she understood and would try to get involved in more activities with Kayla.

Session 7.

Adult-Focused Components:

The participant completed the PSCS. She did not turn in the activity time monitoring log. When asked to complete this form retrospectively, she claimed the log was somewhere she could not get to at the moment. Catch My Child Being Good was initiated this session. Denise and Bob practiced the techniques with the therapist, then in vivo while the children played with a puzzle. They praised the children for cooperation

and completion of the puzzle. Homework from the Self Control intervention that was assigned in the prior session was not completed, although Denise stated that she used the technique to avoid an argument with Bob.

Child-Focused Components:

In this session, Why I'm Special was conducted. The children participated in two activities this session. The activities were suggested by the therapist this session. In response to Denise's statement in the prior session that she wanted to get the same reaction from her daughter as the therapists elicited, activities that could easily be completed at home were selected. Kayla usually picked artistic activities that required supplies, which the family often did not have. In order to demonstrate to the parents and children that fun activities could be performed on a budget and without supplies, activities that required common household items or no materials were selected. The first was a listening game where the object was to repeat a series of rhythmic claps. The next activity was a game of visual attention in which a ball was hidden under one of three identical cups, the cups were rearranged, and the goal was to state which cup the ball was under. At the end of session the children showed their parents their skill with these activities, and then played the games with their parents.

Protocol adherence from the independent reviewer could not be assessed this session due to difficulties with the tape recording. Feasibility data are presented in Table 5.

Lessons Learned:

The activities selected this session were successful without the need for materials the family did not have available. Future sessions of Why I'm Special can include

activities that require little or no materials to be supplied by the therapist. In fact, this may serve to enhance generalization of the activities used in session. Both activities were engaging and held the children's interest. The parents appeared to enjoy these activities, as well. There was a lot of laughter from both the parents and children, and praise from the parents. Overall, these activities led to positive experiences for the family as a whole. For the family, activities that involved competition seemed to get the best reactions, and when the children lost, or made mistakes, they handled it well without becoming upset. Despite continued difficulty with homework compliance, no difficulties implementing the Why I'm Special protocol were noted this session.

Session 8.

Adult-Focused Components:

Denise filled out the PSCS. She had not completed the activity time monitoring log and stated that it had been misplaced and she could not find it. Denise was the only parent present in this session. She reviewed Catch My Child Being Good this session and had not completed the homework from the prior session.

Child-Focused Components:

In this session, Helping Parents, Catch My Parents Being Good, and Why I'm Special were implemented. Helping Parents and Catch My Parents Being Good each required approximately ten minutes to complete and Why I'm Special lasted approximately one hour.

In Helping Parents, the homework had not been completed and the form had been misplaced. Denise reported that she had praised Kayla for completion of helpful behaviors, but that Kayla had not been performing many of these behaviors over the past

week. She noted that Kayla had cleaned her room, and that was the only behavior she had performed over the week. Kayla was instructed to role-play making an offer to help her mother clear the table after dinner. Kayla was engaged during the role-play and asked what she could do to help. She was given a new homework sheet and instructed to make an offer to help before the next session and to try and perform several other supportive behaviors on the list she generated in the first and second implementations of this intervention.

Catch My Parent Being Good was initiated next. Homework had not been completed. Kayla was asked if she had caught her parents being good over the past week, and she stated that she had not. Kayla was instructed to role-play a hypothetical situation where her mother had packed her a good lunch for school. Kayla refused to participate in the role-play and asked if the intervention could be ended. Kayla's younger brother, Mike, participated in the role-play. He smiled and said thank you in response to finding a good lunch had been packed for him. Kayla was given the opportunity to engage in the role-play again, and she refused. She was given homework to catch her parents being good, and stated that she did not want to because it was "too hard." The therapist attempted to define what Kayla meant by this, but Kayla would not answer the questions other than saying no or that she did not want to do it.

During Why I'm Special, the children made Christmas ornaments for their activity. Why I'm Special was modified in session so that Denise could participate in the entire activity, rather than being brought in to participate at the end of session. This modification was made in session to address several concerns. Bob was not in session and child management was unavailable, so extra help was needed monitoring the children

during the activity. Also, bringing Denise into the activity earlier enabled her to have more time to practice Catch My Child Being Good in vivo. Feasibility data are presented in Table 6.

Lessons Learned:

Helping Parents was implemented smoothly, despite issues with homework compliance, and it held the Kayla's attention. As no problems were noted, no changes were necessary.

Catch My Parents Being Good was implemented after Helping Parents. Kayla was very distracted and noncompliant. She claimed it was "too hard" to catch her parents being good and did not want to participate in role-plays where she could practice catching others being good. Kayla had often mentioned things her parents did for her, so her attitude was seen as stemming from a dislike of the intervention, rather than any difficulty associated with catching her parents being good. Also, she knew Why I'm Special was to be implemented next, and may simply have been impatient to initiate that intervention as it was her favorite intervention.

In dealing with Kayla's noncompliance, rather than reinforce her for skipping through the intervention, her brother was asked to participate. This was hoped to ignite some of Kayla's competitive spirit and entice her into participating in the role-plays. It also served to prolong the intervention so that Kayla was not rewarded for ending the intervention prematurely to get to Why I'm Special more quickly. While this approach did not succeed in getting Kayla to participate in the role-plays, it did delay the implementation of Why I'm Special.

Kayla's younger brother, age 4, appeared interested in Catch My Parents Being Good; he was attentive, answered questions, and participated in a role-play. This intervention may be too simple to hold the attention of a 6-year old child; it involves a short, simple role-play where the child shows appreciation for an activity or behavior. It may be found boring by a child of Kayla's age and may require modification for use with older children. However, the intervention's simplicity may make it useful for younger children, such as Kayla's brother.

During the activity in Why I'm Special, the therapist noticed Kayla becoming quiet and upset near the end of session. Handling this situation required going off protocol. The therapist queried what was wrong and Kayla stated that she was sad that her brothers were taking all of the ornaments she made and hanging them on the Christmas tree. At this point, the participant intervened and told her daughter that she needed to share and to stop being sad. She did not make eye contact with Kayla or stop what she was doing when she said this. This did not soothe Kayla, but instead appeared to make her more upset. Rather than openly correct the mother in front of her children, the therapist chose to model a more empathic way of responding to sadness. The therapist sat down at the table with Kayla, listened to why she was sad, and assisted her in coming up with a solution. Kayla was mildly soothed, but still "pouted." Denise did not change her behavior; she continued issuing directives. Denise did not appear to have paid attention to what the therapist was doing with Kayla, or she may have thought that it was not a useful approach in dealing with the problem.

Having the mother more deeply involved in the activity appeared to be an effective way to observe typical interactions with her children. These types of behaviors

had not been observed in prior sessions; the mother was usually very supportive and expressive with her children during activities. Having Denise more involved in the activity seemed to leave less energy to be devoted to social desirability, such that Denise may have revealed her typical interaction style with her children. Another possibility is that Denise may have been under more pressure as the leader in this activity, and may have had difficulties dealing with this added stress. The stress may have caused her to deviate from her usual pattern of supportive behavior. In either case, this activity format may be useful if incorporated into the intervention early in treatment to provide the therapist with opportunities to assess the quality of typical mother/child interactions.

Results Related to Feasibility

Treatment Fidelity.

A protocol adherence rate of 85% or more was predetermined to represent an acceptable level of adherence. Overall, clinician reported protocol adherence across interventions was 85%. Protocol adherence was also calculated for each intervention separately. Across sessions, the Helping Parents intervention achieved 97% protocol adherence, indicating it can be easily implemented by therapists. The Catch My Parents Being Good intervention was implemented with 84% protocol adherence across sessions. Lastly, the Why I'm Special intervention showed a protocol adherence rate of 77%. This intervention underwent several changes in the course of treatment, which are described below. Prior to making these changes protocol adherence was far below acceptable levels (M=70% for sessions before the protocol change). However, after these changes were made, protocol adherence increased to an acceptable level (M=85% for sessions after the protocol change), indicating that the intervention could be faithfully implemented.

Interrater reliability was calculated using Cronbach's alpha and indicated good concordance between raters ($\alpha = .86$).

Consumer Satisfaction.

Although unsupported by research, compliance and helpfulness scores of 5 or more appeared to be appropriate cut-offs as these scores signify at least moderate levels of satisfaction or compliance. The Why I'm Special intervention earned the highest customer satisfaction ratings from both the mother and the child participant, with average helpfulness ratings of 7 (out of 7) points. It also earned the highest compliance ratings from both the child and her mother (M=5.33 for the mother and M=6.33 for the child). Compliance ratings for the Helping Parents intervention were acceptable (M=5.67 for the mother and M=5.67 for the child) and the helpfulness ratings were very high (M=7 for both mother and child). Compliance ratings for the Catch My Parents Being Good intervention were acceptable for the mother (M=6), but below the cut-off for the child (M=4.5). Helpfulness ratings for this intervention were acceptable for the mother (M=5.5), but below the cut-off for the child ratings (M=4).

Protocol Modifications.

The treatments were modified based on the input of the therapist, therapist's supervisor, and the independent reviewer. When difficulties with protocol implementation were noted, a meeting was held to identify possible solutions. In these meetings, protocol steps missed in prior sessions were discussed, as well as troublesome responses by family members. Decisions were made to emphasize or de-emphasize certain steps, or to eliminate or create additional protocol checklist items.

Overarching Modifications.

Overarching modifications are changes to the protocols that affect all three child-focused interventions. For instance, regarding the child's helpfulness ratings, it was observed that the child, despite her obvious lack of interest in some of the interventions, initially gave positive ratings for these interventions. It appeared she liked the happy face scale and was simply showing a preference for the happiest face. In order to elicit a more accurate rating of her perception of the intervention, the child was asked if she would like to participate in the intervention again. "No" responses were coded as a 1 and "yes" responses were coded as a 7, in order to maintain consistency with the prior coding system (1 = extremely unhelpful and 7 = extremely helpful). This procedure was implemented at session six.

Catch My Parents Being Good.

Kayla did not like this intervention. It was difficult to hold her interest during implementation, although her younger brother seemed to enjoy it. Kayla was uninterested in the role-plays, as indicated by her stating she did not want to do them. The techniques in this intervention may be too simple to hold the interest of a six-year old child, or it simply may have not have been to this child's personal taste. The simplicity of this intervention may make it more suitable for younger children. It would be useful to see how other young children (i.e., ages four to five) would react to this intervention, in order to assess if younger children enjoy it, and to see how other six-year olds respond to it, in order to assess if this six-year old's reaction to it was typical of children in her age group. Older children may require an intervention that is more interactive or cognitively challenging to keep them engaged. For instance, situations in which it is more difficult to

identify the positive parenting behavior could be presented, such as taking a child to a doctor (an appropriate parenting behavior, but one that many children dislike). However, the participant dropped out before any changes could be made and analyzed.

Helping Parents.

This intervention was easily implemented, obtained good consumer satisfaction and compliance ratings, and enabled good protocol adherence, thus no changes were made other than to the child consumer satisfaction assessment described in the Overarching Modifications section.

Why I'm Special.

It was noted that one of the protocol steps was to assure the parent approves of the activity to be performed and explain why the activity was beneficial to the child. However, if an activity (such as drawing) had been approved in a prior session by the parent, this protocol step seemed inapplicable or redundant. As such, the therapist was instructed to exclude these steps, resulting in decreased adherence. It was decided in this case to omit asking the parent's approval, but still ask the parent how the activity was beneficial in order to assess the parent's understanding and to allow the therapist an opportunity to re-emphasize why the activity was useful in the event the parent could not identify a reason. This procedure was implemented during session six and appeared to be well received by the parent and informative.

Also regarding Why I'm Special, it was decided that if an activity could not be completed during a particular session, the child's homework should be to complete the activity with their parent. It was also suggested to perform activities that could be completed within one session to avoid such problems in the future. Finally, if for some

reason an intervention could not be completed in session, it was decided the therapist would stop and pick up in the same spot as they left off in the next session. The protocol that the therapist was unable to complete in the prior session would be completed in the subsequent session, rather than moving on to a new protocol. This procedure was implemented during session six and may also have contributed to the increases in adherence.

Compliance Issues.

Meetings were also held to address difficulties in the administration of protocols. Homework compliance was a major issue, and procedures to ensure better compliance were discussed with the supervisor. Various techniques were employed, such as brainstorming with the participant methods to ensure timely completion of homework (implemented during session 4), discussing with the participant the importance of homework completion (implemented in session 5), and calling the participant before session to remind her to complete the homework (implemented before session 6). Ultimately, none of these techniques were successful, as the participant completed no homework assignments. In retrospect, all of these procedures probably should have been implemented for the first missed therapy assignment. Indeed, waiting until the 4th session essentially reinforced the participant that missed assignments were acceptable, and initiating them one at a time was probably an insufficient dosage.

The procedure for one of the assessments that was assigned for homework, the Activity Time Monitoring Log, had to be modified to ensure that it was completed. The participant demonstrated difficulty remembering to fill out the form during the week, so when this happened the therapist instructed her to complete the form retrospectively. This

method relied on the participant's memory to record how much time she had spent with her children the prior week, which likely resulted in decreased accuracy. Additionally, the participant verbalized a reluctance to write down the actual amount of time spent with her children because she did not want anyone to think poorly of her. Attempts were made to reassure the participant that she could be honest and that she was not being judged, but the participant may have still distorted her responses. Given that the participant filled out only four of the activity time monitoring logs (three of them retrospectively, at sessions one and six and the post-treatment assessment), and that she indicated that she feared being truthful when filling out the form, data from the time monitoring log were probably not accurate, and thus were not analyzed in this case examination.

Results Related to Outcome

Although most outcome data from the pre- and post-treatment assessments indicate normal functioning and low levels of problems, validity scales from several post-treatment assessment measures reveal the participant was responding in a socially desirable way and likely minimizing problems. These issues will be discussed in the sections below. Data from the assessments are presented in Table 7 and Table 8.

Child Abuse Potential Inventory.

CAPI results from the pre-treatment assessment were unremarkable, with all subscale scores well under clinical cut-offs. The participant's Abuse score was 54, which is very low. She did not endorse items that are commonly endorsed by individuals who engage in physical abuse of a child. The post-treatment assessment data also reveal a normal profile with all scales below clinical cutoffs, with the exception of the validity

scales that are discussed in a later section. The Abuse scale at the post-treatment assessment (M = 42) was slightly lower than at the pre-treatment assessment.

Parenting Stress Index – Short Form.

PSI-SF data from the pre-treatment assessment yielded a Stress scale score of 80, which is below the clinical cut-off. The Parent/Child Dysfunction scale score of 17 was within normal limits. Post-treatment PSI-SF results revealed similar a similar score on the Parent/Child Dysfunction scale (M = 15). The Stress scale score could not be calculated because of missing items. On the PSI-SF, the participant showed a high level of defensive responding with a scaled score of 18. (See table 7)

Eyberg Child Behavior Inventory.

ECBI data from the pre-treatment assessment included a Problem scale t-score of 59 and an Intensity scale t-score of 47. These scores are in the normal range and indicate the participant experienced a normal amount of problems with her child and that she did not perceive these problems as being particularly concerning. The second and third administrations of the ECBI after the first and second months of treatment yielded average results, as well. The Problem scale t-score was 47 and the Intensity scale t-score was 41 for both of these administrations of the measure. ECBI data from the post-treatment assessment yielded average results with a Problem scale t-score of 42 and the Intensity scale score of 44.

Family Environment Scale.

Pre-treatment assessment results from the FES yielded a family conflict t-score of 39 and a cohesion score of 59, indicating low amounts of conflict within the family and

average levels of cohesion. Results from the post-treatment assessment were within normal limits with a conflict t-score of 44 and a cohesion t-score of 59.

Parent Satisfaction with Child Scale.

Overall parent satisfaction as assessed with the PSCS showed improvement over the course of treatment. At the pre-treatment assessment parental satisfaction was reported to be at 50%. At the last treatment session, satisfaction was reported to be 80%. At the post-treatment assessment satisfaction was reported to be at 100%. For many of the specific areas addressed with the PSCS, responses across sessions varied greatly and no trends of improvement or deterioration were noted. Two of the items (satisfaction with their communication and satisfaction with their relationship) showed a noticeable trend of improvement across sessions. The participant's satisfaction with communication and her relationship with her daughter were reported to be at 30% at the pre-treatment assessment. Satisfaction in both of these areas increased to 80% by the last treatment session and was at 90% at the post-treatment assessment. Data from the PSCS are presented in Table 8.

Time-Line Follow-Back Interview.

TLFB data from the pre-treatment assessment revealed reported marijuana use for 119 out of the 120 days prior to the assessment date. Additionally, one day of methamphetamine use was reported to have occurred one day before the assessment. At the post-treatment assessment, the participant reported 94 days of marijuana use in the 120 days prior to the assessment. The participant reported that she stopped using marijuana 26 days before the post-treatment assessment. She reported no methamphetamine use during this time.

Urine Screen.

The results of the participant's urine drug screen at the pre-treatment assessment corroborated her reported TLFB results; she tested positive for marijuana and methamphetamine. The urine drug screen administered at the post-treatment assessment was inconsistent with the participant's reported TLFB results; she tested positive for marijuana use. However, Redwood Toxicology Laboratory, the producers of the panel dip urine drug screens used in this study, report that chronic (i.e., daily) marijuana use can lead to positive test results for 30 days or longer. If an individual is inactive or overweight, the drug can be detected for longer amounts of time. The participant in this study was moderately overweight and did not exercise. Thus, it is possible the participant was truthfully responding to the TLFB, and that she had not used marijuana in the prior 26 days.

SCID-IV.

In the pre-treatment assessment, using the SCID-IV the participant qualified for diagnoses of current marijuana dependence and current stimulant dependence. At the post-treatment assessment, the participant was diagnosed with marijuana dependence in partial remission and stimulant dependence in partial remission, both of which are lifetime diagnoses rather than current.

Validity.

Results of the pre-treatment assessment measures indicated the participant was not distorting her responses in any detectable way. The CAPI Lie Scale (raw score = 6), Faking Good, Faking Bad, and Random Responding indices were all under standard cut-offs. Additionally, the Defensive Responding score (raw score = 25) on the PSI-SF was

within the acceptable range. These results suggest that the participant was also responding accurately on other measures in this assessment.

Results of the post-treatment assessment revealed that the participant was responding in a socially desirable manner. The CAPI Lie Scale was elevated (raw score = 10) and according to the response distortion indices, she was Faking Good (elevated Lie Scale and a normal range Random Responding Scale). The PSI-SF Defensive Responding score (raw score = 18) also suggested the participant was minimizing problems. In light of these results, the validity of the other self-report assessments is questionable.

CHAPTER 5

DISCUSSION

The purpose of the present study was to develop child-focused interventions that address the needs of victims of neglect and to evaluate the feasibility of incorporating these interventions into an adult-focused Family Behavior Therapy program. The development of the interventions entailed a literature review to identify evidence-based interventions that target the needs of neglected children (e.g., play skills, empathy awareness). These interventions were adapted to fit with the FBT program for mothers founded for child neglect and substance abuse. Protocol checklists that outlined all the steps of the interventions were developed for the therapist to use in session. The protocol checklists also provided a way to measure treatment fidelity; the therapist and independent reviewer recorded the number of steps completed to the total number of steps possible in each intervention. To ensure the protocols were clearly written, before implementing them with a participant, they were used in role-plays with other therapists. Once all therapists could follow the protocols and deliver the treatments as they were intended, the protocol checklists were deemed ready to be used with participants. The protocol checklists for the interventions, particularly Why I'm Special, were modified during the course of treatment as problems with implementation were noted by the therapist or independent reviewer.

Feasibility

To evaluate feasibility, treatment fidelity and consumer satisfaction ratings were assessed. Treatment fidelity was considered an important area to assess to ensure the interventions could be implemented faithfully and consistently. Fidelity was assessed

using the protocol adherence method described above. Consumer satisfaction was evaluated because interventions that were not seen as useful by the participant were not likely to generalize once treatment was terminated. The interventions needed to be face valid to the participants to allow for greater buy-in and, consequently, motivation. Participant compliance was assessed as another measure of consumer satisfaction. Participants are not likely to perform tasks they do not like, so noncompliance can be interpreted as dissatisfaction.

The results of this single case study suggest that two of the child-focused interventions may be successfully incorporated into FBT. Protocol adherence and consumer satisfaction ratings supported the feasibility of implementing the Helping Parents and Why I'm Special interventions. Of these interventions, Why I'm Special was a clear favorite of the participants, as indicated by the consumer satisfaction ratings and statements made to the therapist. Although initially the protocol presented some difficulties, modifications made during treatment enabled the protocol to be administered with acceptable levels of adherence. The Helping Parents intervention was implemented with the highest levels of adherence and also earned high helpfulness ratings from the participants. The Catch My Parents Being Good intervention was just below the cut-off for acceptable adherence. This intervention was reported to be helpful by the mother, but not her daughter. Moreover, the child was relatively noncompliant with this intervention approach, thus demonstrating her dissatisfaction with this intervention behaviorally. It remains to be seen if this intervention can be successfully implemented and whether the lower child helpfulness ratings were something specific to the intervention or simply this child's personal preference. It is important to note that these results are tentative given

that this is a single case study and there were several factors complicating interpretation of the results, including her high likelihood of responding to interventions in a socially desirable manner. Indeed, the participant's decision to drop out of treatment could indicate that she did not feel she was benefitting from treatment and did not find the interventions particularly useful or helpful, despite the relatively high helpfulness ratings she gave them.

Outcome

Outcome data from the pre-treatment assessment indicate problems with substance dependence and normal functioning in regard to parenting. Assessments conducted during treatment reveal a small trend of improvement in the parent/child relationship and communication. The post-treatment assessment revealed a decrease in substance use and normal functioning in regard to parenting. However, validity scales on two of the measures indicated the participant was minimizing problems at this time, so these results may not be accurate.

Limitations

Outcome data reveal a decrease in drug use and an increase in parental satisfaction. However, several instruments indicated that the participant was minimizing problems at the post-treatment assessment. Thus, these results, which are primarily based on self-report, should be interpreted cautiously. Indeed, since the participant gave socially desirable responses at the post-treatment assessment, it is possible that she gave socially desirable responses to the measures used while in treatment. The consumer satisfaction ratings may have been biased in a more positive direction because the participant may have felt it was "correct" to give high helpfulness ratings. Similarly, the PSCS and ECBI

results may be more positive due to the participant minimizing problems to appear more competent or less troubled. The participant's positive drug screen at post-treatment assessment was another indicator, suggesting she may have been using illicit drugs at the time she prematurely terminated treatment.

Another factor that makes it difficult to assess outcome is that there were a limited number of sessions in which to effect change, and that the observed changes in parental satisfaction and drug use may not be due to treatment, but rather extra-therapeutic factors. Further complicating the matter, the participant admitted that her primary reason for participating in treatment was to obtain a cell phone, which suggests that her motivation for therapy and for change was low. So, although the mother was compliant in session, she was likely doing little therapy work outside of session. This interpretation is supported by the participant's noncompliance with homework.

Another limitation of this study is that the child participant was relatively young, at six-years old. Due to her age, she was unable to complete homework assignments on her own and she did not have the support of her mother in completing the assignments. This lack of support likely inhibited the effectiveness of the interventions. Assessment of the child's consumer satisfaction was difficult, also because of her age. It was unclear whether she understood the purpose of the original smiley face scale assessment because she often gave responses that were inconsistent with the therapist's observations of how much the child liked the interventions (e.g., giving the intervention a high rating when she was inattentive during its implementation). She may have felt it was polite to give high ratings or she may have simply picked the picture that she liked best (i.e., the biggest smiley face). Although this assessment process was modified during treatment,

the child may still have felt pressure to be polite and give positive ratings rather than state her true feelings. Lastly, it should be mentioned that this case supports the contention that the success of child-focused interventions may be limited by the lack of therapeutic “buy-in” or participation of the parents. In the present study, it was hoped that the adult-focused interventions would assist in facilitating motivation for the parent to assist in the child-focused treatments. However, the parent’s lack of support in the child-focused treatment, suggested the adult- and child-focused treatments may need better integration.

Overall treatment fidelity was assessed using the therapist’s ratings of protocol adherence. Along these lines, the therapist often had higher adherence ratings than the independent blind assessor. Although therapist ratings may be biased or inaccurate, there is a potential for the independent reviewer’s ratings to be biased or inaccurate, as well. For instance, audiotapes can be difficult to decipher due to background noise or because the therapist was not loud enough to hear.

Future Directions

Due to the fact that the participant terminated therapy halfway through the process, the Catch My Parents Being Good and Helping Parents interventions were only administered two and three times, respectively. There were not many sessions in which to monitor and address difficulties with implementation of these interventions, or to identify the source of participant dissatisfaction. Future research should further evaluate the feasibility of incorporating these interventions into traditional FBT. To accomplish this, these interventions should be administered several more times to permit rapid identification of problem areas within the interventions, making necessary modifications, and re-evaluating adherence and consumer satisfaction after modifications are made.

The child-focused interventions may benefit from modification before they are implemented in future studies. Methods to decrease participant defensiveness and increase compliance may be particularly useful. For instance, the rationales for the interventions (which are currently provided to the children and parents at the same time) might be enhanced by administering them to parents and children separately. Parent rationales might incorporate psycho educational information, including why the interventions are hypothesized to be beneficial to participants. This may result in increased motivation, which could increase parental compliance with homework.

Homework compliance was a problem in this study. The term “homework” may have led the participant to perceive this task as being difficult due to her own past negative experiences with such assignments in school. Thus, it may be more effective to avoid this term, and instead assign the participant to simply practice the learned techniques between sessions. Therapists could simply provide the forms to participants and ask them to practice the techniques, and to record their attempts on the forms. Another solution may be to remove the homework forms completely. To do this, parents would be asked to text message their therapists while, or immediately after, they practice the techniques that are learned during treatment sessions. For instance, the participant might text message the therapist that her family was engaging in an activity for Why I’m Special, or inform the therapist that her child just caught her being good. In this way, the therapist could record how many times the participant engaged in homework activities. Given the widespread usage of text messaging and social media outlets such as Facebook and Twitter, this form of communication may be more easily adopted by parents,

particularly those who are financially restricted to text messaging in their cell phone plans.

Lastly, the child-focused interventions may benefit from adopting a more family-focused approach. Involving the parent in the child's interventions more frequently and qualitatively may lower parent defensiveness. Parents may not know what their children are doing while participating in the child-focused interventions. The parents may worry that their parenting practices are being discussed or criticized, causing them to be suspicious of the treatment provider, which may lead to reduced compliance. If the parents were present for more of the child-focused interventions, they would have greater opportunities to observe that they are not being criticized, and that these interventions are focused on skill development in their children and not their own skill deficits. Also, this could result in greater compliance because the parents will be able to observe their children in role-plays, permitting them to know what behaviors to look for in their children at home.

Research aimed at increasing retention in substance abuse programs has shown that offering reward vouchers for abstinence (i.e., a drug-free urine screen) leads to increased retention and higher rates of abstinence (Higgins, Budney, Bickel, Foerg, Donham, & Badger, 1994; Higgins, Budney, Bickel, Hughes, Foerg, & Badger, 1993). Petry (2002) has shown that these increases in abstinence and retention can be gained by using a drawing procedure, wherein participants earn a chance to draw from a pool of incentives that range in value (small incentives, such as \$1 gift cards to Dunkin Donuts; moderate incentives, such as gift cards to stores; large incentives, such as a stereo). The longer the period of abstinence and the more drugs a person tests clean for, the more

entries into the drawing they are given. Bonus entries are given for having several consecutive clean tests. This model could be adapted for use in the child-focused interventions to increase participant retention and compliance. To enact this procedure, the receipt of incentives would be contingent upon the participant's compliance and/or attendance in the child-focused treatments. Along these lines, minutes of cell phone talk time would be earned by homework completion, high compliance ratings, and attendance. Bonus minutes may be given for "perfect" sessions (i.e., attendance, completed homework, and good compliance) and for having several consecutive "perfect" sessions. Though the results of the present study are tentative, they suggest there is much work to be done in the development of the examined child-focused intervention components within Family Behavior Therapy.

APPENDIX A

**Why I'm Special
Therapist Prompting List
Initial Session**

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session: _____

Materials Required

- **Why I'm Special Homework Sheet**
- **Activity List**

Begin Time: _____

Rationale for "Why I'm Special" (with family)

- ___ 1. State when families share their positive qualities and talents, they:
 - ___ a. Have a sense of family pride
 - ___ b. Have more opportunities see what their children like to do, which makes it easier for them to do those things with them
 - ___ c. Spending that positive time together improves family relationships
 - ___ d. That positive time lowers risk of problem behaviors in the family
- ___ 2. State "Why I'm Special" involves child learning activities that are educational, fun, and in some way benefit you and your family.
- ___ 3. Query how this would benefit client and client's family.
- ___ 4. Solicit and answer potential questions.
- ___ 5. Solicit caregiver's permission to perform activities in desired location.

Selection of activities with child(ren)

- ___ 1. Utilize Activity List to choose, mutually whenever possible, an activity for child(ren) to perform.
 - Adapt activities if necessary to make more age/sex appropriate
 - Modify activity if resources are unavailable – improvise, use imagination
- ___ 2. Assure caregiver approves activity
OR
If activity has been approved previously, query the benefits of the activity
 - ___ a. Explain how chosen activity is both educational and fun, and benefits the family. (e.g., improves motivation to learn, social skills, team work, etc)
OR
Praise parent for identification of benefits.
- ___ 3. State child(ren) will perform activity for caregiver later in session.
- ___ 4. Practice activity with child(ren) until (s)he is able to perform with relatively minimal errors. Use the following:
 - Attends
 - Descriptive praise
 - Immediate reinforcement
 - Pleasant affect

- Tactile reinforcement (e.g. high fives)
 - Pleasant tone
 - Incidental teaching
 - Ask questions
 - Avoid criticism
 - Be silly
- ___5. Inform child activity will now be performed for parent, and take child into room with caregiver.
- ___6. Instruct child to perform activity for parent.
- ___a. Praise & solicit parent praise for what was liked about child's performance.
- ___b. Instruct parent to teach related activity to child in session.
- Assist parent in generating activities, when needed.
- ___c. Praise parent and child for performance of activity.

Homework Assignment (with family)

- ___1. Instruct parent to perform related activity with child throughout the week.
- ___2. Instruct parent to record homework on the child homework sheet.

Child Compliance Rating

- ___1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- ___2. Provide descriptive praise.

Note: If child receives a low score, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- ___1. Query if child would like to perform intervention again in a future session.
- Child Response:** YES or NO

Client Compliance Rating

- ___1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- ___2. Inform client of factors that influenced the rating
- ___a. Support given to child
- ___b. Participation in session

Client Helpfulness Rating

- ___1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.
- Client Rating:** _____

**Why I'm Special
Therapist Prompting List
Future Sessions**

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session: _____

Materials Required

- **Why I'm Special Homework Sheet**

Begin Time: _____

Homework Review (with family)

- ___ 1. Ask child to provide completed homework sheet.
- ___ 2. Praise for homework completion or have child complete in retrospect.
- ___ 3. Solicit what family liked about activity.

Selection of Activities (with children)

- ___ 1. Utilize List of Activities form to choose, mutually whenever possible, an activity for child(ren) to perform.
 - Adapt activities if necessary to make more age/sex appropriate
 - Modify activity if resources are unavailable – improvise, use imagination
- ___ 2. Assure caregiver approves activity
OR
If activity has been approved previously, query the benefits of the activity
 - ___ a. Explain how chosen activity is both educational and fun, and benefits the family. (e.g., improves motivation to learn, social skills, team work, etc)OR
Praise parent for identification of benefits.
- ___ 3. State child(ren) will perform activity for caregiver later in session.
- ___ 4. Practice activity with child(ren) until (s)he is able to perform with relatively minimal errors.
- ___ 5. Inform child activity will now be performed for parent, and take child into room with caregiver.
- ___ 6. Instruct child to perform activity for parent.
 - ___ a. Praise & solicit parent praise for what was liked about child's performance.
 - ___ b. Instruct parent to teach related activity to child in session.
 - Assist parent in generating activities, when needed.
 - ___ c. Praise parent and child for performance of activity.

Homework Assignment (with family)

- ___ 1. Brainstorm with parent related activities that could be done with child throughout the week.
- ___ 2. Record related activity to be completed on homework sheet.

___3. Instruct parent to record activity on the child's homework sheet when completed.

Child Compliance Rating

- ___1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- ___2. Provide descriptive praise.

Note: If child receives a low score, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- ___1. Query if child would like to perform intervention again in a future session.
Child Response: YES or NO

Client Compliance Rating

- ___1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- ___2. Inform client of factors that influenced the rating
 - ___a. Support given to child
 - ___b. Participation in session

Client Helpfulness Rating

- ___1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.
Client Rating:_____

APPENDIX B

Helping Parents Therapist Prompting List Initial Session

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session: _____

Begin Time: _____

Materials Required

- Helping Parents Worksheet

Rationale for Helping Parents (All Children)

- __1. State family members often need help, even when they don't ask for it.
- __2. Query why it would be important to offer to help others.
- __3. State offering to help makes others feel good & improves family relationships.

Empathy Awareness Training

- __1. Provide a hypothetical situation about a child in need of help.
- __2. Solicit how child thinks the child in the story is thinking and feeling.
- __3. Finish the story with the child receiving help from another kid.
- __4. Solicit how child thinks the child in the story is thinking and feeling.
- __5. Solicit how child would feel in that situation, focusing on how they felt before and after receiving help.
- __6. Solicit a recent situation in which child received help.
- __7. Query how child felt/what they were thinking before they received help.
- __8. Query how child felt after (s)he received help (e.g., grateful, relieved).
- __9. Solicit how child thinks their parents feel when they are in need of help.
- __10. Solicit how their parent would feel if they received help.
 - It may be necessary to ask if their parent would feel like the child did when (s)he was helped.

Therapist Modeling of Offers To Help (All Children)

- __1. Brainstorm ways to use Offers To Help in the following situation:
 - “Your mom comes home from the grocery store with a lot of bags of food. You're watching tv and you see her come in with some bags.”
 - Model an offer to help w/ child as parent and therapist as child.
 - __a. State, “How can I help you, Mom?”
 - Avoid criticism.
 - Be pleasant throughout helping process.
 - If help is not wanted, smile and say, “Okay, just checking”.
- __2. Query what was liked about modeled performance.
- __3. Identify useful techniques performed that were not mentioned by children. (e.g. smile)

Child Role Play of Offers To Help (All Children)

- __1. Brainstorm situations in which child(ren) could use Offers To Help with parents.
- __2. Instruct each child to perform an offer to help.
- __3. Descriptively praise child(ren)'s performance & prompt other child(ren) to do so.
- __4. Distribute Helping Parents worksheet to child(ren).
- __5. Show child(ren) how to fill out 'Offers To Help' section in Helping Parents worksheet for role played situations.

Ways to Support Parents (All Children)

- __1. State there are many ways kids can help or support their parents without asking.
 - __a. State having a clean room or making a present helps by making parents happy.
- __2. Ask what other things child(ren) could do to help parents throughout the week.
 - Record responses in 'Ways to Support Parents' form on Helping Parents worksheet.
- __3. Review completed 'Ways to Support Parents' form w/ child(ren).
- __4. Remind child(ren) to try to do these things as much as possible.
- __5. Inform child(ren) that parents will keep track of these behaviors, and will put a smiley face on the Helping Parents worksheet each time they do something on the list.
 - __a. State it is ok if child(ren) don't complete every item on the list. They are just extra things that can be done to help parents.

Homework (All Children)

- __1. Instruct child(ren) to make an Offer To Help to a parent before next session.
 - __a. Instruct child(ren) to record offer in Helping Parents worksheet.
- __2. Remind child(ren) parents will review 'Ways To Support Parents' each night and record support in Helping Parents worksheet..
- __3. Inform child(ren) homework will be reviewed next session.

Review Child(ren)'s List with Mother (Client & Adult Sig. Others)

- __1. Inform client child(ren) has made a list of ways to help/support parents & has learned to make Offers To Help.
- __2. Give client Helping Parents worksheet & show 'Ways To Support Parents' section.
- __3. Instruct client to review 'Ways To Support Parents' each night and put a smiley face in the corresponding box if support was provided that day.
- __4. Show client Offer To Help section of the worksheet.
 - If child(ren) is too young to record an Offer To Help him/herself, ask parent to help child fill out that part of the Helping Parents worksheet.

Child Compliance Rating

- __1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.

- __2. Factors that contribute to compliance ratings are:
- Attendance
 - Participation & conduct in session
 - Homework completion

- __3. Provide descriptive praise.

Note: If child receives a 1 or 2, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- __1. Query if child would like to perform intervention again in a future session.

Child Response: YES or NO

Client Compliance Rating

- __1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- __2. Inform client of factors that influenced the rating
- __a. Support given to child
 - __b. Participation in session

Client Helpfulness Rating

- __1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.

Client Rating: _____

**Helping Parents
Therapist Prompting List
Future Sessions**

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session:

Begin Time: _____

Materials Required

- **Helping Parents Worksheet**

- __1. Instruct child(ren) to provide completed Helping Parents worksheets, or instruct to complete in retrospect if incomplete.
 - If no Offers To Help/Ways to Support Parents were performed over the week, solicit a situation in which they could have been performed, and role-play with child(ren).
- __2. Review Helping Parents worksheet and how parents responded.
 - __a. Provide praise and/or corrective feedback.
- __3. Distribute new Helping Parents worksheet.
- __4. Instruct child to perform at least one Offer To Help during next week.
 - __a. Instruct child to record offer in Offers To Help worksheet.
- __5. Remind child(ren) parents will review Ways To Support Parents and record support on Helping Parents worksheet.
- __6. Provide a hypothetical situation about a child in need of help.
- __7. Solicit how child thinks the child in the story is thinking and feeling.
- __8. Finish the story with the child receiving help from another kid.
- __9. Solicit how child thinks the child in the story is thinking and feeling.
- __10. Solicit how child would feel in that situation, focusing on how they felt before and after receiving help.

Child Compliance Rating

- __1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- __2. Provide descriptive praise.

Note: If child receives a 1 or 2, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- __1. Query if child would like to perform intervention again in a future session.

Child Response: YES or NO

Client Compliance Rating

- __1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- __2. Inform client of factors that influenced the rating

- a. Support given to child
- b. Participation in session

Client Helpfulness Rating

- __1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.

Client Rating: _____

APPENDIX C

Catch My Parents Being Good Therapist Prompting List Initial Session

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session: _____

Materials Required

- **Catch My Parents Being Good Worksheet**

Begin Time: _____

Rationale for CMPBG

- ___ 1. CMPBG is used to let parents know the things they do that you do like.
- ___ 2. Query why it is important to let someone know when they do something you like.
- ___ 3. State other kids think it's important for the following reasons:
 - ___ a. It lets the other person know what you like, so they can keep doing it.
 - ___ b. It makes people feel good when their good deeds are noticed.
 - ___ c. When you show appreciation for having something done for you, it makes people more likely to do other things for you.

Modeling CMPBG

- ___ 1. Give child(ren) the CMPBG worksheet and brainstorm a situation for it's use.
 - Model the following CMPBG steps w/ the child using generated situation:
 - ___ a. Tell the person exactly what was liked about what they did. Be descriptive.
 - ___ b. Thank and/or reward the person immediately.
 - Rewards can include high fives, hugs, or an offer to do something for the person that they like.
 - ___ c. Smile.
 - ___ d. Avoid criticism, only say what you like.
- ___ 2. Ask child to model CMPBG for same situation.
 - ___ a. Praise and provide corrective feedback, as needed.
- ___ 3. Instruct child how to complete CMPBG worksheet using modeled situation (with the help of therapist or older sibling, if necessary).
 - Fill out modeled situation in 1st box in CMPBG worksheet.
- ___ 4. Role play CMPBG for novel situation with other children present, or role play novel situation with same child.

Homework

- ___ 1. Instruct child(ren) to catch each parent being good at least once before next session.
 - ___ a. Instruct child to record in 2nd box of CMPBG worksheet.
- ___ 2. Inform child(ren) homework will be reviewed next session.
- ___ 3. Write homework assignment on the Practice Assignment Worksheet.
- ___ 4. Inform parent of homework assignment and ask to verify that child completes it.

- __5. Instruct parent how to fill out the CMPBG worksheet, so they can ensure child completes it correctly.

Child Compliance Rating

- __1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
__2. Provide descriptive praise.

Note: If child receives a 1 or 2, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- __1. Show child the Smiley Face Scale and ask to rate how helpful the intervention was.

Child Rating: _____

Client Compliance Rating

- __1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
__2. Inform client of factors that influenced the rating
__a. Support given to child
__b. Participation in session

Client Helpfulness Rating

- __1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.

Client Rating:_____

**Catch My Parents Being Good
Therapist Prompting List
Future Sessions**

Client ID#: _____ Clinician: _____ Session #: _____ Date of Session: _____

Materials Required

- **Catch My Parents Being Good Worksheet**

Begin Time: _____

With child(ren)

- __1. Ask child(ren) to provide completed CMPBG worksheets, or instruct to complete in retrospect if incomplete.
- __a. Solicit difficulties encountered using the procedure and role-play solutions.

With family

- __2. Review how child(ren) used CMPBG and how family responded.
- __a. Instruct child to role play how CMPBG was used.
- __3. Provide new CMPBG worksheet and instruct to complete for next week.

Child Compliance Rating

- __1. Rate child's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- __2. Provide descriptive praise.

Note: If child receives a 1 or 2, inform child what can be done to raise the score next time.

Child Helpfulness Rating

- __1. Show child the Smiley Face Scale and ask to rate how helpful the intervention was.

Child Rating: _____

Client Compliance Rating

- __1. Rate client's compliance on a 1-7 scale, where 1 = extremely noncompliant, 4 = somewhat compliant, 7 = Extremely compliant.
- __2. Inform client of factors that influenced the rating
- __a. Support given to child
- __b. Participation in session

Client Helpfulness Rating

- __1. Ask client to rate how helpful they found the intervention on a 1-7 point scale, where 1 = Not At All Helpful, 4 = Somewhat Helpful, 7 = Extremely Helpful.

Client Rating: _____

APPENDIX D

Activity List (by Age)

Two Years Old

- Teach to jump off floor with both feet- hop like a bunny, have child make ears with hands
- Stand on one foot- how flamingos stand
- Kick a ball
- Throw a ball
- Stack blocks or build with legos- encourage talk about what the structure is, using imagination
- Teach how to use crayon, pencil, ect.
- Play dress up and make-believe- put on a puppet show
- Washing hands, throwing away trash-colored soap can encourage hand washing
- Listen to cultural or classical music and dance

Three Years Old

- Teach full name, with age and sex
- Count to three or more and understand the concept of objects, work with child to understand a one-to-one relationship of objects and numbers.
- Colors/ Teach with paint, use paints and exploration to discover how to make colors
- Teach about taking turns and sharing
- Simon says
- Play simple games emphasizing rules
- Explore what happens when mixing liquids (colored water and oil, vinegar and baking soda, ect.)
- Listen to cultural or classical music and dance

Four Years Old

- Draw his/her family members
- Can name colors, use paints and exploration to discover how to make colors
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create there favorite part of the story.
- Create task with multiple steps for child to follow
- Play simple games emphasizing rules
- Explore what happens when mixing liquids (colored water and oil, vinegar and baking soda, ect.)
- Prepare a meal (simple mixing and preparation, no cooking)
- Listen to cultural or classical music and dance

Five Years Old

- Tie shoes
- Color in the lines
- Create task with multiple steps for child to follow
- Count to 100 (by 2's, 5's, and 10's)
- Reciting a poem or Nursery Rhyme

- Acting out a story
- Collages
- Tell stories about situations that involve morality and ask questions to help understand right from wrong.
- Explore what happens when mixing liquids (colored water and oil, vinegar and baking soda, ect.)
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Prepare a meal (simple mixing and preparation, no cooking)
- Listen to cultural or classical music and dance

Six Years Old

- Play catch with baseball mitt
- Tell stories about situations that involve morality and ask questions to help understand right from wrong.
- Jump rope
- Understand cause and effect relationship using examples and role playing
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Count to 100 (by 2's, 5's, and 10's)
- Prepare a meal (simple mixing and preparation, no cooking)
- Listen to cultural or classical music and dance

Seven Years Old

- Arts and Crafts
- Physical Activity
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Have the child write a story, help to generate ideas, then illustrate the story and put it into a finished book.
- Use Tangrams to create pictures
- Read a poem or story with a lot of action, as you read the child acts out what is happening
- Prepare a meal (simple mixing and preparation, no cooking)
- Dancing Statues
- Listen to cultural or classical music and dance

Eight Years Old

- Increase reading skills- have child read a level appropriate passage
- Sports
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Have the child write a story, help to generate ideas, then illustrate the story and put it into a finished book.
- Use Tangrams to create pictures
- Use different tools to measure length, volume, and time, encourage estimation

- Read a poem or story with a lot of action, as you read the child acts out what is happening
- Prepare a meal (mixing and preparation, microwaves emphasizing time)
- Dancing Statues
- Listen to cultural or classical music and dance

Nine Years Old

- Sports
- Drawing, painting
- Make jewelry
- Build models
- Anything that uses fine motor skills
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Have the child write a story, help to generate ideas, then illustrate the story and put it into a finished book.
- Play a board game to encourage following rules and money
- Use different tools to measure length, volume, and time, encourage estimation
- Read a poem or story with a lot of action, as you read the child acts out what is happening
- Prepare a meal (mixing and preparation, microwaves emphasizing time)
- Dancing Statues
- Listen to cultural or classical music and dance

Ten Years Old

- Seek out books and magazines of special interest
- Basketball, soccer, dancing
- Teach to cook a simple dish such as macaroni or bake a simple cake from box
- Read aloud a story to child then ask questions for comprehension, use arts and crafts to expand on the story or create his/her favorite part of the story.
- Have the child write a story, help to generate ideas, then illustrate the story and put it into a finished book.
- Use different tools to measure length, volume, and time, encourage estimation
- Read a poem or story with a lot of action, as you read the child acts out what is happening
- Listen to cultural or classical music and dance

Thirteen to Eighteen

- Help increase positive study habits
- Introduce new ways of studying
- Develop ways for child to help around the house, alleviating the parent from heavy workload.
- Physical Activity
- Discuss eating habits and ways to eat healthy
- Cook a full meal with more than one dish

Specific Activities by Topic

Math and Spatial Skills

- **Dime in My Pocket (Ages 5+)**
Handful of change consisting of enough coins to practice math skills.
Example:
How many ways can we make \$0.12
Can you make me \$0.27 using five coins? Three coins?
Other math additions or subtractions
For younger children, teach them to identify coins and the value of each coin.
- **Math Madness (Ages 6+)**
Provide approximately ten math problems that are age appropriate. Have the child practice until they can do them in a set amount of time – for instance 2 minutes. Do a race with the child.
- **Matching Shapes (Ages 4-6)**
Draw shapes on paper. Have child find the matching shape hiding among the other shapes.
Example:
- **Number Sequencing (Ages 5+)**
Write a series of numbers, leaving some numbers out. Have child fill in the missing number.
Example: 1 2 ___ 4 5 6 ___ 8
- **Taller or Shorter (Ages 4+)**
Draw similar shapes of different heights/lengths. Have child point out which one is longer/shorter than the other.
- **Puzzles (Ages 5+)**
Have the child draw a picture. Without the child looking, cut it up, mix up the pieces, then have child put it back together.
- **Dominoes (Ages 4+)**
Teach child how to match the ends of dominoes to make a line. Teach and play Mexican Train or another type of game.
With small children, you can have them line up the dominoes and tip them over. This helps develop fine motor skills.

Memory

- **ABC Meal (Ages 5+)**
Take turns going through alphabet in order, naming foods in alphabetical orders.
A – apple
B – bread
C – candy
- **ABC Animals (Ages 4+)**
Take turns naming animals. First one starts with any letter. All others must say an animal which starts with the word the last animal ended with.
Example: Buffalo, Otter, Rat, etc.
or
Pick a letter. Each child takes a turn naming an animal whose name starts with that letter. If only one child, have child think of as many animals whose name starts with that letter as possible or the therapist can take turns. Once you run out, move on to the next letter.
Example: Ant, antelope, anteater, ape, etc.
- **Picture Memory (Ages 4+)**
Have children draw 8 pictures of objects (a house, horse, cupcake, etc.) on index cards or small pieces of paper. Next have them draw a copy of each picture so each picture has an identical pair. (If necessary, cut the paper so the paper so that each card is the same size) Now, mix up the cards and lay them face down on the floor or table. Each child has a turn flipping over 2 cards. If the child turns over 2 identical pictures, the cards are removed from the board and set in front of the child. If a child turns over 2 mismatched cards, they are flipped back over. Once all the cards have been paired and removed from the board, each child counts the number of matches made. The child with the most pairs, wins.

Music

Homemade Musical Instruments (Ages 4+)

- **Rain Stick**
MATERIALS
 - 1 empty paper towel roll
 - Heavy duty aluminum foil
 - Uncooked rice or dried beans
 - Rubber bands or duct tape
 - Embellishments: markers, stickers, crayons, wrapping paper, ribbons, etc.

STEP 1: Have child decorate the paper towel roll with available embellishments.

STEP 2: Rip off two pieces of aluminum foil and trim them into equal-sized squares approximately twice the size of a paper towel roll opening. (If the child is doing the ripping, make sure he minds his hands on the serrated edge of the foil box.)

STEP 3: Have the child cover one end of a paper towel roll with aluminum foil and secure it with a rubber band or duct tape. If you don't have heavy-duty foil, make your foil three-ply.

STEP 4: Tear another couple of pieces of aluminum foil and have the child crumple it up into balls small enough to pass easily through the paper towel tube. Try not to crumple them too tightly. They should be small enough to fit in, but not so small that they're rattling around in there like marbles.

STEP 5: Help child fill the tube $\frac{1}{4}$ full with uncooked rice. Put the aluminum foil ball into the tube as well.

STEP 6: Fasten the second square of aluminum foil to the open end of the paper towel roll with duct tape or a rubber band.

STEP 7: Instruct the child turn the tube upside down to create the sound of rain.

- **Piano Jars (Ages 5+)**

Materials:

- 8 Glass bottles or jars (the same size is best)
- Metal spoons
- Funnel and access to water
- 1 cup measure (optional)
- Sponge or rag in case of spill
- Food coloring (optional)

1. With the funnel, fill the bottles up with different amounts of water.
2. Tap each bottle with your spoon to see if you like the note it makes. Add more water to make a lower note and pour out some if you want a higher note.
3. Find a place where you can play the piano. Make sure you can have an audience sit comfortably there if you want to play for people or that there's space for your friends to play their instruments with you.
4. Line the bottles up. Use an arrangement you like or try lining them up from lowest to highest tone.
5. (Optional) Use the food coloring to color the water differently for each bottle. You might want to use the colors of the rainbow: Red, Orange, Yellow, Green, Blue, Indigo, Violet (add LOTS of blue dye), and then red again for

the last note. This is a good opportunity to teach children about mixing colors (Red + Yellow = Orange).

- **Cymbals** (Ages 3+)

Make cymbals out of old tin foil pans. Attach a string for a handle.

- **Drums** (Ages 3+)

Create drums out of empty coffee cans with plastic lids, plastic ice cream pails, or oatmeal boxes. The children can decorate as desired with paper, paint, markers, or crayons.

- **Guitar** (Ages 5+)

Use a shoebox to create a guitar. Cut a hole in the center of the shoebox lid. Help the children stretch five rubber bands of different widths across one shoebox. The different size rubber bands will provide different pitches.

- **Kazoos** (Ages 4+)

Make Kazoos with empty paper towel rolls and waxed paper. The children can decorate the outside of the kazoos with markers. Place a piece of waxed paper over one end of the roll and secure it with a rubber band. Poke 2 or 3 small holes into the waxed paper allowing sound to be produced.

- **Maracas** (Ages 5+)

Pour small stones, dried beans, or uncooked rice into a plastic cup and seal with the lid. Have child decorate the outside of the cup, if appropriate.

- **Rhythm Sticks** (Ages 4+)

Two wooden dowels should be given to each child. The sticks can be decorated with paint or markers.

- **Tambourines** (Ages 5+)

Two paper plates can be made into a tambourine. Have children color with crayons or markers the bottom of the paper plates. Place small stones or uncooked rice between the plates. Staple the paper plates together. Shake to produce a sound.

Theater

- **Puppet Show (Ages 5+)**
Make puppets out of old socks or lunch bags, or finger puppets with paper. Can even act out a book or story the kids enjoy
- **Storybook Play (Ages 5+)**
Child or therapist acts out story while the other reads
- **My Favorite Day (Ages 5+)**
Have the child describe a favorite memory and develop a “skit” to re-enact that memory.
- **Dance (Ages 3+)**
Have the child pick a song and create a hand jive, dance, or made up sign language to describe the song
- **Charades (Ages 5+)**
Create the game and play for parents
- **Animal Hokey Pokey (Ages 4+)**
Teach children to do the hokey pokey, but pick an animal (i.e. elephant) sing the song with the animal parts, not human parts (i.e. put your trunk in).
- **Chin-a-gins (Ages 7+)**
Draw an upside-down face (eyes and nose only) on child’s chin. Have child hang upside-down on a chair or couch, covering his/her face exposing only his mouth and chin. Have child put on a show lip singing to a favorite song. If possible, videotape to show family afterward.

Science

- **Cornstarch Suspension or Goo! (Ages 6+)**

Materials:

- 1 cup cornstarch
- About ½ cup of water
- Bowl

Put cornstarch in bowl. Slowly add water while stirring – the mixture should look like thick pancake batter. It may not be necessary to add all of the water. Now, have the child note what the mixture looks and feels like (a liquid). Have the child roll the mixture around in his hands. Now have the child note what it looks and feels like (a solid). Have the child stop rolling the mixture on his hands. It will turn back to liquid! This is called a suspension. When the mixture is

squeezed, the molecules tighten up and feel solid. When left alone, the molecules relax and act more like liquid.

The cornstarch suspension is a non-Newtonian fluid, meaning its ability to move depends on the force or stress applied to it. These fluids do not act like ones we are more familiar with (e.g. water or honey) which move according to their temperature and pressure. A light pressure, such as pouring or gently pressing the cornstarch-water mixture, allows it to move like a liquid. But a high pressure, such as punching firmly, causes the cornstarch-water mixture to act as a solid. This same principle applies to quicksand. When it is lightly stepped on by the unaware adventurer, the quicksand liquefies and the foot of the adventurer starts to sink. Panicking, the adventurer tries to quickly pull his or her foot out, only to find that now the quicksand is acting like a solid, encasing the foot all the more firmly in this unpredictable substance

- **Layered Liquids - Oil and Water (Ages 5+)**

Materials:

- ¼ cup water
- ¼ cup vegetable oil
- a small glass
- food coloring

First pour the water into the glass. Add a couple of drops of food coloring and mix. Next add the oil. The oil is lighter than water, so it floats to the top. Tightly cover the glass with plastic wrap or your hand (if it's big enough). While holding the glass over a sink (in case you spill), shake the glass so that the two liquids are thoroughly mixed. Set the glass down and watch what happens. Do oil and water mix? Try adding other liquids of differing density to make more layers (e.g., corn syrup, dish soap).

- **Homemade Lava Lamp (Ages 5+)**

Materials:

- 1 empty 2 liter bottle
- ¾ cup of water
- Vegetable oil
- Fizzing tablets (e.g., Alka Seltzer)
- Food coloring

1. Pour the water into the bottle.
2. Use a measuring cup or funnel to slowly pour the vegetable oil into the bottle until it's almost full. You may have to wait a few minutes for the oil and water separate.
3. Add 10 drops of food coloring to the bottle. The drops will pass through the oil and mix with the water below.
4. Break a seltzer tablet in half and drop the half tablet into the bottle. Watch it sink to the bottom and let the blobby greatness begin!
5. To keep the effect going, just add another tablet piece. For a true lava lamp effect, shine a flashlight through the bottom of the bottle.

The oil floats above the water because the oil is lighter than the water or, more specifically, less dense than water. The oil and water do not mix because of something called "intermolecular polarity." That term is fun to bring up in dinner conversation. When you added the tablet piece, it sank to the bottom and started dissolving and creating a gas. As the gas bubbles rose, they took some of the colored water with them. When the blob of water reached the top, the gas escaped and down went the water. Cool, huh? By the way, you can store your "Blobs In A Bottle" with the cap on, and then anytime you want to bring it back to life, just add another tablet piece.

If you don't have the materials for the homemade lava lamp, try this one:

- **Blobs! (Ages 5+)**

Materials:

- One clear glass or plastic cup
 - Vegetable oil
 - Water
 - Salt
 - Food coloring
1. Fill the glass about 3/4 full of water.
 2. Add about 5 drops of food coloring - I like red for the lava look.
 3. Slowly pour the vegetable oil into the glass. See how the oil floats on top?
 4. Now the fun part: Sprinkle the salt on top of the oil.
 5. Watch blobs of lava move up and down in your glass!
 6. If you liked that, add another teaspoon of salt to keep the effect going.

- **Bending Water (Ages 8+)**

Materials:

- 1 nylon comb
- A water faucet

Adjust the faucet to produce a small stream of water. The stream should be about 1/16 inch in diameter.

Run the comb through your hair several times. Slowly bring the teeth of the comb near the stream of water, 3 or 4 inches below the faucet. When the teeth of the comb are about an inch or less away from the stream, the stream will bend toward the comb. This is caused by static electricity.

When you brushed that comb through your hair, tiny parts of the atoms in your hair, called ELECTRONS, collected on the comb. These electrons have a NEGATIVE charge. Remember that, its important. Now that the comb has a negative charge, it is attracted to things that have a POSITIVE charge. It is similar to the way some magnets are attracted to certain metals.

When you bring the negatively charged comb near the faucet it is attracted to the POSITIVE force of the water. The attraction is strong enough to actually pull the water towards the comb as it is flowing!

- **Dancing Raisins (Ages 5+)**

Materials:

- 1 can of clear soda (e.g., soda water, Sprite)
- 1 tall clear glass or plastic cup
- Several raisins (fresh work best)

Raisins are denser than the liquid in the soda, so initially they sink to the bottom of the glass. The carbonated soft drink releases carbon dioxide bubbles. When these bubbles stick to the rough surface of a raisin, the raisin is lifted because of the increase in buoyancy. When the raisin reaches the surface, the bubbles pop, and the carbon dioxide gas escapes into the air. This causes the raisin to lose buoyancy and sink. This rising and sinking of the raisins continues until most of the carbon dioxide has escaped, and the soda goes flat. Furthermore, with time the raisin gets soggy and becomes too heavy to rise to the surface.

- **Silly Putty (Ages 6+)**

Materials:

- ½ cup of Elmer's Glue
- ½ cup of liquid starch
- Food coloring (optional)

Steps:

1. Gather ingredients
2. Mix well the Elmer's Glue and starch together
3. Mix in the food coloring (optional)
4. Have fun playing with your silly putty!

Suggestions: Roll putty into a ball. Press flat. Place on a piece of newspaper. Peel off of newspaper carefully. The image will have transferred to the putty!

Art Projects

- **Paper Plate Butterfly (Ages 5+)**

Materials:

- 1 paper plate
- Glue
- 1 Empty toilet paper tube

- Markers, paints, and/or construction paper
 - Scissors
 - 1 pipe cleaner (optional)
 - Wiggle eyes (optional)
1. Decorate the paper plate. The plate will be the butterfly's wings.
 2. Paint, color, or wrap the toilet paper tube in paper, so that it is black.
 3. Cut the paper plate in half. Make it wavy like the edge of a butterfly's wing.
 4. Glue the wings onto the roll so that the rounded plate edges are touching the body.
 5. Draw or glue eyes onto the body.
 6. Cut a piece of pipe cleaner (3-4 in.) and bend in middle to make antennae. Glue antennae to the body.

- **Spiral Snake (Ages 5+)**

Materials:

- 1 paper plate
 - Paint, markers, or crayons
 - Scissors
 - Ribbon or paper
 - Wiggle eyes (optional)
1. Color both sides of the plate however you want your snake decorated.
 2. Start cutting the plate, working from the outside-in. Cut into a spiral shape. The outside edge will be the tail and the inside edge will be the head, so you want to cut the outside edge a little thinner and get thicker as you get towards the middle.
 3. Make the snake's face. Glue or draw on eyes. Cut a piece of ribbon or paper to look like the tongue. Glue tongue to the edge of the plate.

- **Edible Play Dough (Ages 3+)**

Materials:

- Measuring cup
- Mixing bowl
- Spoon/spatula
- Equal Parts-
 - Honey
 - Sugar
 - Peanut Butter

Description:

Ingredients form an edible dough that can be shaped and molded.

Steps

1. Combine ingredients in mixing bowl.

2. Stir/knead until the mixture achieves a semi-firm consistency
3. Distribute dough to children
4. Get creative!
5. Eat after done (optional)

Suggestions: Can work on conservation skills with children 4+. Divide dough into 2 equal pieces. Roll one piece into a fat snake shape and roll the other piece in a long skinny snake shape. Ask which one “has more”.

- **Dryer Lint as Modeling Dough (Ages 6+)**

Materials:

- Dryer lint (about 3 cups)
- Water
- Flour
- Vegetable Oil
- Food coloring (optional)

Description:

In this activity, dryer lint is turned in to a Play-Doh type substance that can be shaped and molded.

To make the modeling dough:

1. Place 3 cups (shredded) dryer lint into a pot.
2. Pour in 2 cups water.
3. Stir in 1 cup flour.
4. Add ½ teaspoon vegetable oil. (add food coloring, if desired)
5. Stir continuously over low heat until the mixture binds together and is of a smooth consistency.
6. Pour onto a sheet of wax paper to cool.

- **Bubble Paint (Ages 4+)**

Materials:

- Bottled bubbles (that comes with bubble wand)
- Tempra paint/ Poster paint
- Paper

Description:

This is an art activity where kids can make paint creations with bubbles blown onto pieces of paper. The paint creates a swirly effect on the bubble. When the bubble hits the paper, it pops, leaving the swirly paint design behind.

Steps:

1. Mix paint with bubble potion
2. Lay down a piece of paper

3. Demonstrate how to blow a bubble directed at the paper
4. Point out the swirly paint effect
5. Allow child(ren) to take their turn

Suggestions: Make a solar system using bubbles to make the planets (e.g., use blue and green paint for Earth, red for Mars. etc)

Physical Activities

- **Hot and Cold (Ages 4+)**

Materials:

Anything!

Description:

This is a game where children are able to hide and find objects. An object is hidden. The finder wanders the room trying to discover the object. The finder is given clues that he is close to the item, "hot," or far from the item, "cold".

Steps:

1. Choose one child to be the "Finder."
2. Send him out of the room while the rest of the players hide an object, like a red ball, somewhere in the room.
3. Ask the Finder to come back and look for the ball, while the other players shout out hints: "You're getting hotter" or "you're getting colder."
4. Play until the object is found, then give everyone a turn as the Finder.

- **Call Ball (Ages 4+)**

Materials:

1 Ball

Group of children

Description:

A simple, quick, and exciting game that gets kids out of the house and into physical activity.

Steps:

1. Children stand in a circle
2. Choose a leader, the leader then stands in the center of the circle
3. Players should be 2 arm lengths apart
4. The leader tosses a rubber ball into the air, as it then hits the ground he shouts the name of a child in the circle. That child then must catch the ball before it bounces a second time.
5. If he can, then he is the winner and the new leader

- **Hopscotch (Ages 4+)**

Materials:

Chalk
Open area
Rock/bean bag

Steps:

1. Use chalk to draw a hopscotch pattern on the ground
2. Create a diagram with 8 sections and number them, similar to the picture
3. Each player has a marker such as a rock or bean bag
4. The first player stands behind the starting line and tosses their marker in square 1. Hop over square 1 to square 2 and then continue hopping to square 8, turn around, and hop back again. Pause in square 2 to pick up the marker, hop in square 1, and out. Then continue by tossing the stone in square 2.
 - *All hopping is done on one foot unless the hopscotch design is such that two squares are side-by-side. Then two feet can be placed down with one in each square.
 - *A player must always hop over any square where a marker has been placed.

Note: A player is out if the marker fails to land in the proper square, the hopper steps on a line, the hopper loses balance when bending over to pick up the marker and puts a second hand or foot down, the hopper goes into a square where a marker is, or if a player puts two feet down in a single box. The player puts the marker in the square where he or she will resume playing on the next turn, and the next player begins.

APPENDIX E

Smiley Face Satisfaction Scale



Table 1.

Session 2 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	7	7

Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	83%	70%

Table 2.

Session 3 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	5	7
<hr/>		
Helping Parents		
Helpfulness ratings	7	7
Compliance ratings	7	7
<hr/>		
Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	81%	67%
Helping Parents	98%	98%

Table 3.

Session 5 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	7	7
<hr/>		
Helping Parents		
Helpfulness ratings	7	7
Compliance ratings	5	5
<hr/>		
Catch My Parents Being Good		
Helpfulness ratings	5	7
Compliance ratings	5	5
<hr/>		
Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	45%	42%
Helping Parents	94%	89%
Catch My Parents Being Good	96%	97%

Table 4.

Session 6 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	5	7

Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	92%	71%

Table 5.

Session 7 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	5	7
Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	91%	--

Table 6.

Session 8 Feasibility Data

Why I'm Special	Mother	Daughter
Helpfulness ratings	7	7
Compliance ratings	5	5
<hr/>		
Helping Parents		
Helpfulness ratings	7	7
Compliance ratings	5	5
<hr/>		
Catch My Parents Being Good		
Helpfulness ratings	6	1
Compliance ratings	5	4
<hr/>		
Protocol Adherence	Therapist	Independent Reviewer
Why I'm Special	71%	80%
Helping Parents	100%	100%
Catch My Parents Being Good	72%	72%

Table 7.

Scores on Outcome Measures

Outcome Measure/ Subscale	Assessment			
	Pre-treatment	Month 1	Month 2	Post-treatment
CAPI Abuse	54			42
CAPI Lie	6			10
CAPI Inconsistency	2			4
CAPI Random Responding	3			5
PSI-SF Stress	80			--
PSI-SF Parent/Child Dysfunction	17			15
PSI-SF Defensive Responding	25			18
FES Conflict	39*			44*
FES Cohesion	59*			59*
ECBI Problem	59*	47*	47*	42*
ECBI Intensity	47*	41*	41*	44*
TLFB Marijuana	119			94
TLFB Methamphetamine	1			0
SCID-IV Marijuana Dependence	Present (Current)			Present (Lifetime)
SCID-IV Methamphetamine Dependence	Present (Current)			Present (Lifetime)
Urinalysis: Marijuana	Positive			Positive
Urinalysis: Methamphetamine	Positive			Negative

*Scores reported are T-scores.

Table 8.

PSCS scores

Parental satisfaction with child's:	Assessment/Treatment session									
	Pre	1	2	3	4	5	6	7	8	Post
1. Communication	30	30	70	80	90	80	70	80	80	90
2. Relationship with parent	30	40	60	80	80	80	70	100	80	90
3. Reaction to praise/attention	70	90	90	80	100	80	90	100	80	90
4. Compliance	80	50	60	80	80	80	50	90	80	90
5. Reaction to redirection/punishment	80	60	0	80	80	80	50	80	80	90
6. Ability to follow household rules	80	60	70	80	80	80	70	80	80	80
7. Family involvement	80	60	70	80	90	80	70	100	80	70
8. Safety skills	80	90	90	80	90	80	90	90	80	90
9. Performance of household chores	80	80	50	80	70	80	50	100	80	90
10. School & educational activities	100	90	100	80	100	80	80	100	80	100
11. Overall satisfaction with child	50	60	80	80	80	80	50	100	80	100

REFERENCES

- Abidin, R.R. (1995). *Parenting Stress Index: Professional Manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources, Inc.
- Allin, H., Wathen, C. N., & MacMillan, H. (2005). Treatment of child neglect: A systematic review. *Canadian Journal of Psychiatry*, 50, 497-504.
- Andreas, J.B., O'Farrell, T.J., & Fals-Stewart, W. (2006). Does individual treatment for alcoholic fathers benefit their children? A longitudinal assessment. *Journal of Consulting and Clinical Psychology*, 74, 191-198.
- Aragona, J.A. & Eyberg, S. (1981). Neglected children: Mothers' report of child behavior problems and observed verbal behavior. *Child Development*, 52, 596-602.
- Azrin, N.H., Acierno, R., Kogan, E.S., Donohue, B., Besalel, V.A., & McMahon, P.T. (1996). Follow-up results of supportive versus behavioral therapy for illicit drug use. *Behaviour Research and Therapy*, 34, 41-46.
- Azrin, N.H., Donohue, B., Besalel, V.A., Kogan, E.S., & Acierno, R. (1994). Youth drug abuse treatment: A controlled outcome study. *Journal of Child & Adolescent Substance Abuse*, 3, 1-15.
- Azrin, N.H., McMahon, P.T., Donohue, B., Besalel, V.A., Lapinski, K.J., Kogan, E.S., et al. (1994). Behavior therapy for drug abuse: A controlled treatment outcome study. *Behaviour Research and Therapy*, 32, 857-866.
- Bartlett, M.Y., & DeSteno, D. (2006). Gratitude and prosocial behavior: helping when it costs you. *Psychological Science*, 17, 319-325.

- Black, M. M. (2000). The roots of child neglect. In R. M. Reece (Ed.), *Treatment of child abuse: Common ground for mental health, medical, and legal practitioners* (pp. 157–164). Baltimore: Johns Hopkins University Press.
- Block, R.W., Krebs, N.F., Hibbard, R.A., Jenny, C., Kellogg, N.D., Spivak, B.S., et al. (2005). Failure to thrive as a manifestation of child neglect. *Pediatrics*, 116, 1234-1237.
- Boyer, D. & Fine, D. (1990). *Victimization and Other Risk Factors for Child Maltreatment Among School Age Parents: A Longitudinal Study*. Washington, DC: U.S. Department of Health and Human Services.
- Brown, J., Cohen, P., Johnson, J. G., & Salzinger, S. (1998). A longitudinal analysis of risk factors for child maltreatment: Findings of a 17-year prospective study of officially recorded and self-reported child abuse and neglect. *Child Abuse and Neglect*, 22, 1065-1078.
- Brunk, M., Henggeller, S.W., & Whelan, J.P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, 55, 171–193.
- Bugental, D.B. & Happeney, K. (2004). Predicting child maltreatment in low-income families: The interactive effect of maternal attributions and child status at birth. *Developmental Psychology*, 40, 234-243.
- Burack, J.A., Flanagan, T., Peled, T., Sutton, H.M., Zygmuntowicz, C., & Manly, J.T. (2006). Social perspective-taking skills in maltreated children and adolescents. *Developmental Psychology*, 42, 207-217.

- Burgess, R.L. & Conger, R.D. (1978). Family interaction in abusive, neglectful and normal families. *Child Development*, 49, 1163-1173.
- Carter, V., & Myers, M. (2007). Exploring the risks of substantiated physical neglect related to poverty and parental characteristics: A national sample. *Children and Youth Services Review*, 29, 110-121.
- Ceballo, R., & McLoyd, V.C. (2002). Social support and parenting in poor, dangerous neighborhoods. *Child Development*, 73, 1310-1321.
- Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse Neglect*, 20, 191-203.
- Chandra, A., Martinez, G.M., Mosher, W.D., Abma, J.C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital Health Stat*, 23.
- Child Welfare Information Gateway. (2008). What is child abuse and neglect. Retrieved online from www.childwelfare.gov/pubs/factsheets/whatiscan.cfm.
- Cohen, J.A., Mannarino, A.P., Murray, L.K., & Igleman, R. (2006). Psychosocial interventions for maltreated and violence exposed children. *Journal of Social Issues*, 62, 737-766.
- Colvin, A., Eyberg, S.M. & Adams, C.D. (1999). Restandardization of the Eyberg Child Inventory. Gainesville, FL: University of Florida, Child Study Laboratory. Available online at <http://www.pcit.org>.

- Crittenden, P.M. (1999). Child neglect: Causes and contributors. In H. Dubowitz (Ed.), *Neglected children: Research, practice, and policy* (pp. 47–68). Thousand Oaks, CA: Sage Publications.
- Crozier, J.C. & Barth, R.P. (2005). Cognitive and academic functioning in maltreated children. *Children and Schools*, 27, 197-206.
- Culp, R.E., Little, V., Letts, D., & Lawrence, H. (1991). Maltreated children's self-concept: Effects of a comprehensive treatment program. *American Journal of Orthopsychiatry*, 6, 114–21.
- Curenton, S.M., McWey, L.M., & Bolen, M.G. (2009). Distinguishing maltreating versus normal treating at-risk families: Implications for foster care and early childhood education interventions. *Families in Society: The Journal of Contemporary Social Services*, 90, 176-182.
- De-Oliveira, C.A., Moran, G., & Pederson, D.R. (2005). Understanding the link between maternal adult attachment classifications and thoughts and feelings about emotions. *Attachment & Human Development*, 7, 153–170.
- De Paul, J., & Guibert, M. (2008). Empathy and child neglect: A theoretical model. *Child Abuse and Neglect*, 32, 1063-1071.
- DePanifilis, D. & Salus, M.K. (2008). *A Coordinated Response to Child Abuse and Neglect: A Basic Manual*. McClean, VA: Circle, Inc.
- Donnellan, M.B., Trzesniewski, K.H., Robins, R.W., Moffitt, T.E., & Caspi, A. (2005). Low self-esteem is related to aggression, antisocial behavior, and delinquency. *Psychological Science*, 16, 328-335.

- Donohue, B., Azrin, N.H., Strada, M.J., Silver, N.C., Teichner, G., Murphy, H. (2004). Psychometric evaluation of self- and collateral Timeline Follow-Back Reports of drug and alcohol use in a sample of drug-abusing and conduct-disordered adolescents and their parents. *Psychology of Addictive Behaviors*, 18, 184-189.
- Donohue, B., DeCato, L. A., Azrin, N. H., & Teichner, G. A. (2001). Satisfaction of parents with their conduct-disordered and substance-abusing youth. *Behavior Modification*, 25, 21-44.
- Donohue, B., Romero, V., & Hill, H.H. (2006). Treatment of co-occurring child maltreatment and substance abuse. *Aggression and Violent Behavior*, 11, 626-640.
- Downing-Tsushima, T.M. (2006). Parents' Perceptions of their Adolescent Children, Parental Resources, and Satisfaction in the Parent Role. Paper presented at the annual meeting of the American Sociological Association, Montreal Convention Center, Montreal, Quebec, Canada Online <PDF>. 2009-05-25 from http://www.allacademic.com/meta/p105403_index.html
- Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P., Williamson, D.F., & Giles, W.H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*, 286, 3089-3096.
- Dubowitz, H. (1999). The families of neglected children. In M. E. Lam (Eds.), *Parenting and child development in "non-traditional" families* (pp. 327-345). Mahwah: Lawrence Erlbaum Associates.

- Dunst, C.J., Trivette, C.M., & Cross, A.H. (2002). Mediating influences of social support: Personal, family, and child outcomes. In J. Blacher & B. L. Baker (Eds.). *The Best of AAMR: Families and Mental Retardation: A Collection of Notable AAMR Journal Articles Across the 20th Century* (pp. 119-133). American Association on Mental Retardation. Washington, DC.
- Eberly, M.B., & Montemayor, R. (1998). Doing good deeds: An examination of adolescent prosocial behavior in the context of parent-adolescent relationships. *Journal of Adolescent Research*, 13, 403-432.
- Egeland, B. & Sroufe, L.A. (1981). Attachment and early maltreatment. *Child Development*, 52, 44-52.
- Eisenberg, N., Fabes, R.A. (1991). Prosocial behavior and empathy: A multimethod developmental perspective. In M.S. Clark, (Ed), *Prosocial behavior. Review of personality and social psychology*, Vol. 12. (pp. 34-61). Thousand Oaks, CA: Sage Publications, Inc.
- Erickson, M. F., & Egeland, B. (2002). Child neglect. In J. E. B. Myers & L. Berliner (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 3-20). Thousand Oaks, CA: Sage Publications.
- Eyberg, S.M., Funderburk, B.W., Hembree-Kigin, T.L., McNeil, C.B., Querido, J.G. & Hood, K.K. (2001). Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child & Family Behavior Therapy*, 23, 1-20.

- Eyberg, S.M. & Pincus, D. (1999). ECBI Eyberg Child Behavior Inventory and SESBI-R Sutter - Eyberg Student Behavior Inventory - Revised, Professional manual. Odessa, FL: Psychological Assessment Resources, Inc.
- Fals-Stewart, W., Birchler, G.R., & O'Farrell, T.J. (1996). Behavioral couples therapy for male substance-abusing patients: Effects on relationship adjustment and drug-using behavior. *Journal of Consulting and Clinical Psychology*, 64, 959-972.
- Fals-Stewart, W., Golden, J., & Schumacher, J. (2003). Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviors*, 28, 1555-1574.
- Fantuzzo J., Sutton-Smith B., Atkins M., Meyers R., Stevenson H., Coolahan, K., et al. (1996). Community-based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Consulting and Clinical Psychology*, 64, 1377-1386.
- Fantuzzo, J., Weiss, A., Atkins, M., Meyers, R., & Noone, M. (1998). A contextually relevant assessment of the impact of child maltreatment on the social competencies of low-income urban children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1201-1208.
- Farrel, A.F., Britner, P.A., Guzzardo, M., & Goodrich, S. (2010). Supportive housing for families in child welfare: Client characteristics and their outcomes at discharge. *Child and Youth Services Review*, 32, 145-154.
- Field, T.M., Scafidi, F., Pickens, J., Prodromidis, M., Pelaez-Nogueras, M., Torquati, J., Wilcox, H., Malphurs, J., Schanberg, S., & Kuhn, C. (1998). Polydrug-using

adolescent mothers and their infants receiving early intervention.

Adolescence, 33, 117-143.

FitzGerald, D.P. & White, K.J. (2003). Linking children's social worlds: Perspective-taking in parent-child and peer contexts. *Social Behavior and Personality*, 31 (5), 509-522.

First, M.B., Spitzer, R.L, Gibbon, M., & Williams, J.B.W. (1996). *Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV)*. Washington, D.C.: American Psychiatric Press, Inc.

Foote, R.C., Schuhmann, E.M., Jones, M.L., & Eyberg, S.M. (1998). Parent-child interaction therapy: A guide for clinicians. *Clinical Child Psychology and Psychiatry*, 3, 361-373.

Gershater-Molko, R.M., Lutzker, J.R., & Wesch, D. (2002). Using recidivism data to evaluate Project SafeCare: Teaching “bonding”, safety, and health care skills to parents. *Child Maltreatment*, 7, 277-285.

Gershater-Molko, R.M., Lutzker, J.R., & Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at risk for child maltreatment. *Journal of Family Violence*, 18, 377-386.

Gilbert, R., Widom, C.S., Browne, K., Fergusson, E., Webb, D., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, 373, 68-81.

Glaser, D. (2008). Child maltreatment: Influences of Psychopathology. *Psychiatry*; 7, 295-298.

- Gross, D., Fogg, L., & Tucker, S. (1995). The efficacy of parent training for promoting positive parent–toddler relationships. *Research in Nursing & Health*, 18, 489-499.
- Guendelman, S., Wyn, R., & Tsai, Y. (2000). Children of working low-income families in California: Does parental work benefit children's insurance status, access, and utilization of primary health care? *Health Services Research*, 35, 417-441.
- Guterman, N.B., Lee, S.J., Taylor, C.A., & Rathouz, P.J. (2009). Parental perceptions of neighborhood processes, stress, personal control, and risk for physical child abuse and neglect. *Child Abuse and Neglect*, 33, 897-906.
- Haveman, R., Wolfe, B. & Peterson, E. (1997). Children of Early Childbearers as Young Adults. In R. Maynard (Ed.). *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. Washington, DC: Urban Institute Press.
- Higgins S.T., Budney A.J., Bickel W.K., Hughes J.R., Foerg F., & Badger G. (1993). Achieving cocaine abstinence with a behavioral approach. *American Journal of Psychiatry*, 150, 763-769.
- Higgins, S.T., Budney, A.J., Bickel, W.K., Foerg, F.E., Donham R., & Badger, G.J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry*, 51, 568-76.
- Hildyard, K.L. & Wolfe, D.A. (2002). Child neglect: developmental issues and outcomes. *Child Abuse Neglect*, 26, 679-695
- Hildyard, K.L. & Wolfe, D.A. (2007). Cognitive processes associated with child neglect. *Child Abuse and Neglect*, 31, 895-907.
- Hoffman, S.D. (2008). *Kids having kids: economic costs and social consequences of teen pregnancy*. The Urban Institute Press.

- Hood, K.K. & Eyberg, S.M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child & Adolescent Psychology*, 32, 419-429.
- Hopkins, K.D. & Stanley, J.C. (1981). *Educational and psychological measurement and evaluation* (6th ed.). Englewood Cliffs: Prentice Hall.
- Hoza, B., Owens, J. S., Pelham, W. E., Jr., Swanson, J. M., Conners, C. K., Hinshaw, S. P., et al. (2000). Parent cognitions as predictors of child treatment response in attention-deficit/hyperactivity disorder. *Journal of Abnormal Child Psychology*, 28, 569-583.
- Jinseok, K. (2009). Type-specific intergenerational transmission of neglectful and physically abusive parenting behaviors among young parents. *Children and Youth Services Review*, 31, 761-767.
- Jones, T.L. & Prinze, R.J. (2005). Potential roles of parental self-efficacy in parent and child adjustment: A review. *Clinical Psychology Review*, 25, 341-363.
- Kelleher, K., Chaffin, M., Hollenberg, J., & Fischer, E. (1994). Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample. *American Journal of Public Health*, 84, 1586-1590.
- Kelley, M.L. & Fals-Stewart, W. (2004). Psychiatric disorders of children living with drug-abusing, alcohol-abusing, and non-substance-abusing fathers. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 621-628.
- Kelley, M.L. & Fals-Stewart, W. (2008). Treating paternal drug abuse using Learning Sobriety Together: Effects on adolescents versus children. *Drug and Alcohol Dependence*, 92, 228-238.

- Kelly, S. J. (2002). Child maltreatment in the context of substance abuse. In J. E. B. Myers, L. Belmer, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reed (Eds.), *The APSAC handbook on child maltreatment* (pp. 105–115). Thousand Oaks, CA: Sage.
- Kestenbaum, R., Farber, E.A., & Sroufe, L.A. (1989). Individual differences in empathy among preschoolers: Relation to attachment history. In I. Bretherton & M.W. Watson (Eds.), *Children's perspectives on the family: New directions for child development* (pp. 51–64). San Francisco: Jossey-Bass.
- Kim, J. & Cicchetti, D. (2004). A longitudinal study of child maltreatment, mother-child relationship quality, and maladjustment: The role of self-esteem and social competence. *Journal of Abnormal Child Psychology*, 32, 341-354.
- Klevens, R.M. & Luman, E.T. (2001). U.S. children living in and near poverty: risk of vaccine-preventable diseases. *American Journal of Preventative Medicine*, 20, 41-46.
- Knafo, A. & Plomin, R. (2006). Parental discipline and affection and children's prosocial behavior: Genetic and environmental links. *Journal of Personality and Social Psychology*, 90, 147-164.
- Kohen, D.E., Leventhal, T., Dahinten, V.S., & McIntosh, C.N. (2008). Neighborhood disadvantage: Pathways of effects for young children. *Child Development*, (79), 156-169.
- Lam, W.K., Fals-Stewart, W., & Kelley, M.L. (2009). Parent training with behavioral couples therapy for father's alcohol abuse: Effects on substance use, parental relationship, parenting, and CPS involvement. *Child Maltreatment*, 14, 243-254.

- Levendosky, A., Okun, A., & Parker, J. (1995). Depression and maltreatment as predictors of social competence and social problem-solving skills in school-age children. *Child Abuse & Neglect*, 19, 1183-1195.
- Liu, J., Bann, C., Lester, B., Tronick, E., Das, A., Lagasse, L., Bauer, C., Shankaran, S., & Bada, H. (2010). Neonatal neurobehavior predicts medical and behavioral outcome. *Pediatrics*, 125, 90-98.
- Lupinetti, L.J. (1999). "Perspective-taking, social competence, gender, and prosocial behavior of suburban preschool children". ETD Collection for Fordham University. Paper AAI9960949.
- Lutzker, J.R., Bigelow, K.M., Doctor, R.M., Kessler, M.L. (1998). Safety, health care, and bonding within an ecobehavioral approach to treating and preventing child abuse and neglect. *Journal of Family Violence*, 13, 163-185.
- Maughan, A. & Cicchetti, D. (2002). Impact of child maltreatment and interadult violence on children's emotion regulation abilities and socioemotional adjustment. *Child Development*, 73, 1525-1542.
- Mersky, J.P., Berger, L.M., Reynolds, A.J., & Gromoske, A.N. (2009). Risk factors for child and adolescent maltreatment. *Child maltreatment*, 14, 73-88.
- McCauley, J., Kern, D.E., Kolodner, K., Dill, L., Schroeder, A.F., DeChant, H.K., et al. (1997). Clinical characteristics of women with a history of childhood abuse: Unhealed wounds. *Journal of the American Medical Association*, 277, 1362-1368.
- McCullough, M.E., Kimeldorf, M.B., & Cohen, A.D. (2008). An adaptation for altruism? The social causes, social effects, and social evolution of gratitude. *Current Directions in Psychological Science*, 17, 281-285.

- McMahon, S.D., Wernsman, J., & Parnes, A.L. (2006). Understanding prosocial behavior: The impact of empathy and gender among African American adolescents. *Journal of Adolescent Health, 39*, 135-137.
- Milner, J. (1986). *The Child Abuse Potential Inventory Manual*, DeKalb, IL: Psytec Inc.
- Moos, R. & Moos, B. (1994). *Family Environment Scale Manual: Development, Applications, Research* (3rd ed.). Palo Alto, CA: Consulting Psychologist Press.
- O'Farrell, T. J. & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse*. New York: Guilford.
- O'Farrell, T.J., Murphy, M., Alter, J., & Fals-Stewart, W. (2010). Behavioral family counseling for substance use: A treatment development pilot study. *Addictive Behaviors, 35*, 1-6.
- O'Leary, K. D. & Schumacher, J. A. (2003). The association between alcohol use and intimate partner violence: Linear effect, threshold effect, or both? *Addictive Behaviors, 28*, 1575-1585.
- Ondersma, Simpson, S.M., Brestan E.V., & Ward, M. (2000). Prenatal drug exposure and social policy: The search for an appropriate response. *Child Maltreatment, 5*, 93-108.
- Ornoy, (2002). The effects of alcohol and illicit drugs on the human embryo and fetus. *The Israel Journal of Psychiatry and Related Sciences, 39*, 120-132.
- Osborne, C. & Berger, L. M. (2009). Parental substance abuse and child well-being: A consideration of parents' gender and coresidence. *Journal of Family Issues, 30*, 341–370.

- Pears, K.C. & Capaldi, D.M. (1999). Intergenerational transmission of abuse: A two-generational prospective study of an at-risk sample. *Child Abuse and Neglect*, 25, 1439-1461.
- Peterson, L., Gable, S., Doyle, C., & Ewigman, B. (1997). Beyond parenting skills: Battling barriers and building bonds to prevent child abuse and neglect. *Cognitive and Behavioral Practice*, 4, 53-74.
- Petry, N.M. (2002). Low-cost contingency management for treating cocaine- and opioid-abusing methadone patients. *Journal of Consulting and Clinical Psychology*, 70, 398-404.
- Pulsifer, M.B., Butz, A.M., Foran, M., & Belcher, H.M. (2008). Prenatal drug exposure: Effects on cognitive functioning at 5 years of age. *Clinical Pediatrics*, 47, 58-65.
- Reams, R. & Friedrich, W. (1994). The efficacy of time-limited play therapy with maltreated preschoolers. *Journal of Clinical Psychology*, 50, 889-899.
- Romero, V., Donohue, B., & Allen, D.N. (2010). Treatment of concurrent substance dependence, child neglect, and domestic violence: A single case examination involving family behavior therapy. *Journal of Family Violence*.
- Saewyc, E.M. & Tonkin, R. (2008). Surveying adolescents: Focusing on positive development. *Paediatrics and Child Health*, 13, 43-47.
- Sagy, S. & Dotan, N. (2001). Coping resources of maltreated children in the family: A salutogenic approach. *Child Abuse and Neglect*, 25, 1463-1480.
- Santisteban, D.A., Coatsworth, J.D., Perez-Vidal, A., Kurtines, W.M., Schwartz, S.J., LaPerriere, A., & Szapocnik, J. (2003). Efficacy of brief strategic family therapy

- in modifying Hispanic adolescent behavior problems and substance use. *Journal of Family Psychology*, 17, 121-133.
- Scafidi, F.A., Field, T.M., Wheeden, A., Schanberg, S., Kuhn, C., Symanski, R., Zimmerman, E., Bandstra, E.S. (1996). Cocaine-exposed preterm neonates show behavioral and hormonal differences. *Pediatrics*, 97, 851-85.
- Scannapieco, M. & Connell-Carrick, K. (2005). *Understanding child maltreatment: An ecological and behavioral perspective*. New York: Oxford.
- Schatz, J.N., Smith, L.E., Borkowski, J.G., Whitman, T.L., & Keogh, D.A. (2008). Maltreatment risk, self-regulation, and maladjustment in at-risk children. *Child Abuse and Neglect*, 32, 972-982.
- Schuhmann, E.M., Foote, R.C., Eyberg, S.M., Boggs, S.R., & Algina, J. (1998). Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short term maintenance. *Journal of Clinical Child Psychology*, 27, 34-45.
- Schumacher, J.A., Slep, A.M.S., & Heyman, R.E. (2001). Risk factors for child neglect. *Aggression and Violent Behavior*, 6, 231–254.
- Sedlak, A.J. & Broadhurst, D.D. (1996). *Third national incidence study of child abuse and neglect. Executive summary*. Washington, DC: U.S. Department of Health and Human Services.
- Shonk, S.M. & Cicchetti, D. (2001). Maltreatment risk, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology*, 37, 3-17.
- Slack, K.S., Holl, J.L., McDaniel, M., Yoo, J., & Bolger, K. (2004). Understanding the risk of child neglect: An exploration of poverty and parenting characteristics. *Child Maltreatment*, 9, 395-408.

- Sobell, M.B., Sobell, L.C., Klajner, F., Pavan, D., & Basian, E. (1986). The reliability of a timeline method for assessing normal drinker college students' recent drinking history: Utility for alcohol research. *Addictive Behaviors*, 11, 149-161.
- Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1992). The structured clinical interview for the DSM-III-R (SCID): I. History, rationale, and description. *Archives of General Psychiatry*, 49, 624-629.
- Sprang, G., Clark, J.J., & Bass, S. (2005). Factors that contribute to child maltreatment severity: A multi-method and multidimensional investigation. *Child Abuse and Neglect*, 29, 335-350.
- Stanger, C., Higgins, S.T., Bickel, W.K., Elk, R., Grabowski, J., Schmitz, J., Amass, L., Kirby, K.C., & Seracini, A. M. (1999). Behavioral and emotional problems among children of cocaine- and opiate dependent opiate dependent parents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 421-428.
- Sullivan, P.M. & Knuston, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect*, 24, 1257-1273.
- Timmer, S.G., Urquiza, A.J., Zebell, N.M., & McGrath, J.M. (2005). Parent-child interaction therapy: application to maltreating parent-child dyads. *Child Abuse and Neglect*, 29, 845-842.
- Tsang, J.A. (2006). Gratitude and prosocial behaviour: An experimental test of gratitude. *Cognition and Emotion*, 20, 138-148.
- Tyler, S., Allison, A., & Winsler, A. (2006). Child neglect: Developmental consequences, intervention, and policy implications. *Child and Youth Care Forum*, 35, 1-20.

- Tyler, K.A., Hoyt, D.R., Whitbeck, L.B., & Cauce, A.M. (2001b). The effects of a high-risk environment on the sexual victimization of homeless and runaway youth. *Violence & Victims*, 16, 441–455.
- Tyler, K.A., Johnson, K.A., & Brownridge, D.A. (2008). A longitudinal study of the effects of child maltreatment on later outcomes among high-risk adolescents. *Journal of Youth and Adolescence*, 37, 506-521.
- Udwin, O. (1983). Imaginative play training as an intervention method with institutionalized preschool children. *British Journal of Educational Psychology*, 53, 32–39.
- Urquiza, A.J. & McNeil, C.B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment*, 1, 134-144.
- U.S. Department of Health and Human Services. (2009). *Child Maltreatment 2007*. Washington, DC: U.S. Government Printing Office.
- Velleman, R. & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment*, 13, 79-89.
- Webster-Stratton, C. (1990b). Long-term follow-up of families with young conduct problem children: From preschool to grade school. *Journal of Clinical Child Psychology*, 19, 144-149.
- Webster-Stratton, C. (1990c). Stress: A potential disruptor of parent perceptions and family interactions. *Journal of Clinical Child Psychology*, 19, 302-312.

- Webster-Stratton, C. & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65*, 93-109.
- Webster-Stratton, C. & Reid, J.M. (2003). Treating conduct problems and strengthening social and emotional competence in young children: The Dina Dinosaur treatment program. *Journal of Emotional and Behavior Disorders, 11*, 130-143.
- Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Social skills and problem solving training for children with early onset conduct problems: Who benefits? *Journal of Child Psychology and Psychiatry, 42*, 943-952.
- Whitbeck, L.B., & Simons, R.L. (1990). Life on the streets: The victimization of runaway and homeless adolescents. *Youth & Society, 22*, 108-125.
- Williams, J.H., & Ross, L. (2007). Consequences of prenatal toxin exposure for mental health in children and adolescents: A systematic review. *European Journal of Child and Adolescent Psychiatry, 16*, 243-253.
- William son, J., Borduin, C., & Howe, B. (1991). The ecology of adolescent maltreatment: A multi- level examination of adolescent physical abuse, sexual abuse, and neglect. *Journal of Consulting and Clinical Psychology, 59*, 449-457.
- Wilson, S.R., Rack, J.J., Shi, X., & Norris, A.M. (2008). Comparing physically abusive, neglectful, and non-maltreating parents during interactions with their children: A meta analysis of observational studies. *Child Abuse and Neglect, 32*, 897-911.
- Winters, J., Fals-Stewart, W., O'Farrell, T.J., Birchler, G.R., & Kelley, M.L. (2002). Behavioral couples therapy for female substance-abusing patients: Effects on

substance use and relationship adjustment. *Journal of Consulting and Clinical Psychology*, 70, 344-355.

Wolfe, D.A. (1994). The role of intervention and treatment services in the prevention of child abuse and neglect. In G.B. Melton & F.D. Barry (Eds.), *Protecting children from abuse and neglect: Foundations for a new national strategy*. New York: Guilford.

Wood, A.M., Maltby, J., Gillett, R., Linley, P.A., & Joseph, S. (2008). The role of gratitude in the development of social support, stress, and depression: Two longitudinal studies. *Journal of Research in Personality*, 42, 854-871.

Young, N.K., Boles, S.M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment*, 12, 137-149.

Zirpoli, T.J. & Bell, R.Q. (1987). Unresponsiveness in children with severe disabilities: Potential effects on parent-child interactions. *The Exceptional Child*, 34, 31-40.

VITA

Graduate College
University of Nevada, Las Vegas

Kendra Tracy

Degrees:

San Diego State University
B.A. in Psychology, May 2003

Publications:

- Donohue, B., Tracy, K., & Sheidow, A.J. (2009). Substance use disorders. In J.C. Thomas & M. Hersen (Eds.), *Handbook of Clinical Psychology Competencies* (pp. 1461-1480). NY: Springer.
- Donohue, B., Allen, D.N., Romero, V., Hill, H.H., Vasaeli, K., LaPota, H., Tracy, K., et al., (2009). Description of a standardized treatment center that utilizes evidence-based clinic operations to facilitate implementation of an evidence-based treatment. *Behavior Modification*, 33, 411-436.
- Donohue, B., Tracy, K., Gorney, S. (2008). Anger (negative impulse) management. In W. O'Donohue & J.E Fisher (Eds.), *General Principles and Empirically Supported Techniques of Cognitive Behavior Therapy* (pp. 115-123). New Jersey: Wiley.

Thesis Title: The Initial Development of Child-Focused Interventions in the Treatment of Maternal Substance Abuse and Child Neglect.

Thesis Examination Committee:

Chairperson, Bradley Donohue, Ph.D.
Committee Member, Daniel Allen, Ph.D.
Committee Member, Jennifer Rennels, Ph.D.
Graduate Faculty Representative, Chad Cross, Ph.D.