Everyone in the agency knows the Smith family. The Smiths and their four children, now ages 8 to 14, first came to the agency’s attention 7 years ago. At that time the family was about to be evicted due to nonpayment of rent and the oldest child was not in school. Mrs. Smith had recently had a miscarriage and the next-to-youngest child was hospitalized with bronchiolitis.

Mr. Smith works only sporadically due to alcoholism and Mrs. Smith has resisted working due to various health problems and because she prefers to stay home with her children. Over the years, despite numerous and frequent crises, the agency has managed to keep the Smiths together. Reports of child neglect have been received intermittently from concerned school officials (the children are not attending), doctors (missed appointments) and recreation leaders (lack of adequate food, poor hygiene). Nearly every resource in the agency and the community has been offered and/or utilized with the family. Now the juvenile court is involved due to shoplifting by the oldest two children.

The Edwards family is new to the CPS workers. A neighbor reported that Ms. Edwards, a single-26 year-old, left her 3-year-old daughter in the care of her 7-year-old while she “went out”. The neighbor heard the younger child crying, knocked on the apartment door and found the children alone. The mother did not return until the following morning.

Incidence

Nationally, in 1993, approximately 879,000 children suffered physical, emotional or educational neglect. This is a rate of 13.1 per 1,000 and accounts for 54 percent of child maltreatment cases (Federal Interagency Forum on Child and Family Statistics, 1997).

Other sources confirm that neglect is the most prevalent form of child maltreatment. Investigations in 1995 determined that about 52 percent of confirmed cases of child maltreatment were due to neglect with an additional 5 percent experiencing emotional maltreatment and an additional 3 percent identified as medical neglect. The 60 percent figure for all types of neglect combined compares to 25 percent for physical abuse, 13 percent for sexual abuse and 14 percent listed as “other abuse”. The figures equal more than 100 percent because some children suffered more than one type of maltreatment (National Child Abuse and Neglect Fact Sheet, 1998).

Cases of neglect are also increasing more rapidly than other forms of child maltreatment. From 1986 to 1993, estimated cases of neglect increased from 507,700 to 1,335,100 nationally, a 163 percent increase. During the same time period estimated cases of physical abuse increased 97 percent to 614,100 and estimated cases of sexual abuse increased 125 percent to 300,200. (National Incidence Study of Child Abuse and Neglect, Sedlack & Broadhurst, 1996).

Neglect can also kill. Statistics on child maltreatment fatalities show that neglect is almost as common a cause as abuse. Gaudin’s review (1993) places the percentage of child maltreatment fatalities due to neglect in the range of 25 to 70 percent with most studies in the range of 40 to 50 percent. In Virginia in FY 1994-95, 11 children (41 percent) died from neglect, while 16 (59 percent) died as a result of abuse. These figures are similar to national data where the range of maltreatment deaths due to neglect for 1992-94 was 40 to 47 percent. Virginia data from FY 1995-96 shows a somewhat different pattern. Five children (20 percent) died from neglect and 20 children (80 percent) died due to physical abuse.

In spite of its prevalence, child neglect receives comparatively little attention in professional literature and research studies (DiLeonardi & Johnson, 1992; Erickson & Egeland, 1996; Trainor, 1983; Wolock & Horowitz, 1984). In 1993, the National Resource Center on Child Abuse and Neglect and the National Clearinghouse on Child Abuse and Neglect Information joined in a compilation and analysis of published research in the area of child neglect for the years 1988-1991. Only 36 research studies and 41 additional articles were found. The author notes that well over 200 journals are published in the field of social work alone. He concludes, “Given the abundance of re-

search journals in several disciplines, the limited amount of published research on child neglect during the four-year period that is the focus of this paper is surprising” (Lloyd, 1993, p. 11).

Defining Neglect

Defining neglect is difficult. It is difficult because of differing cultural and community standards of care. Communities grapple with setting clear guidelines for a minimal acceptable level of care for children. It is also difficult because of the sheer number of subtypes of neglect. Professionals also disagree about whether to focus on parental behaviors, child outcomes, or both. Neglect that is chronic and ongoing may differ from neglect that is transitory, although either can cause severe harm or fatality.

McGovern (1993) notes that each state has independently defined neglect. His examination of state laws yielded 14 different “grounds of neglect” delineated in the codes of the 50 states. McGovern also notes that some states have multiple definitions continued on page 3
PREVENT CHILD ABUSE AFFILIATES

On the Eastern Shore, Children and Parents of the Shore promotes public awareness by serving as a Parent Resource Center. In addition, Nurturing Programs are offered for parents of adolescents and children ages 4 to 12. The Buddies program, based on the Big Brothers-Big Sisters program, has been developed to provide adult mentors to at-risk kids ages 6 to 16. A new program for this affiliate is Healthy Teens, an abstinence-based pregnancy prevention program now offered in Northampton and Accomac County Middle Schools. Contact: Trina Mapp (757) 442-5085.

SCAN (Stop Child Abuse Now) of Northern Virginia is the home of the Court Appointed Special Advocate (CASA) program for Alexandria. Parent Nurturing classes serve Fairfax, Arlington and Alexandria. SCAN has an active speakers’ bureau, with engagements before civic groups and at business and community events. In addition, SCAN provides public education through the distribution of parenting guides, newsletters and public service announcements. The organization offers packets of information on infant care and development to new parents and distributes information on other parenting challenges to parents with children of all ages. Contact: Laura Walsh (703) 836-1820.

Our other northern Virginia Affiliate, Northern Virginia Family Service (NVFS), is a private, nonprofit social service agency whose work is based on a conviction that families are the foundation of our society. Services of the organization address issues of relationships, homelessness, child abuse and health, both mental and physical. Intensive family services offered by the agency include counseling, family preservation services and therapeutic foster care. NVFS is the home agency for three Healthy Families Virginia sites, in Alexandria, Prince William and Arlington. The agency offers Parents Anonymous programs in Alexandria and Arlington. Contact: Trish Thacker (703) 533-9727.

The Waynesboro Office on Youth sponsors a variety of parenting classes. The Parent Nurturing Program for Parents and Adolescents, as well as the Parent Nurturing Program for ages 4 to 12, is offered four times per year. In conjunction with the AMC Wellness Center, a class focusing on Parenting Birth to 5 Years is offered continuously. New this fall is an in-home education program entitled Thrive. In addition to individual instruction, the Thrive program will sponsor twice monthly group parenting workshops designed to offer support and education to area families. The Office is very involved in Child Abuse Prevention Month activities. During April, visitors to local fast-food restaurants received a prevention message through the tray liner project and children participated in a Prevent Child Abuse poster and essay contest. Contact: Carol Blair or Jayne Shaw (540) 942-6757.

Greater Richmond SCAN (Stop Child Abuse Now) coordinates The Family Support Program. This program consists of six professionally-led Parent Support Groups and five Children’s Groups. The groups are free, ongoing and neighborhood-based. Other services that are offered to participants include management, individual/home family therapy, assessments and referrals. SCAN also provides public education to the community through public speaking engagements, the April Blue Ribbon Campaign and newsletters. Contact: Sherry Coor (804) 673-7226.

Bristol Youth Services continues to provide programs for children and youth in the community. During the summer months the agency provides programming and teaches team-building skills at Girls Inc., DARE camp and DSS camp. The team-building program includes adventure games, initiative problems, trust activities and low ropes. It is designed to prevent negative behavior and to create trust, communication, cooperation and fun. During the school year, Second Step, a violence-prevention curriculum, is taught at the elementary school level. The curriculum is designed to reduce impulsive and aggressive behavior in children and increase their level of social competence. Contact: Becky Sensky (540) 645-3793.

These are just a few of the Prevent Child Abuse affiliates serving communities across Virginia. For information on programs available in your community, please call Prevent Child Abuse, Virginia at 1-800-CHILDREN.
Subcategories of Neglect

There is no standardized way to divide neglect into subgroups. Virginia’s Department of Social Services recognizes the following subcategories:

- **Physical Neglect**
  - Abandonment
  - Inadequate supervision
  - Inadequate clothing
  - Inadequate shelter
  - Inadequate personal hygiene
  - Inadequate food
  - Malnutrition

- **Medical Neglect**
  - Failure to obtain emergency care or treatment
  - Failure to obtain necessary emergency care or treatment
  - Failure to obtain necessary dental care or treatment
  - Failure to obtain necessary mental care or treatment

- **Mental Abuse**
- **Failure to Thrive**

The National Incidence Study utilized 17 categories of neglect. Zuravin (1989; 1991) delineates 14 subtypes. Categories of neglect reflect a number of different behaviors. It should be noted that neglect categories tell nothing about the families involved in these behaviors or the factors causing the behaviors (Daro, 1988). Thus, families exhibiting the same type of neglect may not resemble each other and may have different factors accounting for the neglectful acts.

Little attention has been given to severity of neglect (Crouch & Milner, 1993). Differing community standards of care can result in variations in defining neglect. Thus, judgement of neglect is influenced by what a given community considers adequate supervision, household cleanliness, or medical care (Daro, 1988).

Some literature distinguishes between acute and chronic neglect. Chronic neglect is defined as occurring over a three-year or more period of time or as intergenerational. In contrast, newly-neglecting caretakers are thought to be responding to sudden stressors or changes (such as divorce, recent illness, sudden job loss).

One study has documented differences between newly-neglecting parents and chronically-neglecting families (Nelson, Saunders & Landsman, 1993). Those who were categorized as chronic neglectors (when compared to newly-neglecting parents) were more likely to be a two-parent family, be older, be unemployed, have more children, have older children, and have had a child removed from the family’s care. Families with patterns of chronic neglect had more health problems, more inappropriate expectations of their children, and a greater lack in knowledge of child development and parenting. The incomes of the two groups did not differ but those who chronically neglected had a greater number of children, thus fewer dollars per household member. There were no differences in the support services and systems (each group averaged involvement of 5.7 community agencies). While the chronic neglectors had a greater number of problems, the newly-neglecting group was more likely to present with substance abuse problems and confused thinking. Newly-neglecting families were described as facing a crisis because of illness, injury or family dissolution. Newly-neglecting parents (generally mothers) resided far from family support systems and were likely to live in dangerous, drug-ridden neighborhoods (Nelson et al., 1993).

**Factors Contributing to Neglect**

A complex set of factors appear to “set the stage” for neglect. The factors may be inter-related. They can roughly be grouped into headings of demographics, socio-economic, and characterological.

**Demographics.** Families with problems of neglect frequently are headed by a single mother. These families are larger than average, meaning that resources must be spread among a greater number of children (Brayden, et al., 1992; Daro, 1988; Gaudin, 1993; Trainor, 1983).

Teen mothers in particular are thought to be at risk for neglect. Attempts have been made to determine differences between teens who neglect and those who provide adequate parenting. A multiple regression study by Zuravin and DiBlasio (1992) found significant differences between neglectors and non-neglectors in a sample of low income, single-parent teens. Of 11 characteristics examined, 5 distinguished the two groups. Neglect was more likely if mothers had been sexually abused while growing up, and had their first child at a younger age, completed fewer years of school, had a premature or low birth-weight first child and had more than one child during teen-age years.

Further, a model including two variables was moderately successful in predicting neglect. Variables which independently predicted neglect were number of children and educational attainment. Results suggested that these factors are additive. That is, mothers who have fewer years of education and bear their first child at a very young age are at greater risk for neglect than mothers who have only one of these characteristics.

**Special Thanks to…...**

Sarah Malone  
Christine Mace  
Ben Trout  
Michael Rutz  
Ashley Hardwicke

**Continued on page 4**
Publications by the abstract

Chronic Child Neglect

Further analysis suggested that a young age at first birth leads to neglect indirectly by increasing the likelihood of bearing additional children during the teen years.

A five year NCCAN-funded longitudinal study of child abuse and neglect (LONG SCAN) found similar results to Zuravin & DiBlasio. Two of the four factors predicting maltreatment were number of children and educational attainment (Runyan, et al., 1997).

Social-economic. Factors of importance for neglect appear to include low educational attainment (Brayden, et al., 1992; Runyan, et al., 1997) mentioned above, and unemployment (Daro, 1988; Gaudin, 1993). Poverty has been consistently linked to chronic neglect. For example, in 1993-94, children from families with incomes below $15,000 were 44 times more likely to experience physical neglect and were 56 times more likely to be educationally neglected than children from families with incomes above $30,000 (Third National Incidence Study of Child Abuse and Neglect, Sedlak & Broadhurst, 1996). While most families in poverty manage to provide adequate care for their children, the association between child neglect and poverty is clearly supported in many studies (Gaudin, 1993; Howing et al., 1993; Runyan et al., 1997).

Lack of knowledge has been cited as another factor. Jones and McNeely (1980) found significant differences between 29 neglectful and 29 non-neglectful mothers in nurturing knowledge. For example, neglectful mothers disagreed with statements such as “you must stay in the bathroom if your baby is in the tub,” (17 percent disagreed) and “A baby should be seen by a doctor every few months during the first year of life” (31 percent disagreed) while all of the control group endorsed these statements. Of the neglectful mothers, 58 percent thought “All babies have diaper rash” while only 10 percent of the control group agreed.

Whether the responses of neglectful mothers were indicative of lack of knowledge or simply reflected attitudes was not always clear. For example, most (24) of the neglectful mothers knew that “all babies should have shots during the first year of life” yet only three of the neglectful mothers’ children were up-to-date on shots. The neglectful mothers said they did not know where the clinic was located, that they lacked transportation or that they were simply too overwhelmed to take their children.

Social isolation has also been suggested as a factor in neglect, although some studies do not find differences between neglectful and controls on this variable (Howing et al., 1993). Others (Gaudin, 1993; Maidman, 1984) cite findings that neglectful families are less likely to be involved in a church or other organizations that might be sources of support. Interactions with relatives may be frequent, but unhelpful or even critical of the neglectful parent. For example, Jones & McNeely (1980) compared neglectful and non-neglectful mothers. They found that neglectful mothers had fewer social contacts and that their social interactions were more aversive and conflict-laden than non-neglectful mothers. A more recent study (Gaudin, et al., 1993) compared neglectful and non-neglectful low SES parents. Neglectful parents reported more life stresses, greater depression and loneliness and weaker informal social supports.

In contrast to those who cite socio-economic factors as causative in neglect, Crouch and Milner (1993) question linking neglect to poverty, single parenting, and low educational levels. They suggest that studies relying upon founded cases through social services will be confounded by these variables unless the studies also utilize matched control groups of poor, single parent subjects with limited education who do not neglect. Even if matched control groups are utilized, Crouch & Milner feel the generalizability of the findings are limited.

Characterological. It has been hypothesized (Belsky, 1984) that neglectful mothers showed poor attachment to their primary caretakers while growing up. Egeland and colleagues have concluded from their longitudinal study that neglectful mothers’ immediacy and lack of secure attachment to their children may result from inadequate care they themselves received as children. This study found that regardless of the level of stress or the availability of support, the emotional stability of the mother was the most significant predictor of child maltreatment (cited in Gaudin, 1993). Mothers who are physically or emotionally inaccessible or unresponsive will be more likely to have attachment patterns that are anxious or insecure and will likely be unable to offer consistent nurturing.

Copings problems, low self-esteem, external locus of control and physical abuse and/or neglect as children are also cited as factors leading to neglect. The literature is not clear regarding these variables. One study comparing neglectful and non-neglectful teen mothers found no differences on these measures (Zuravin & DiBlasio, 1992).

Neglectful parents have been found to be negative in their interactions, showing more expressions of dislike and disapproval than of encouragement or praise. Neglectful parents issue more commands and exhibit few positive behaviors towards their children (Felt, 1983; Maidman, 1984). Parents who neglect appear more pathological when compared to controls and to those who physically abuse (Friedrich, Tyler, & Clark, 1985). There is an overlap with substance abuse. Substance abuse is thought to be a factor in as many as 70 percent of neglect cases (Gaudin, 1993 & 1995; Green, 1991). A prior issue of VCPN (volume 53) reported upon the relationship between substance abuse and child maltreatment. Problems such as low cognitive abilities and depression are noted. Others (Green, 1991) have noted high rates of psychosis and chronic physical illness. Neglectful parents have been described as bored, restless, impulsive and lacking in drive or persistence. Their social supports are deficient or they fail to use available social supports.

Polansky et al. (1981) have identified a particular syndrome found in many neglecting families. The “apathy-futility syndrome”, it is characterized by a conviction that nothing is worth doing, emotional numbness, loneliness, desperate clinging in interpersonal relationships, lack of competence in many areas, expression of anger through passive-aggression, reluctance to talk about feelings and poor problem-solving.

Polansky and colleagues identified four other patterns as well. These were: a) impulsive mothers; b) mothers suffering from reactive depression; c) mothers with mental retardation; and d) mothers diagnosed as psychotic. All five patterns are characterized by immaturity, inability to delay gratification, and inability to put another’s needs first. Polansky et al. note that neglect patterns can be intergenerational.

Gladstone (1968, cited in Green, 1991) suggests two types of psychological functioning in neglectful families. Some parents use projection to attribute their own undesirable characteristics to a child, then withdraw from the child due to labeling the child as unacceptable. A second group does not identify with child, but does not and are unable to empathize, thus have difficulty in even basic care such as feeding.

A very comprehensive long-term project in Alaska based on a psychoanalytic orientation identified five subtypes of neglecting families (Andreini & Mangiardi, 1991). The “pervasive-chaotic” families were similar to Polansky’s “apathy-futility” syndrome. This group was highly resistant to change but generally accessible. It was imperative to their identity to stay in the middle of the mess and to keep recreating it” (p.38). The clients were willing to meet as long as nothing changed. One group was termed “manipulative-sadistic”. Par-
Consequences of Neglect

Interest in the consequences of neglect has developed slowly. In a literature search performed by Crouch & Milner (1993) no summaries of research related specifically to consequences of neglect were found (although some reviews covered both physical child abuse and neglect). Many studies examining child neglect victim effects utilized child maltreatment groups which were broad in inclusion, containing both abuse and neglect victims.

It should be noted that, for an individual child, abuse and neglect can be concurrent. For instance, Ney, Fung & Wickett (1992) found that physical abuse, verbal abuse, physical neglect, emotional neglect, intellectual neglect and sexual abuse occurred alone in only five percent of cases. In the other 95 percent, children were maltreated in more than one way. A study of 160 maltreated adolescents by McGee, et al. (1995) found that over 90 percent had experienced more than one kind of maltreatment.

Thus, it is not unusual for several forms of maltreatment to occur together. Neglect may cause a child to be vulnerable to mistreatment from others. Neglect damages self-esteem and leaves the child likely to seek attention "in the wrong places at wrong times from the wrong people" (Ney, Fung & Wickett, 1992, p. 404).

Both the acute and long-term effects of neglect are likely to vary according to the severity and chronicity of the neglect and its interaction with the child's developmental needs (Drotar, 1992). For example, a three-year-old child is likely to experience greater harm from a parent's failure to prepare meals than a 14-year-old would. Older children might be able to procure or prepare their own food or at least be better able to withstand erratic eating patterns. Given the importance of developmental considerations, it is necessary to have an understanding of the conditions necessary and sufficient to foster growth at a given age, stage and to evaluate neglect within that developmental context.

The need for a safe and nourishing environment begins even prior to birth. Health-related behaviors of the mother (lack of adequate nutrition, for example, or use of drugs) can result in varying degrees of damage to the fetus (see VCPN, volume 33, for a review of substance-exposed babies).

At birth, the infant's need for continued safety and nurturing is paramount. Nutritional and/or psychosocial deprivation can result in Failure-To-Thrive (see separate article, this issue).

In a research review, Crouch & Milner (1993) noted that numerous researchers have reported a relationship between neglect and attachment problems. Avoidant and resistant attachments, in particular, have been noted in neglectful families. Neglected children display fewer overtures of affection, initiate play behaviors with their...
The links between neglect and later delinquency appear complex. Risk for delinquency stems in part from lack of discipline or feedback to the child, sending a message that children are free to do as they please. Children fail to learn self-discipline as they model the lack of direction and lack of perseverance of their parents. Influence of peers in the neighborhood, lack of interest in or success in school, cultural influences, and lack of opportunity are some of the additional factors that influence adolescent delinquency.

Some researchers report behavioral difficulties in older youth. According to Crouch and Milner (1993), there are mixed findings regarding the relationship between neglect and behavioral difficulties for older children. For example, Kendall-Tackett and Eckenrode (1996) found neglected children in junior high school had more suspensions and disciplinary referrals than nonmaltreated students, and the number continued to increase through senior high. They found a mixture of findings in studies that examined the relationship between neglect and aggression, as well.

Others (Gaudin, 1993) cite findings of developmental deficits. The deficits in concentration, persistence and problem-solving worsened over time. Egeland et al. (1988, cited in Gaudin, 1993; Egeland, 1993) found that compared to physically-abused children, to sexually-abused children and to children whose parents were "psychologically unavailable", children of neglect had the worst long-term outcomes. Further, the effects of neglect were cumulative with children showing increasing declines as they aged.

Long-term negative patterns may be due to distorted beliefs. It may be easier for children to believe that the mistreatment is because of a deficiency in themselves, rather than blame their parent. Even when the child discovers that the neglect continues regardless of his or her behavior, the feeling of fault does not dissolve. Instead, the child develops a conviction that he or she does not deserve any better care (Ney, Fung, & Wickett, 1992).

In contrast to the mixed findings concerning behavioral difficulties, antisocial behavior and aggression, the findings concerning effects of neglect upon academic achievement appear very consistent.

The National Center on Child Abuse and Neglect commissioned the University of Georgia School of Social Work to conduct a study to determine effects of maltreatment on older abused or neglected children (Howing, et al., 1993). Over a 2 year period, 2,500 questionnaires and 500 interviews were completed on 69 maltreated children and 70 nonmaltreated peers. A variety of developmental and family factors were examined. Maltreated children were either physically abused (n=22) or neglected (n=47).

The University of Georgia study found distinct differences between the three groups. The physically-abused children experienced an overwhelming set of problems in school, at home, among peers and in the community. They differed significantly from comparison children on all ten measures of academic and social/emotional adjustment. Measures included assessment of aggression, delinquency, emotional adjustment, motor skills, personal care skills, community skills, peer relationships, self-concept, home and school behaviors and academic performance.

The neglected children showed a different profile of deficits. On most measures of social relations and emotional adjustment, the neglected children were comparable to the control children. However, academic difficulties were pronounced. Neglected children showed difficulties in overall performance, in language, reading and math, excessive absences, poor classroom performance and achievement below their expected level. Although there was improvement between initial interviews and followup, neglected children were still performing far below their nonmaltreated peers. Twenty-one percent of the neglected youth had dropped out of school by the end of the study. The neglected children's raw scores on standardized tests of language, math and reading were much lower even than those of the physically abused children (who were significantly lower than the non-abused children). Of the neglected children, 60 percent had repeated one or more grades compared to 24 percent of non-abused children. The neglect group's rate of absence was nearly five times that of the nonmaltreated group (21.35 days for the prior year compared to 4.5 days) and the neglected children had low educational aspirations (Howing, et al., 1993). Howing's findings are similar to other research findings (Gaudin, 1993; Kendall-Tackett & Eckenrode, 1996; Maimdan, 1984).

Some researchers report affective emotional problems in neglected children, although these consequences have not been studied extensively. For example, Egeland and colleagues (as reported in Crouch & Milner, 1993) found more anger expressed by 2-year-old neglected children compared to physically abused and control children. In followup, the neglected children were less flexible and less creative in approaching problem-solving and displayed less effective coping behaviors. Other studies

mothers less frequently, remain more isolated from peers and show less prosocial behaviors.

Neglected preschool children show lowered self-esteem, poor impulse control, and more negative and less positive affect. Neglected preschoolers were the least creative in problem-solving. They were distractible and hyperactive, did not seek adult help and were not persistent (cited in Gaudin, 1993).

Lack of care can have a range of physical consequences. Children who are inadequately clothed or fed are at risk for illness and impaired physical development. Lack of routine pediatric care means that detectable, correctable problems are left to worsen. Immunizations may not be up-to-date. Likewise, failure to obtain timely medical care can allow injuries to worsen, compromising long-term physical health. Learning and safety can be compromised or delayed by poor eyesight that is not corrected by glasses or poor hearing that is not diagnosed and corrected.

Dental neglect can cause cavities, tooth loss, swollen jaws and cheeks, and episodes of around-the-clock pain. Unhealthy teeth may make a child unattractive and lacking in self-confidence. Lack of preventative dental care can adversely affect how jaws and teeth function as the child matures and can lead to periodontal disease (Badger, 1982; Lewit & Kerrebrock, 1998). According to a survey of state child welfare commissioners (Battistelli, 1998), children in the foster care system or in out-of-home care frequently have pervasive and serious dental problems and the severity often requires extensive, time-consuming and expensive work.

Lack of supervision can lead to accidents, injuries, burns, ingesting of household poisons, harm from other adults and children, as well as emotional disturbances such as anxiety, fears and nightmares. For older children, lack of supervision increases risk for delinquent activity, early sexual activity, experimentation with drugs and alcohol, and teen pregnancy (see VCPN, volume 36 "At Risk Youth", and volumes 13 & 52 "Teen Pregnancy").

Chronic Child Neglect
continued from page 5
have found motivational problems, apathy, withdrawal and/or undisiplined behaviors (Gaudin, 1993).

Assessment of Neglect

There are a limited number of structured assessment inventories that workers can use to help assess the adequacy of care for children such as The Childhood Level of Living Scale. Many state social service agencies have also developed risk assessment procedures. (The next issue of VCPN will examine risk assessment in further detail). An adequate assessment should identify all the relevant conditions that prevent proper care for the child. The assessment, if performed well, should form the basis for treatment and intervention efforts. Special attention should be given to diagnosing and treating substance abuse due to the large amount of overlap between substance abuse and chronic neglect. (VCPN, Volume 53 discusses child maltreatment and substance abuse.)

Intervention:

Models That Are Effective

Treatment of chronic neglect is neither simple nor short-term. Further, not all families will respond positively to intervention.

Neglecting parents may not feel guilty about their omissions, simply failing to recognize the harm to their children (Hall, DeLa Cruz and Russell, 1984). Thus, workers' efforts to help the family can be met with indifference. Neglectful mothers may mistrust "outsiders" and resist intervention or new ideas (Gaudin et al., 1993; Green, 1991).

Physical problems, chronic illness, substance abuse or mental illness, when present, demand attention prior to attempting to teach effective parenting skills. Thus, parents may require services from a network of specialists in order to gain sufficient physical or mental stability to approach the task of learning to parent (Green, 1991).

Lack of planning and poor problem-solving can perpetuate or create problems, even as progress is being made (Green, 1991). Impulsive spending, sudden moves, unplanned pregnancy and accidents are examples of situations that can complicate or even stymie efforts to improve the family's status.

Outcome studies dating back to the 1970s indicate how challenging chronic neglect can be. For example, a review by Daro (1988) of 19 demonstration programs from 1978 to 1982 indicated that there was improvement in overall functioning in 53 percent of families. For 66 percent of neglectful parents, there were additional reports to CPS of further neglect even while the family was receiving intervention services. Daro concluded that, regardless of the type of intervention, the severity of the family's problems was the most powerful predictor of outcome, with the factor of substance abuse correlated with less successful outcomes.

Even so, some interventions appear more promising than others. Much has been learned in the last 20 years about the types of interventions that are promising in protecting neglected children from poor outcomes and in supporting their distressed families. It should be noted that no single approach will be effective with all families, rather the challenge is to choose an appropriate mix of strategies. Also, no one approach will be sufficient for multiple-problem families (Cameron & Vanderwoerd, 1997).

Traditional, in-office, one-to-one counseling appears ineffective with neglect. Rather, the dysfunctional family patterns must be addressed. Family interventions should seek to establish clear family roles, clarify and improve communications, correct inaccurate perceptions, improve knowledge of child development and enable the parent(s) to assume a strong leadership role (Gaudin, 1993).

One example of a time-limited intervention with some success is the Nurturing Program. (See VCPN, Volume 37 for more information on the Nurturing Program.) This 16-week program has groups for both parents and children as well as combined activities where parents and children practice their newly-learned skills. The Nurturing Program has been field tested with families referred for chronic neglect. In January, 1986, a grant project began in six agencies throughout the Salt Lake City metropolitan area. Of the 125 parents who began the 15-week program, 103 parents completed it (82 percent). Significant changes in pretest versus post-test scores were found in the areas of parenting attitudes, knowledge of parenting techniques and family interaction patterns as measured by the Adult-Adolescent Parenting Inventory (AAPI) and the Family Environment Scale (FES). Personality profiles as measured by the 16 PF did not change.

Gains in parent training programs, in general, are linked to the content of the program. Typical findings include improved anger management, better parent-child interaction, lower stress levels and fewer aversive parent behaviors. Parents who are coping with high stress levels and multiple problems generally benefit less. Despite positive gains, it should be noted that parent training, by itself, is unlikely to be sufficient to eliminate neglectful parenting (Cameron & Vanderwoerd, 1997).

Family preservation services have also been successful. This approach uses an intensive in-home worker, on call for the family 24 hours a day. Most programs provide the intensive service from 3 to 6 months. The emphasis is upon preventing out-of-home placement for the children while the immediate family problems are rectified. The family is then transitioned to more traditional, less intensive service.

Family preservation efforts have been more successful with abusive families than with neglectful families. They are also more successful with non-chronic neglectors. (See VCPN, volumes 24, 46 and 47 for more details about family preservation efforts.)

Support groups have also been helpful to parents who neglect. Parents Anonymous groups have been especially effective. (See VCPN, Volume 5 for more information about Parents Anonymous.) Other similar groups, such as Gaudin's Social Network Intervention Project and the Oregon Self Sufficiency Project (reported in Cameron & Vanderwoerd, 1997 and in Gaudin, 1993) have also achieved some success. Those working in the Chronic Neglect Consortium felt that group support and/or group treatment was a key component in families with positive outcomes (DiLeonardi & Johnson, 1992). Still, there is relatively little evaluative literature about self-help/informal helping mutual aid for neglectful families.

Group leaders need to be aware that many neglectful parents lack good social skills and, therefore, can be ill-at-ease in groups. Group cohesion is enhanced by homogeneity, limited membership (8-12 members) and admitting new members only if the group agrees. Individual contacts are advisable in order to get to know the parent personally and to check on progress. Time-limited groups (3 to 6 months) and limiting meetings to 90 minutes are suggested. Structured activity, especially in the beginning phases, is generally necessary. Refreshments are important and can also be a method for teaching good nutrition.

INTERVENTION PRINCIPLES

For families who absorb high levels of service without seeming to improve, the following principles are offered (Cameron & Vanderwoerd, 1997):

• Use a coordinated service package rather than a single specialized intervention.
• The service package should include concrete resources, education and ways to reduce social isolation.
• Build competence rather than focus on treatment of pathology.
• Use resources from many different helpers.
• Recognize the importance of informal support systems.
• Designate one person as case manager.
• View the child in the context of the family and view the family in the context of their surroundings.

continued on page 12
FAILURE-TO-THRIVE

There are various definitions for “failure-to-thrive” syndrome (FTT). Children whose physical development falls below the third percentile in height or weight without a known medical reason are termed “nonorganic failure to thrive” according to Gaudin (1993). This definition seems to be the most frequent one encountered in literature.

However, Ludwig (1992) takes a somewhat different approach. According to Ludwig, FTT is a clinical, diagnostic term used to describe children who are not growing according to expected norms. It identifies children, who, at a given point in time, are unhealthy in terms of their physical growth, and an underlying cause for the growth failure is unknown. According to Ludwig, the growth failure might be an absolute deficiency of more than two standard deviations below the mean height or weight for the child’s age. In other cases it is a relative deficiency or shifting in the growth pattern, for example, a child who was growing at the 75th percentile who has now shifted to the 10th percentile curve.

Types of Failure-To-Thrive

It used to be presumed that FTT was the result of an organic disorder; however, study of children in orphanages in the post-World War II period changed that perception. FTT began to be divided into two subtypes, organic FTT (meaning that a physical impairment could be found that explained the FTT) and nonorganic FTT (indicating that the physically intact child needed a change in environment to resume normal growth patterns).

Causes for organic FTT can include deficits in food assimilation, excessive loss of ingested calories, increased energy requirements or prenatal insults. For example, a major childhood disease might be the trigger for FTT. Other organic causes might be a cleft palate, chronic diarrhea or a chronic infection. Nonorganic FTT may occur accidently (for example, if there are errors in formula preparation, improper feeding technique, or parental misconceptions about the nutritional needs of the child) or it may be related to economic or emotional deprivation, as well as to child abuse or neglect (Leung, Robson & Fagan, 1993).

Inadequate feeding due to child neglect may occur when parents are overworked, depressed or otherwise preoccupied with problems. Substance abuse, chronic physical problems, ongoing psychological problems or severe marital difficulties may result in neglect leading to FTT. Infants with growth failure due to emotional deprivation may also show decreased appetite or suppressed growth hormones. In cases of child abuse, there may be active withholding of food by the caretaker.

Soon it became clear that these two distinctions (organic versus nonorganic FTT) often were inadequate as cases could not fit into one category or the other. Thus, a third categorization, mixed FTT, was proposed for children who showed a combination of problems such as a minor organic problem coupled with a family that was unable to cope with that problem (Ludwig, 1992).

It was not long before mixed FTT began to be subcategorized. Three subtypes were proposed: a) an abnormal environment leading to an affected child being cared for poorly; b) an affected environment and an affected child occurring simultaneously; c) an affected child whose care requirements disrupted the family and caused environmental breakdown (Gorgon & Vaquez, cited in Ludwig, 1992).

Thus, while the immediate cause of FTT is inadequate nutrition, more recent work has focused on the interaction between nutritional factors, biological factors, disease factors and the child’s social environment (Gahagan and Holmes, 1998; Kedesdy & Budd, 1998). It should also be noted that dissatisfaction has been expressed with the term “failure to thrive.” Some experts maintain that FTT is not a diagnosis but rather is a term describing a group of symptoms associated with malnutrition and developmental delay. These individuals prefer a term such as “undernutrition” (Gahagan & Holmes, 1998; Kessler & Dawson, 1999) “growth deficiency” (Kedesdy & Budd, 1999) or “growth faltering” (Kessler & Dawson, 1999).

Prevalence/Incidence

No recent population prevalence data was found, although FTT was cited as accounting for between 1 to 5 percent of pediatric hospital admissions (Drotar, 1992, Kedesdy & Budd, 1998). Kessler (1999) cites studies in the 1980’s estimating a general population prevalence of 5 to 10 percent. A more recent estimate of inadequate growth (rather than FTT) is offered by Sherry (1999). Sherry cites data from three National Health and Nutrition Examination Surveys showing low weight-for-height populations figures of 2.0 percent for 1971-74, 2.2 percent for 1976-80 and 2.7 percent for 1988-91. A survey by the Center for Disease Control and Prevention cited by Sherry placed the prevalence of low weight-for-height among 2- to 5-year-olds as 2.8 percent in 1980 and 2.6 percent in 1996. Data from Virginia’s found cases of child abuse and neglect for 1994-95 show 12 (0.1 percent) of the 12,038 funded cases were due to FTT.

There are some studies examining the relative percentage of subtypes of FTT. In a review of 185 children admitted to a hospital because of FTT, organic causes were found for 34 (18.4 percent) and nonorganic causes were identified for 106 children (57.3 percent). In the remaining 45 children (24.3 percent) no specific causes could be identified. Of the 106 diagnosed as nonorganic FTT, 92 (87 percent) had experienced environmental deprivation and 5 (5 percent) had feeding problems (Sills, cited in Leung et al., 1993). In more recent review of the literature, Guinedney (1997) suggests that 15 to 30 percent of FTT children have organic problems severe enough to explain their growth failure and estimates that 10 to 35 percent of infants with FTT have a combination organic and nonorganic causes.

Assessment

The cause of poor weight gain is always suboptimal nutrition which results from inadequate access to food, inadequate intake, inadequate utilization (retention and absorption) of calories or some combination of these factors (Kedesdy & Budd, 1998).

The task of assessing children diagnosed with FTT is identifying the causes of the suboptimal nutrition. Assessment involves consideration of several aspects including: the child’s physical competence in eating; appetite; diet; illnesses; interaction with caregivers; competence of the caregivers; socioeconomic factors; and constitutional factors such as the child’s temperament or developmental delay (Kedesdy & Budd, 1998). Kedesdy and Budd discuss the reasons a child may experience inadequate access to food, inadequate intake, or inadequate utilization.

Inadequate access to food can be related to poverty. It can also be due to maladaptive parental health beliefs and eating practices, regardless of income. For example, parents may place severe restrictions on an infant or child’s diet in the mistaken belief that their child will become obese, develop atherosclerosis or develop “unhealthy” eating habits. Macrobiotic diets or a mistaken belief about food allergies have also been documented as causative factors in FTT.

Inattentive, preoccupied, or otherwise neglectful parents may fail to feed a child
sufficiently, even if food is available. A parent who is depressed or addicted to substances may sleep through feedings. Children with multiple caregivers may not receive enough to eat if communication is not maintained. Finally, in a few cases, parents may restrict access to food as punishment. Inadequate intake and/or utilization can occur even if the infant is offered sufficient and nutritious food. Infants with FTT often have an early history of feeding difficulty and/or food refusal. This aspect has received little systematic research attention, according to Kedesdy & Budd (1998). The potential roles of infant temperament, parental mismanagement and undetected oral-motor dysfunction are not known.

Kedesdy & Budd note that often the quality of parent-child interaction in cases of FTT is problematic, not only for feeding but in other aspects of the relationship. Parents of FTT infants have been found to be less nurturing and less organized. Meal schedules are less predictable and meals are offered in distracting environments. Feeding resistance may also be acquired secondary to aversive or traumatic events such as choking, recurring pain associated with swallowing, or forced feeding.

Due to the mixed etiology, only a subgroup of cases of FTT can be considered child neglect. So how does one identify when FTT is due in total or in part to neglect? According to Ludwig (1992), there are a number of markers and symptoms that are suggestive. Be on the alert if:

- The child is described as eating the ideal diet while having no abnormal weight loss through diarrhea or vomiting.
- The history of growth failure is not recognized by the parent.
- The reason for the consultation or visit is something other than weight loss or growth failure.
- The growth failure coincides with a major stressor such as a marital separation.
- There is an overall pattern of neglect such as a lack of prenatal or postnatal care, lack of immunizations, failure to keep "well-baby" appointments or obtain routine medical care, and/or a disorganized and chaotic parental lifestyle.

There are also physical markers that physicians can assess. Interested readers are referred to Ludwig (1992), to Leung et al. (1993) and to Gahagan & Holmes (1998) for these. Assessment should include the clinical history (medical background, family history, social and developmental history, nutritional history, prenatal and postnatal history), a physical exam, and laboratory studies. Physicians must rule out conditions such as intrauterine growth retardation, fetal alcohol syndrome, HIV, and syphilis. A medical history format as well as a description of the other assessment components is available in Rider & Bithoney (1999).

Deficits in the critical bonding and attachment process between parent and child are thought to be at least partially responsible for nonorganic FTT (Ayoub & Milner, 1985; Gahagan & Holmes, 1998; Gaudin, 1993; Gaedene, 1997). Thus, observation of parent-child interaction and assessment of bonding is important. Try to observe an actual feeding. Consider the choice of food, the approach of the parent, and the response of the child. Ludwig (1992) lists positive parent feeding behaviors that make an infant secure and that respond to infant cues. Ludwig also offers a list of behaviors that encourage good eating habits for older infants and toddlers.

Accurate measurement of actual caloric intake is the best diagnostic test. This can be difficult if the parent is not cooperative and/or willing to keep data, unless the clinician attends all feedings and measures actual food intake.

Time must also be spent in understanding the parents' view of their infant's condition. The family may not appreciate the seriousness of the child's condition. For parents who are concerned about their child's condition, anxiety, guilt, or worry over possible removal of the infant may make it difficult for a parent to share observations or give accurate information about the infant's care. Learning the parents' viewpoint is crucial in designing effective intervention plans (Strum & Dawson, 1999).

**Intervention**

The most recent standard of care is an interdisciplinary intervention. Medical centers in urban areas often have pediatric specialty clinics that are staffed with physicians, nutritionists and mental health clinicians.

Infants and children treated in such clinics show improvements that are superior to children seen only by primary care physicians (Kedesdy & Budd, 1998). Treatment involves a number of steps. If a child is at imminent risk, hospitalization is suggested. Often FTT children improve rapidly in an inpatient setting, both in weight gain and in developmental progress. The problem is that normal developmental progress often does not continue when the child is discharged.
Failure-To-Thrive
continued from page 9

turned home (Gaudin, 1993). Involving the
parents in the hospital care can improve the
chances for continued progress. The hospit-
al setting provides an opportunity for close
and continued observation of parent and
child interaction. Inappropriate feeding
techniques can be observed and corrected.
Active involvement of parents can allow them
to share in the success of the child’s
improvement which may aid in establish-
ing a sense of ongoing parenting success
(Drotar, Maier, & Negray, 1979; Cahagan &
Holmes, 1998).

Depression, personality problems, lack
of knowledge about child care, poverty and
other sources of stress have all been identi-
fied as factors contributing to FTT (Gaudin,
1993). Thus, staff should evaluate these fac-
tors as they work with the parents. The con-
dition of the child, both nutritionally and
developmentally should be determined as
well. It is important to know the timing, du-
ration, and intensity of the deprivation.
Once malnourishment has existed for a
time, it is a long-term process to establish
health and rectify any secondary problems
such as infections or anemia. An acceptable
diet and feeding regime must be achieved.
The feeding must also be acceptable to and
achievable by the parent. Providers must
evaluate all the factors that may need to
change in order for a parent to implement
suggestions or changes. These might in-
table tangible obstacles (for instance, need-
ing to allocate more time, money and effort
to feeding the infant) as well as changes in
attitudes and beliefs. For example, if a par-
ent wants to bottle-feed the child in order
to keep that child an infant, this psychologi-
cal problem must be addressed. If a parent
cannot tolerate the “mess” of a young child
learning to feed herself, then this roadblock
must be addressed.

All families need adequate support and
the presence of continuing environment
stress should be evaluated. The family may
need to be more functional in many areas.
Home-based services are considered desir-
able. The worker’s background may be
medical, child developmental or family sys-
tems. All can achieve success with FTT
families.

As treatment proceeds, it is necessary to
continue careful assessment of the family.
Ongoing risk assessment as well as identifi-
cation of family strengths and resources
is needed. Clinicians should note that it is
difficult to predict outcome because nonorganic failure to thrive often has more
than one cause. Children with FTT fre-
quently reside in families with multiple and
complex needs that require comprehensive
care coordination. Long-term, ongoing
follow-up and monitoring is often necessary
(Kedesdy & Budd, 1998; Leung, et al., 1993).

Outcome

The most severe effect of FTT is death
through starvation. In less severe cases,
the consequences can still be serious and can
last a lifetime. FTT children are more vul-
nerable than others to disease. They show
reduced ability to work or play and lowered
productivity. Cognitive impairments and
gerazed IQ have been documented. Some
followup studies report that some chil-
dren diagnosed with FTT can gain nor-
gal growth rates; other studies find many
FTT children have continued growth im-
pairments. Ongoing behavioral and devel-
oment problems have been noted,
although no single behavior or set of behav-
iors characterize all children with FTT.

According to Gaudin (1993) followup
studies indicate continuing developmental
delays in about half the children with FTT.
Other reports are even less optimistic. One
long-term study of 14 children with nonorganic FTT revealed the FTT children had
lower scores on IQ tests, poorer lan-
guage development, lower reading skills,
less social maturity and more frequent be-
havior problems than normal children of
the same age (Oates, Peacock, and Forest,
reported in Leung, et al., 1993).

In a review of home-visiting programs,
Black, Berenson-Howard and Cureton
(1999) found mixed results. Two studies
(Haynes et al., 1984 and Drotar & Sturm,
1988, 1989) found no differences between
home-visiting and less extensive interven-
tions. However, studies by Black et al.
(1995) and by Casey et al. (1994) documented
significant positive differences for the groups
with home-visiting service.

In the first systematic evaluation and
followup of children with FTT, Hutchinson,
et al. (1997) evaluated 74 FTT children over
a four-year time period. As a group, chil-
dren receiving home-based intervention
were superior to those who received only
clinical intervention. Both groups, however,
showed cognitive declines. The children re-
ceiving clinical intervention declined
less than those receiving clinical intervention.
Data further suggested that children whose
mothers reported a high number of symp-
toms of depression, hostility and anxiety
fared equally poorly, regardless of interven-
tion. Therefore home-based intervention
was most effective with children of less
impaired mothers.

As discussed earlier, followup, often
long-term, is necessary. Intervention must
extend beyond the immediate period of
diagnosis and “catch-up” growth (Leung,
et al., 1993). Outreach is particularly impor-
tant, as FTT families may be mobile.

Outcomes of intervention appear to be
related to the cause of the growth failure
and the parents’ degree of awareness and
cognition with the intervention. The less
chronic the developmental failure and the
greater the awareness and cooperation of
the parents, the more positive the outcome
(Ayoub & Milner, 1985; Gaudin, 1993).

References Available Upon Request

Failure to Thrive and Pediatric Undernutrition: A Transdisciplinary
Approach, edited by Daniel B. Kessler, M.D., and Peter Dawson, M.D.,
M.P.H., 1999, 592 pages (approximate), $62.95 (hard), stock number
3483.

Available from: Paul H. Brookes Publishing Company, P.O. Box 10624,
Baltimore, MD 21285-0624, 1-800-638-3775, web site:
 www.pbrookes.com

This is a comprehensive compendium of knowledge and practice
innovations for Failure-to-Thrive (FTT). Section I (five chapters) sets
the historical context of FTT, examines inadequate growth in a broad-
based, cross-cultural perspective, talks about general principles of
working with families and examines difficulties and limitations in research.
Section II (three chapters) considers nutrition, supplements, catch-up
growth, and the feeding relationship. These initial sections prepare
the reader for the more specific information that follows.

In Section III the medical assessment and management is described. One chapter
focuses on gastrointestinal problems, another explores cardiopulmonary problems and disorders of
the head and neck; still another chapter relates information specific to infectious diseases. Neuro-
logical problems, genetic disorders and endocrine disorders are all related conditions to FTT. These
are examined. Adverse reactions to food (such as allergies), lead exposure, renal disease, dental
problems and anemia are discussed in relation to FTT. Finally, a chapter is devoted to prenatal
exposure to alcohol, tobacco and other substances.

The alternatives for diagnostic coding are examined and implications of managed care are dis-
ussed. A very interesting chapter relates communication difficulties to feeding problems. Ocular
skills and swallowing are also covered. Prevention issues are addressed in discussions of early
intervention nutrition services.

Family variables such as culture and family routines are explored. Treatment models of psycho-
therapy and home-visiting are described. The roles of child protective services and coordinated com-
unity services are addressed. The volume ends with chapters about advocacy and policy. Appendix
information includes a variety of assessment scales.

This volume contains considerable and detailed information. There is some overlap between some
of the chapters. A specific assessment and treatment model is not endorsed, rather, readers are offered
multi-faceted information that can assist in fashioning effective detection and intervention programs.
Given the dearth of recent publication about FTT, this work is a welcome addition to the
field.
The Kluge Children’s Rehabilitation Center (KCRC) in Charlottesville serves a wide variety of children with special needs from Virginia, West Virginia and across the United States. Located on 12 acres in the foothills of the Blue Ridge Mountains, KCRC is part of the University of Virginia Hospital. Their 23-bed hospital unit serves over 550 children a year and the outpatient department handles over 10,000 visits a year in the 22 specialty clinics.

Referrals for Failure-to-Thrive (FTT) average between 20 and 30 in a typical year, according to Polly Tarbell. Tarbell works with the Encouragement Feeding Program which is better known for its work with children who have been maintained on a feeding tube, but are now learning to eat normally.

“Our emphasis is upon family-centered care and helping families function well,” explains Tarbell. “We don’t want to see families split, thus we ask how we can make the family successful.”

KCRC writes an individualized treatment plan for each FTT client. Most FTT cases that enter KCRC are complicated and local efforts to solve the family’s difficulties have failed.

The first step upon entry to the program is the assessment. Routine components include a medical (physical) examination to rule out organic causes for the FTT. A very thorough medical and nutritional history is taken. The degree of malnutrition is determined. Staff calculate what the infant’s ideal body weight should be and how far from this weight the infant is. An oral motor examination checks for undiagnosed cerebral palsy, for hypersensitivity, for obstructions and for gagging. The infant’s feeding apparatus is examined to determine if nipples have the proper sized holes and are positioned properly.

Other evaluation tools are the cognitive testing of the infant (and sometimes of the parent) to determine amount of delay. A psychosocial history can help pinpoint stressors and long-term maladaptive patterns and strengths.

A chemical workup will check for such conditions as anemia, vitamin depletion and underlying storage disease at the cellular level because of a missing enzyme. A complete schedule and diet schedule can help determine if the parent is feeding frequently enough and if appropriate food is being offered. An important component of the assessment is to observe parent-child interactions. Is the parent “reading” and responding to the infant’s cues? Is the parent interactive?

The family is interviewed to determine their goals and perspectives. Does the family have concerns about the infant’s growth? What has been tried already?

After the assessment is complete (generally this takes at least 3 days), it is utilized to create an intervention plan. The intervention plan is crafted by the team and is then shared with the family. Each treatment plan is individualized according to the family’s needs.

The parents (and foster parents, if appropriate) are coached by hospital staff in proper feeding and interaction with the infant. Every effort is made to help the parent feel competent and involved. “We used to be able to keep the infants longer,” explains Tarbell. “Now, due to shorter hospital stays, it is very important to train the local community professionals who will be following the case.”

Tarbell notes that the most difficult skills to teach are interactive skills. “If the parent is not interested, or if they never experienced positive interactions as a child, the bonding and positive interactions are very slow to build,” she comments.

More information about the program can be obtained from Polly Tarbell, KCRC, Speech Department, 2270 Ivy Road, Charlottesville, VA 22903, (804) 924-5272 or (800) 627-8596.

---

ORGANIZING KIT AVAILABLE FOR CHILD ABUSE PREVENTION MONTH - APRIL, 1999

April is Child Abuse Prevention Month, both nationally and in Virginia. Again this year, the Virginia Coalition for Child Abuse Prevention will mail out a community organizing packet to any individual or group interested in promoting the prevention of child abuse and neglect. The Prevention Month Packet is available free of charge.

The Child Abuse Prevention Month packet contains reproducible masters for making brochures, posters and flyers that promote good parenting and remind people to support children and families. Directions are included for mounting the traditional Blue Ribbon Campaign. The campaign reminds the public to "wear a blue ribbon to show that you care," and to be a "blue ribbon parent" or "blue ribbon community." Also included in the packet are statistics and background information that can be used in speeches, articles and awareness materials.

Each year over 2,000 public and private agencies, clubs, schools and religious organizations use the Prevention Month packet as a basis for activities that support children and families. A first mailing in early fall provides help in getting started. The complete packet will be mailed in January, 1999 to allow time for planning.

To receive a Prevention Month packet, please contact the Virginia Coalition for Child Abuse Prevention, c/o Prevent Child Abuse, Virginia, 4901 Fitzhugh Ave. Suite 200, Richmond, VA 23220. Requests may be also faxed to 804-359-5065.
Chronic Child Neglect continued from page 7

are essential. Treatment or support groups for children should occur while the parents are meeting. Support group leaders should also plan social events in order to accustom the parents to attending these and to build group cohesion. Picnics, a trip to a ball game or similar outings are helpful.

A behavioral approach that emphasizes social skills training can also be useful in remediating neglect conditions. Parents and children can be taught specific skills related to proper hygiene, safe home conditions and child management. Teaching parents and children to "break down" tasks into manageable steps can be achieved through modeling, coaching, rehearsing, feedback and positive reinforcement. Printed materials, charts and handouts can assist families in maintenance efforts when the practitioner is not present.

One published intervention of behavioral skills training focused on a mother with four children, ages 5, 9, 13, and 15 who had been a chronic neglect case for 10 years. Goals were to improve the substandard and unhealthy hygiene of the children. Using laundry service and contingent cash incentives to the children, significant gains were made. The mother's role was minimized as she refused to assume responsibility for the children's bathing and care. The older children were rewarded for assisting the younger ones. This study raises many controversial issues about the extent of effort government should offer in order to keep a family intact. In this case, the state in which this family lived ultimately decided that efforts to compensate for the neglect were unreasonable and removed the children. The study also raises questions about the appropriateness of making older siblings responsible for younger ones (Rosenfield-Schlacter, et al., 1983).

A different approach to behavioral treatment was reported by Lutzker (1990). Using a "simple, colorful chart" and stickers, as well as a feedback "report card" from the teacher, the mother was taught to clean her house and bathe her children. The opportunity to earn stickers was effective in teaching basic cleanliness to several families.

Several similar studies have been published by J.R. and S.Z. Lutzker and associates, according to a review by a workgroup of the American Psychological Association (Becker, et al., 1995). These case studies show some success using a ecologically-based behavioral skills approach in improving home safety, menu-planning, grocery shopping, infant stimulation and parent-child interactions. In each case, interventions were tailored to the particular family.

Felt (1983) used a behavioral educational treatment with families of young children who were identified as abused or neglected by social services. Twenty-eight abusive parents and 23 neglectful parents received an average of 8.4 months of treatment. Services were the same for both groups and included therapeutic child care, a parent training group and in-home family services. Both groups had similar baseline behaviors at intake which were high levels of criticism, lower levels of praise and inappropriate attention to negative child behaviors.

Both groups improved with treatment, however, abusive parents made significantly greater gains in all areas. The attendance of abusive parents was better, as well. Felt concluded that neglectful parents respond at a slower rate and may require a longer period of treatment.

There are other program options that could be helpful to neglectful families. These include: after school programs, family resource centers (see VCPN, volume 30), preschool school and recreational programming, nutrition programs and health programs. Time and space preclude a thorough review of these and similar programs.

Enhancing the informal network of support is also important. Social networks of neglectful parents may be unstable, closed and dominated by critical relatives. Linking parents with group activities for their children (such as sports or interest groups at schools) is one avenue. Sports groups, for example, generally have parent components to help with fund-raising, transportation and supervision. All parental help is welcomed and neglectful parents could find good role models in the other parents participating. Recreation available through local organizations can be another positive component in an informal network. Job training and job enhancement programs often teach concrete skills.

Intervention should also focus on the neglected child or children. Neglected children need treatment to remediate their developmental deficits, and the treatment is needed at an early age (Felt, 1983). Untreated deficits can magnify over time, as neglected children slip further and further behind peers. Treatment for neglected children is also a priority because of the limited success in trying to remediate neglectful parents. Preventing a repetition of the "cycle of neglect" many depend upon ameliorating the serious problems of child victims (Gaudin, 1995).

Unfortunately, there is limited data available about effectiveness of treatment for neglected children, and most of the empirical information focuses on infants and preschool-age children. Additionally, it is often difficult to be certain of the generalizability of results since study samples may contain both abused children and neglected children (Becket, et al., 1995).

Therapeutic day care, counseling, and skill-building activities all show positive results. School and after-school programs that develop interests and enhance academic performance are effective. Mentoring programs such as Big-Brother / Big-Sister have achieved significant positive results.

High quality preschool programs have shown positive outcomes for neglected and disadvantaged children. Gains have been documented in cognitive functioning (such as fewer grade retentions and fewer referrals to special education), social and emotional development (higher self-concept, higher motivation, better relationships), and in long-term adaptive behavior such as fewer arrests, teenage pregnancies, high rates of employment (Cameron & Vanderwoerd, 1997).

There are also lessons to be learned from literature examining how children develop competence under unfavorable conditions. Conclusions from a review of this literature are that children who do well have adults who care for and nurture them, have brains that are developing normally and who learn, as they grow, to manage their attention, emotions and behavior. In the U.S., a combination of warm, structured childrearing practices along with reasonably high expectations for competence correlates with children who are successful in multiple domains and to resilience among children at risk. In short, each child requires caring, competent adults in his or her life, must develop good cognitive skills and must learn to self-regulate. Children grow in many contexts-families, schools, peer groups, recreational activities, religious organizations - and each context is a potential source of protective factors as well as a potential source of risk. (Masten & Coatsworth, 1998).

Outcome

Those professionals working with families who neglect are only too aware that many will not improve. For example, Yuan and Struckman-Johnson (1991) studied 1,740 children from 709 families that received intensive in-home services in eight California demonstration projects. Children at risk for placement due to neglect were 2.5 times more likely to be placed after receiving intensive family preservation treatment than were children at risk of placement for other types of maltreatment (27.1 percent of neglected children were placed compared to 11.7 percent of the other maltreated children).

In 1988, NCCAN funded a group of six demonstration projects to develop methods
for working with chronically neglectful families. Together, the projects comprised the Chronic Neglect Consortium. The Consortium leader, Children’s Home and Aid Society of Illinois, was charged with developing an evaluation plan, in concert with the other agencies (DiLeonardi & Johnson, 1992).

The grant emphasized a multidisciplinary model of service delivery, family diagnosis, and the capacity to deliver services specific to depression, substance abuse, physical illness and mental illness of caretakers. Consortium members devised ways to deal with social isolation, lack of trust and apathy. Family empowerment and family participation were stressed. Each project identified ways to support workers and volunteers and help them maintain energy and commitment. Beyond these basics, the projects varied significantly in locales, demographics of clients and criteria for recruitment and admission to services.

Families received services for a mean of about 18 months. Of the 132 families with Childhood Level of Living Scales at both intake and termination, 73 percent showed positive changes. A longer length of service correlated with greater positive change.

Staff on the projects attributed the limitations of service to several factors. Client denial, resistance and lack of motivation was one primary category. The other was lack of time or skills on the part of the clinician. The majority of families were felt to be high risk to continue to neglect their children. Those families with substance abuse or serious mental illness appeared particularly at risk. In families where positive change resulted, the use of groups, the philosophy of empowerment and the in-home service by paraprofessionals were felt to be the most helpful services.

A comprehensive, long-term project in Alaska offered intensive services to 49 families (63 adults and 157 children) referred for chronic neglect. Families were served from 6 to 30 months (Andreini & Mangiardi, 1991). This project offered intensive intervention and multiple services. Some families improved. Those with reactive depression and those with an initially high level of functioning that was impaired by stress generally responded well. With other groups, the response was not as positive. Improvements did not occur at all for some families and for others, a long-term, ongoing high level of staff resources was necessary to support and maintain the gains.

An Omaha, Nebraska program, Building Nurturing Families (BNF), was originally established as a demonstration project providing family-based services to reduce chronic neglect. Rather than imposing services, families were involved in decision-making and developed their own “service package”. An independent evaluation concluded BNF had a positive cumulative effect, although it was difficult to determine which interventions were associated with improvement. Improvements in measurements such as the Childhood Level of Living Scale (CLL) were directly related to the length of family participation (Beavers, 1993).

An Iowa City study of 67 cases of families with chronic neglect underscored the need for lengthy services, rather than short-term intensive intervention (Nelson, 1993). Additionally, the Family Empowerment Program (Witt, 1993) found that persistence on the part of the outreach worker and the skill of the family therapist were crucial in engaging families.

There appears to be widespread agreement that comprehensive, intensive programs are the best service delivery model for neglectful families. However, data on intervention effectiveness is limited, in part due to the challenges of assessing complex program models.

Evaluation studies on comprehensive intervention programs are difficult to inter-
INTERDISCIPLINARY TRAINING OFFERED ON ABUSE AND NEGLECT OF CHILDREN WITH DISABILITIES

Children with disabilities are nearly twice as likely to be abused, both at home and at school, as children without disabilities, according to a study sponsored by the National Center on Child Abuse and Neglect. Risk factors which make children with disabilities more vulnerable to abuse and neglect include life-long dependency, which can render children more trusting and less likely to question caregiver actions, as well as fearful of repercussions if they report abuse. Children with disabilities also may be unable to defend themselves or to avoid/escape abuse, as well as unable to communicate clearly about what has happened.

Training will be offered through a new project of the Virginia Institute for Developmental Disabilities entitled “Partners Protecting Children With Disabilities From Abuse and Neglect.” The project will target educators, parents, law enforcement officers, and child protective services. Local teams will be trained together to insure a coordinated response to investigation, treatment, and prevention.

Training for Trainers is scheduled for November, 1998, with the course delivered in central and south central Virginia during February and March, 1999. This course will subsequently be offered in other regions of the state.

For more information contact Patricia Conet, Project Director, VIDD/VCU, 700 East Franklin Street, PO Box 843020, Richmond, VA 23284-5020 FAX: 804

Virginia’s Picture

Virginia’s child abuse and neglect statistics reflect the national trends. Neglect constitutes the largest percentage of founded reports. Virginia’s most current child abuse and neglect statistics cover the period from July 1, 1995 to June 30, 1996. As in previous years, physical neglect continued to be the most prevalent type of child maltreatment in Virginia, accounting for 56.5 percent of all founded child abuse and neglect reports. Mental abuse/neglect accounted for 3.9 percent of founded reports. Other types of founded neglect reports involved medical neglect (2.1 percent of all founded reports), failure-to-thrive (0.2 percent of all founded reports) and educational neglect (0.6 percent of all founded reports).

Physical neglect (56.5 percent of all founded reports) is subdivided into several categories: inadequate shelter (8.7 percent); abandonment (5.1 percent); inadequate hygiene (3.9 percent); inadequate food (2.3 percent); and inadequate clothing (0.8 percent).

Thus, all types of neglect account for 59.4 percent of founded abuse and neglect reports for FY 1995-96 in Virginia (63.3 percent when mental abuse/neglect is included). The remaining 36.4 percent of cases are divided between physical abuse (22.2 percent), sexual abuse (13 percent) and other (1.2 percent).

For this reporting period, mothers (including birth, adoptive and stepmothers) were responsible for 47.1 percent of founded neglect reports. Both parents accounted for 24.8 percent, fathers (including birth, adoptive and stepfathers) were responsible for 16.8 percent and all other caretakers represented 11.3 percent. These statistics are similar to prior years.

During FY 1995-96, five children, ages 20 months to six years, died due to physical neglect. All neglect deaths were a result of inadequate supervision. Additionally, twenty children died as a result of physical abuse during FY 1995-96.

CPS staff from 31 of Virginia’s departments of social services were surveyed regarding their experiences with assisting families with chronic neglect complaints. Since VCPN was focusing on chronic neglect, we did not ask about situations where neglect was less serious or occasional.

Staff were asked what factors were present in families experiencing chronic neglect. The most frequently mentioned factor, mentioned by 84 percent, was either poverty (cited by 22 staff or 71 percent) or financial problems (mentioned by 4 staff or 13 percent). The next most frequent re-

Chronic Child Neglect continued from page 13

pret. These projects offered services to a mixed population of families with problems of physical abuse and/or neglect and often included "at-risk" families. It is impossible to decipher if positive results were equally true for all types of maltreating families. Additionally, many of the larger studies are ten or more years old. The available data shows that some participants in comprehensive support programs lowered their rates of child maltreatment and had lower rates of child placement outside the home. However, according to a review by Beckler et al. (1995), the success rates of demonstration projects are fairly low (about 30 percent) and reoccurrence of maltreating behaviors are high (around 66 percent). Longer participation (a year or more) and use of in-home services produced better outcomes (Cameron & Vanderwoerd, 1997).

It is important to note that no one intervention is likely to result in positive outcomes for a majority of families. The particular interventions should be matched to the needs of the family. A multiservice approach, including provision of concrete resources, intense contact, strategies to improve social skills, development of personal networks and utilization of structured parenting and support groups can result in modest improvements in the parenting behavior of neglectful parents (DePanfilis, 1996).

Options of foster care and eventual termination of parental rights are additional ways to intervene. By performing risk assessments and by providing intensive assistance quickly, agencies can better determine which children may need substitute families in order to obtain proper care.

Professionals who are working with neglectful families need a support system themselves, as the stress of working with this population can be enormous. For example, in one project, over 70 percent of the neglectful families experienced a major life stress event every two months during treatment. For the project staff, this meant a major stress factor occurred among the caseload at the rate of over once per day. Dealing with this level of consistent crisis response can be difficult for staff.

Additional stresses for staff are the low levels of attachment found in many neglected families, the lack of trust found in many neglectful families and slow pace of change. Parents who lack the skills to praise their children are unlikely to thank their workers.

Polansky et al., 1981 (cited in Gaudin, 1995) warn that service providers need to guard against slowly adopting the attitude of futility that is a characteristic of many chronically neglecting parents. Staff need to be able to reinforce each other, and agencies need to offer support through staffing, consultants, flextime work schedules, and inservice training.
response was “lack of knowledge of child development” (mentioned by 52 percent) and substance abuse (mentioned by 48 percent). A parent with mental illness or mental retardation was cited by 42 percent of staff and 23 percent talked about lack of motivation. Factors mentioned by less than 20 percent of those interviewed included single parent status, young parents, lack of social support, intergenerational patterns, lack of employment, lack of transportation and domestic violence. Readers should note that this question was “open-ended”. Workers were asked to name what each thought were the most important factors in neglect cases. No list was given. It is likely that a higher percentage would have endorsed each factor, if a list of factors had been provided. The open-ended question, however, provides a spontaneous response of what is foremost in that particular worker’s experience.

It is interesting to compare the spontaneous responses of Virginia CPS workers to the factors found in the research literature. The influence of poverty is notable in both published literature and the worker survey. Also, the second most frequent worker response, “lack of knowledge of child development” is supported in research literature. The third most frequent factor mentioned by Virginia’s workers was a parent with mental illness or mental retardation. Literature specific to this factor appears sparse. Factors emphasized in the literature that were mentioned only occasionally by Virginia CPS workers include single mothers, teen mothers, lack of employment and bonding failure (attachment problems).

In the 31 Virginia localities surveyed, the majority of children living in chronic neglect remained in their families with the department of social services providing intervention. Over half (55 percent) of agencies had removed less than one-fourth of children with confirmed cases of chronic neglect. Twenty-four percent of those surveyed said less than half of children in homes with chronic neglect were removed. Four agencies (14 percent) estimated from half to three-quarters of chronic neglect resulted in removal. Only two agencies (7 percent) said they had removed over three-quarters of children in chronic neglect.

Agencies offer a wide range of services to families with chronic neglect problems. The most frequent response was “parenting training”. The next most usual services were assistance with obtaining food, housing, clothing, and medical services through both government assistance (such as food stamps or subsidized housing) and through voluntary or non-profit groups such as Salvation Army or food pantries. The third largest response was to provide intensive in-home family preservation services. Other service provision included counseling, mentoring for children, finding support systems for families by networking with other agencies and service providers and assistance with employment.

WHERE DO I OBTAIN THE LATEST STATISTICS?

Child Maltreatment 1995: Reports from the States
To obtain a free copy, call (800) FYI-3366 or send an E-mail to nocanch@calib.com (Please include the publication name, and your name, address and phone number). You may also access this publication online through the Children’s Bureau web site at http://www.acf.hhs.gov/programs/cb/stats/nocands/index.html

Third National Incidence Study of Child Abuse and Neglect
To receive a copy of the full report, contact the Clearinghouse at nocanch@calib.com (Please include the publication name, and your name, address and phone number in your E-mail message.)


This federal report presents, in a single document, 25 key indicators of child well-being. The report, required by Presidential Executive Order 13045, is the first in a planned annual series that will monitor the overall status of the nation’s children.

The indicators include child poverty, infant mortality, substance abuse, math and reading proficiency, high school completion, and child maltreatment data. The indicators reflect children’s health, behavioral and social aspects, economic security, and education.

Although many federal agencies collect and report data about children, this is the first interagency effort to provide an easy-to-understand composite portrait of child well-being, similar to the reporting on the nation’s economic status.

RESOURCES FROM NCPDA

Preventing Child Neglect, by Patricia M. Crittenden, 1992, 23 pages, Item number J703504, $1.40 each for 1 to 99.

This booklet defines neglect and describes the type of neglect. The effects of neglect are detailed. The potential causes of neglect are explored and treatment approaches are discussed. This brief booklet is a good summary for those who want an introduction to the literature about neglect.

Child Neglect-You Can Prevent It, Real Style Format, 1987, 16 pages, Item number 71654 .89 each for 1 to 99.

This Real Style Scriptographic book by Channing L. Bete Co. is written in very basic language and illustrated with drawings. It lists the major types of neglect, common signs and reasons for neglect. The booklet tells how to prevent neglect. Sources of help and prevention strategies are highlighted.

Available from: NCPDA Fulfillment Center, 200 State Road, South Deerfield, MA 01373, (800) 835-2671, Fax: (800) 499-6464

© Commonwealth of Virginia Department of Social Services

VCPN is copyrighted but may be reproduced or reprinted with permission. Write for “Request to Reprint” forms. Request or inquiry is addressed to: Joann Grayson, Ph.D., Department of Psychology, MSC 7401, James Madison University, Harrisonburg, VA 22807, or call (540) 568-6482. E-mail: graysoj@jmu.edu

When requesting an address change, please include a copy of your old mailing label.

continued on page 16
Chronic Child Neglect
continued from page 13

eents” appeared to be the crucial variable although some parents face problems such as addiction, mental illness or cognitive limitations that prove formidable, even if the parent is cooperative.

Virginia’s picture may be more optimistic than that of many states due to a strong economy and good employment possibilities. In July, 1998, unemployment rates for Virginia were 3.1 percent compared to a national rate of 4.7 percent. In July, 1997, Virginia’s unemployment rate was also low, at 4.2 percent compared to a national rate of 5.0 percent (Daily News Record, August 29, 1998).

In the 1998 edition of KIDS COUNT, (a profile of the status of children across the United States, using 1995 data), Virginia ranks 19th overall in child well-being indicators. Virginia is better than the national average on 8 of 10 key indicators of child well-being. Only the percentage of low birth weight babies and the infant mortality rate are lower than national average and these rates are very close to national averages.

Of the indicators measured by KIDS COUNT, the most relevant one for chronic neglect is the poverty level. Virginia ranks as the 10th best state for numbers of children living in poverty. Twenty percent of Virginia’s children live in poverty compared to a national average of 22 percent. Six percent of Virginia’s children live in extreme poverty (50 percent below poverty level) compared to 9 percent of the nation’s children.

Also important in children maintaining adequate levels of care is the rate of child support by absent fathers. In 1995, 43 percent of female-headed families in Virginia received child support or alimony compared to a national average of only 33 percent (KIDS COUNT, 1998). Child support in single-parent families is crucial to preventing poverty. Nationally, in 1995 only 10 percent of children in two-parent families lived in poverty whereas 50 percent of children in female-headed single-parent families were in poverty (Federal Interagency Forum on Child and Family Statistics, 1997).

Summary
Current literature suggests that long-term, multiservice comprehensive models are the best choice for chronically neglecting families. Since neglect has proven to be a particularly damaging form of maltreatment, greater attention must be focused on developing effective interventions.

References Available Upon Request

James Madison University
Department of Psychology
MSC 7401
800 S. Main Street
Harrisonburg, VA 22807
Attn: J. Grayson

Nonprofit Organization
U.S. POSTAGE PAID
Harrisonburg, VA 22801
PERMIT NO. 4

Return Service Requested