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Perspectives on Child Maltreatment in the Mid '80s

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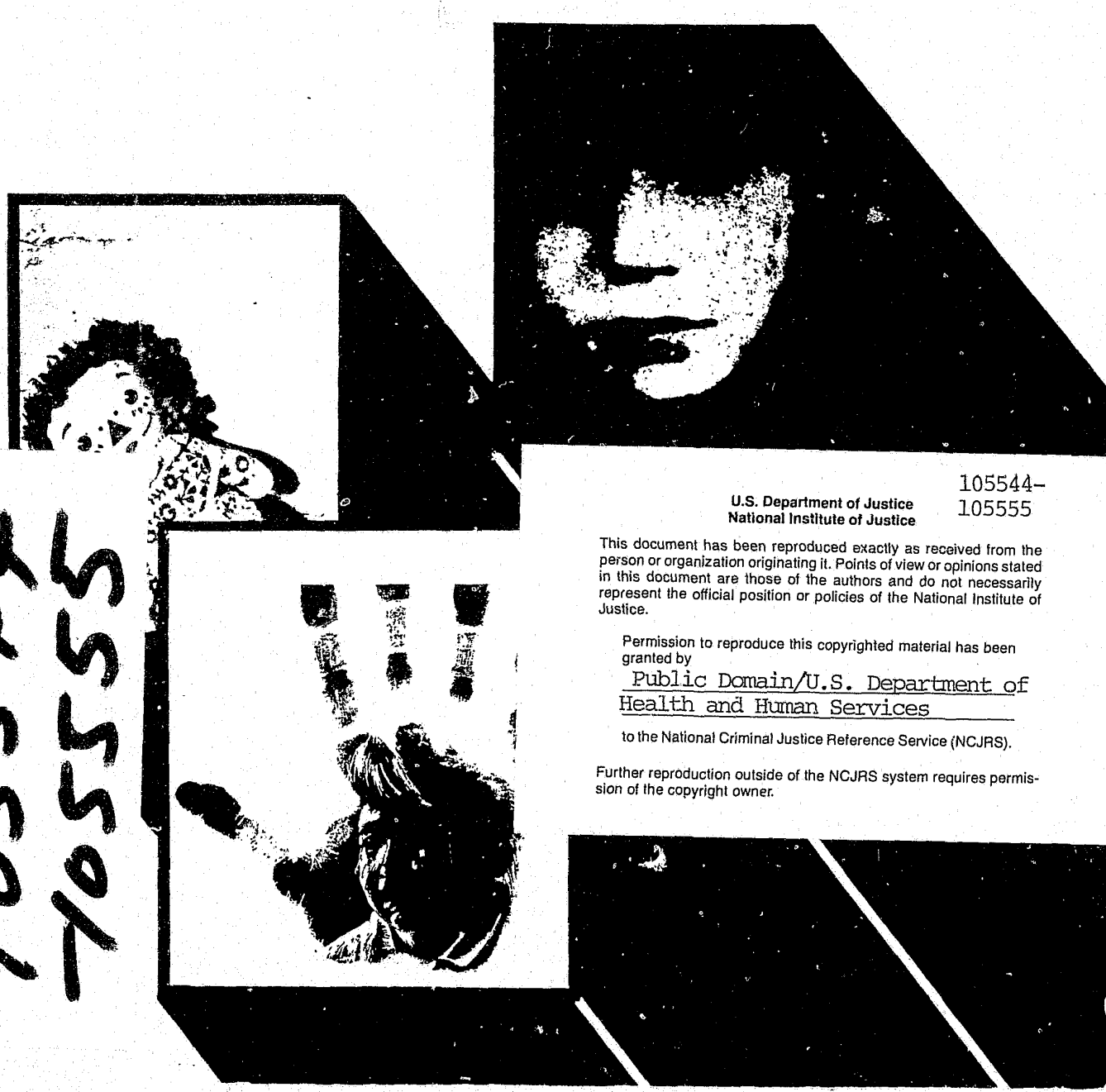

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Programs and Projects

Working With Neglecting Families

by Marilyn Hall, Angelica DeLaCruz and Peggy Russell

Marilyn Hall served as manager of the Child Neglect Project, Children and Youth Project, University of Texas Health Science Center, Dallas. Angelica DeLaCruz and Peggy Russell were social workers with, respectively, the Children and Youth Project's Saldviar Children's Clinic and the Carver Children's Clinic. Their article is reprinted from CHILDREN TODAY, Mar.-Apr., 1982.

At times all parents experience some guilt over not providing for their children's needs and wants. It may be not buying that extra costume for dance class, or not listening carefully enough to your child's woes while you are busy preparing supper. This is a normal part of parenting. However, there are parents who continually fail to provide for their children's needs, and usually in many ways. These failures eventually affect the child's health and/or development adversely. Characteristically, these parents do not feel guilty over their omissions, and often simply fail to recognize the harmful consequences of the chronic neglected state of their children.

These families are not rare. In 1978 the American Humane Association counted nearly 47,000 substantiated cases of child neglect.* These are only the cases that have come to the attention of child protective services agencies. One wonders how many neglected children and their families are distressed and not receiving any help or guidance. The neglecting families who are brought to the attention of human service professionals usually are considered the most difficult to treat. The chronic and severe multiple problems that characterize neglecting families drain agency resources and staff time and energy. Often, agencies hesitate to take on these cases because of the tremendous demands they make and the poor prognosis for change.

Staff members of the Children and Youth Project of the University of Texas Health Science Center at Dallas are acutely aware of the problems involved in treating child neglect and sought to demonstrate a cost-effective treatment of the problem through a demonstration project supported by a grant from the National Center on Child Abuse and Neglect. Project staff members believe it offers an optimal setting to treat these difficult families. Its location, the types of services provided, the method of delivery and the use of a multidisciplinary team approach to care all contribute to maximizing treatment outcomes.

The C & Y Project operates through three clinics located on school grounds in a low-income, public housing area of West Dallas. Two pediatric clinics serve all residents from birth through age 12 and the adolescent clinic serves the 13- to 18-year-old group. Combined, the clinics treat over 12,000 children and youth, providing both health maintenance services and acute care to all registrants.

Health care is a primary need of this population which, prior to the C & Y Project's intervention in 1970, was characterized by high infant mortality, morbidity and hospitalization rates. Such a situation is not unusual in urban settings where there is an area, like West Dallas, populated by families whose income is below poverty level, who often live only by public assistance in substandard, high-density housing and who constitute one of three minority groups (black, Mexican American and Southeast Asian).

Clinic staff members are particularly sensitive to multi-problem families and have developed systems to locate new or non-registrants and to follow up on missed appointments. Staff nurses make visits to the homes of all newborns to identify immediate problems and schedule an appointment to register the family at

the clinic. If a registered family misses an appointment, the clinic's social worker visits the home. High risk families (such as neglecting families), who traditionally drop out of service systems, are identified and closely monitored.

The multidisciplinary team approach has been the model used to deliver comprehensive health care to children of the community. Each clinic is staffed with a full-time pediatrician (or adolescent specialist), two pediatric nurse practitioners, one licensed vocational nurse, a social worker and supportive clerical staff. Rotating through the clinics are a psychologist, nutritionist and rehabilitation specialist. An attorney consults on legal issues pertaining to child abuse and neglect cases. Two of the clinics provide comprehensive dental services and the project subcontracts home-maker services from the local Visiting Nurse Association as needed. The multidisciplinary team approach to health care provides multiple resources under one roof and a concentration of staff energies necessary to work with the demands of neglecting families.

The first job of the Child Neglect Project, which began in 1978, was to develop an operational definition of what exactly constitutes child neglect. Staff members perceived neglect to have two main characteristics: It was often a chronic, long-standing problem and it most likely permeated several aspects of a child's life or was so severe in one area it could endanger that life.

With this in mind, project staff members developed an instrument called the Child Neglect Severity Scale that qualifies and quantifies nine categories of child neglect: abandonment, health care, nutrition, supervision, personal hygiene, clothing, shelter, emotional neglect and education.[2] The Scale offers both area subscores and a cumulative score. Several of the nine areas include subcategories which involve a total of 21 items (categories and subcategories included). For example, the category of emotional neglect incorporates the subcategories of stimulation, expectation, nurturance and discipline.

Since the level of care a child receives is not absolute, but rather on a continuum, each category and subcategory is explicitly defined according to four levels of care: no problem, mild, moderate and severe neglect. Thus, it is possible to obtain a profile of a family's strengths and weaknesses, as well as a cumulative relative score of the level of neglect. The scale is used in two ways—as a diagnostic tool (to delineate problems and strengths) and as an evaluative tool (to measure change over time).

Neglected children are usually identified in such settings as health facilities, day care centers and schools, or by neighbors. For a number of reasons, a parent will rarely seek help. Neglecting parents (the mother, in our experience) are usually oblivious to the negative effects their omissions have on their children. They often live isolated either physically or emotionally from their extended family and the community. Initially distrustful of intervention efforts, they want to be left alone.

A social worker's first contact with neglecting mothers is usually met with apathy or suspicious but controlled anger. However, once a worker breaks through the initial barriers and establishes a relationship with the mother, he or she finds a scared, frustrated, needy and dependent person who will readily engage with a nonauthoritative and patient individual. Building that trusting relationship is a delicate task.

Intervention

The first step toward engaging a neglecting parent in treatment is to determine a neutral point of intervention. Accomplishing this depends upon the worker's ability to determine what the mother perceives her problem to be, *not* what the health professional or other worker thinks the child's problem is. Telling a neglecting mother that she is not feeding her child correctly, for example, or showing her a declining growth chart only reinforces her poor self-concept and feelings of inadequacy—and makes her withdraw even more from services. However, if the intervention effort is directed first toward the mother and her problems, the effect on the child will eventually be positive. This approach is most effective in situations in which a child's life is not immediately in danger.

This intervention strategy worked effectively with Mrs. Smith, the mother of five children ranging in age from one to 14. A protective services worker had initially contacted the clinic to obtain health services for the children. Visiting the Smith's home, the clinic social worker found the mother and her children, together with Mrs. Smith's brother and father, living in a vermin-infested, 3-room wood frame house with no working utilities. At this time, Mr. Smith was in jail, although he did appear at times during treatment to exacerbate the neglecting situation.

All of the children had major health problems; the diagnosis for the two youngest children was failure to thrive. The children were either not clothed or wore ill-fitting, filthy rags. The two oldest, ages 8 and 14, were not registered in school, and neither the parents nor the school system were successful in getting them to attend.

A variety of emotional and social problems were also prevalent among the children; mental retardation in the 14-year-old; theft and running away in the 8-year-old; the 3-year-old was not toilet trained; and the 2-year-old had no language. The siblings were known to abuse one another physically; their injuries ranged from bite marks to first-degree burns. All of the children lacked social controls and responded to the world in a totally unsocialized way.

The protective services worker felt that he had provided every available service to the family, but he wanted to try a homemaker to see whether the mother could improve the children's physical and nutritional environment. However, the mother had continually refused the offer, saying that she did not need anyone to help her with her house, especially someone who would "spy" on her.

With the protective services worker's cooperation, the project social worker approached the mother from a neutral intervention point—the medical clinic—and encouraged her to talk about what disturbed her the most. Much to everyone's surprise, her most distressing concern was to "get protective services off my back"; she thought she could do that if she could only get the two oldest children to go to school. The social worker renewed the offer of homemaker services, explaining to the mother that the homemaker's specific purpose was to come early every morning and help get the children off to school.

Mrs. Smith readily accepted the offer. Gradually, as she began to trust the homemaker and social worker, Mrs. Smith agreed to have the homemaker's time extended to help her in cleaning the house, cooking nutritious meals and managing her children.

Another mother who continually neglected to give her child medication for a major health problem was found, on a home visit, to be living in overcrowded, deplorable conditions and in a conflicting relationship with her husband. The mother's main concern, however, was how she could obtain Christmas presents for her children. Once the social worker was able to acquire gifts from local churches and the Salvation Army, the mother could accept the social worker's visits and gentle approaches to helping her with many other problems.

On another occasion, a social worker making a home visit was greeted by an angry mother who bodily lifted her into the house and proceeded to scream at her about all the personal injustices she had experienced. As the tirade diminished, the worker was able to empathize with the mother's dilemma, which allowed her to express her greatest concern, her obesity. From there, a treatment plan could be devised.

One of the most successful intervention strategies with a neglecting mother is to accept her on her terms and interact with her in her own environment. Relationships are built in agency waiting rooms, cars, laundromats and neighborhood grocery stores—wherever a family can be contacted.

All project workers report a "click" in their relationship with mothers when trust is gained. Sometimes it takes months and repeated home visits; at other times it can occur in a daylong wait at a clinic. However long it takes, once it occurs the social worker knows that the mother is ready to take some serious steps into treatment.

Treatment

Members of each clinic's multidisciplinary team together evaluate each neglecting family to diagnose the multiple problem areas and develop a treatment plan. Once a plan is implemented, it is reviewed at intervals—ranging from weekly to every six months, depending on the problem—to monitor changes and to modify the plan in accordance with the family's changing needs. Resources provided by other community agencies—housing, day care and supplemental food plans, for example—are often needed for neglecting families, and staff members of other agencies involved with the family are also included in the project's case planning.

The case of the Brown family illustrates one treatment plan.

Ms. Brown, age 18, and her 4-month-old son were brought to the attention of the neglect project by health clinic staff who had observed several problems: the baby's poor weight gain and feeding problems: the poor personal hygiene of both mother and child; the mother's inappropriate expectations of child development (spanking as a way of disciplining an infant, for example); and unstable residence (mother and child rotated living with parents, friends and relatives).

Under the treatment plan, the Browns were referred to a neighborhood parent-child center, where both mother and child received two prepared meals a day. Additional food was provided by the clinic's WIC program, thus alleviating lack of food as a cause of the baby's low weight. Since the parent-child center also offers supervised instruction and modeling in positive parent-child interaction, workers there assisted the clinic worker in helping to teach the mother appropriate responses to her child's developmental stages and mod-

eled successful feeding techniques—steps toward resolving two other problems.

Since poor hygiene is more often a symptom of a problem rather than a problem itself, project staff members decided not to work directly on that area. Invariably, personal care improves as other problem areas are resolved.

The family living arrangement was a long-range problem involving major difficulties in the mother's interpersonal relationships and self-concept. Ms. Brown was considerably immature and sometimes rebellious. She felt quite alone in the world.

Staff members learned that the best approach with Ms. Brown was the type of gentle, playful back-and-forth bantering that is often effective with young adolescents. In frequent but informal sessions with Ms. Brown—at weekly medical appointments to check her son's progress, for example—the clinic's social worker always made a point of "visiting" with Ms. Brown. The worker discussed whatever the mother was interested in talking about; boyfriends, new clothes, how tough her child was or the unfair treatment she received at home. All talks were low-keyed and nonthreatening and were structured in such a way as to include personal humor and positive remarks concerning any part of the mother's life—her mothering skills, the child's weight gain, personal care, clothes and attendance at the center, for example. Gradually, Ms. Brown began to seek out the social worker for help and advice.

The Brown's case was reviewed monthly for any necessary changes in the treatment plan and progress recorded. After over a year of treatment, the child's weight gain became medically stable and the feeding problem was resolved. The center and clinic staff also noted marked improvement in the mother's interaction with her child, especially in disciplining him. She also displayed a more mature approach to life by being able to solve problems, follow instructions and meet appointments. Her personal hygiene improved dramatically and her residence stabilized.

After a family's situation has stabilized, the case is reviewed every six months. Cases are not terminated—all children cared for by the clinics are on the caseload until they are 18 years old or move out of the target area.

Outcome

Successful outcome with a neglecting family is difficult to determine. Is terminating parental rights and placing children for adoption considered a successful outcome? Or is success a mother who now sends her child to school regularly but continues to live in filthy, hazardous and chaotic surroundings? Should all parents be expected to provide a minimally acceptable standard of child care, or are slow, successive approximations toward that level considered adequate? If so, what is the minimum acceptable level and how long should the parents be allowed to work to attain it—while the child's time clock ticks away?

These are some of the questions that are of primary concern to the project. Staff members feel strongly that all cases must be objectively evaluated, rather than have outcomes based purely on subjective viewpoints or personal values. This objective evaluation is being done with 40 test families every six months during the 3-year period of the grant. The evaluation is reviewed from the child's perspective, since a child has no control or defense against parents' continued omissions of care.

Outcome evaluations can be either global ratings from a knowledgeable group with respect to the previously delineated problem areas, or outcome can be measured using objective tests or tools. The project, in conjunction with measures in the medical charts (growth charts, hematocrit), uses eight tools to evaluate outcomes. One such measure is examining videotaped sequences of the mother interacting with her child. Unbiased raters score these tapes behaviorally, looking at any changes in the quality and quantity of the interaction over time. Other areas being measured include the child's behavior; the social worker's perception of the mother; the mother's personality characteristics; the mother's outlook on life; the child's perception of life; the child's locus of control; and the child's intelligence.

Data collected over the 3-year period are now being analyzed and results will be available later this year.

Families are the nurturing centers for the development of our children today. It is important that these children receive the necessary support, acceptance and opportunities for personal growth in their interaction with their world. When this is thwarted, it is imperative to intervene early and quickly in order to interrupt chronic generational neglect, and to help parents and children work together in meeting the growing demands of today's world.

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*American Humane Association, *National Analysis of Official Child Neglect and Abuse Reporting*, Denver, Colo., Denver Research Institute, 1978.