

### Childhood Neglect: Improving Outcomes for Children

#### Learning Outcomes

To recognise signs and symptoms of children and young people who are, or may be, neglected.

**Audience** Groups 2-6 (Working Together 2010)

**Time** 45 minutes

#### Key Reading

Breslau, N. and Davis, G.C. (1987) "Posttraumatic stress disorder: the etiologic specificity of wartime stressors". *American Journal of Psychiatry* 144, 578-583.

Glaser, D. (2000) 'Child abuse and neglect and the brain - a review.' *Journal of Child Psychology and Psychiatry* 41(1): 97-116.

Perry, B. (2002) "Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture" *Brain and Mind* 3, 79-100.

Perry, B. and Szalavitz, M. (2006) *The Boy who was Raised as a Dog*. New York, NY: Basic Books.

Widom, C.S. (1999) "Post-traumatic Stress Disorder in abused and neglected children grown up". *American Journal of Psychiatry* 156(8) 1223-1229.

#### Links to Common Core

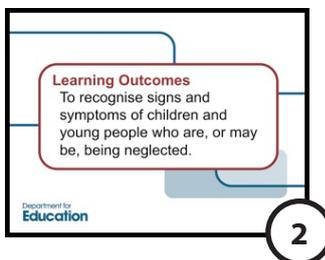
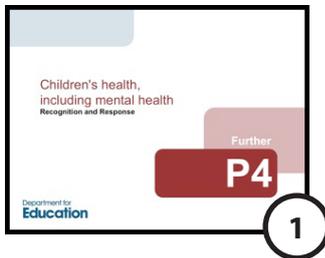
**Common Core 2** Child and young person development (knowledge: understand how babies, children and young people develop). Know that development includes emotional, physical, intellectual, social, moral and character growth, and know that they can all affect one another.

**Common Core 3** Safeguarding and promoting the welfare of the child (skills: personal skills). Understand the different forms and extent of abuse and their impact on children's development.

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The consequences of neglect are generally cumulative, and negatively affect the child's development. Common physical and psychological reactions to neglect include stunted growth (for example failure to thrive), chronic medical problems, inadequate bone and muscle growth and lack of neurological development that negatively affects normal brain functioning and information processing.

Processing problems may often make it difficult for children to understand directions, may negatively impact the child's ability to understand social relationships, or may make completion of some academic tasks impossible without assistance or intervention from others. Lack of adequate medical care may result in long-term health problems or impairments such as hearing loss from untreated ear infections.

Neglect often accompanies other forms of abuse, but is the one that is most overlooked – health professionals have a key role to play.

Only two professions have near universal contact with young children: GPs and health visitors (HVs) and midwives (for the first ten days of life).

See more at [www.minddisorders.com/Kau-Nu/Neglect.html](http://www.minddisorders.com/Kau-Nu/Neglect.html)



Nutritional neglect

Indicators -

- begging for or stealing food
- frequently hungry
- rummaging through rubbish bins for food
- gorging self, eating in large gulps
- hoarding food
- obesity
- overeating junk food.

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Nutritional neglect occurs when a child is undernourished or is repeatedly hungry for long periods of time. Lack of calorie intake can be evidenced by poor growth. Nutritional neglect often is included in the category of “other physical neglect”.

Poor nutrition has negative consequences on the child’s physical and psychological development. If proper nutrients are not available at critical growth periods, the child’s development will not follow the normal and usual pattern.

See more at [www.safechild.org/childabuse4.htm](http://www.safechild.org/childabuse4.htm)

Medical neglect

- Denial of health care.
- Delay in health care.
- Indicators of poor health:
  - drowsiness, easily fatigued
  - puffiness under the eyes
  - frequent untreated upper respiratory infections
  - itching, scratching, long existing skin eruptions
  - frequent diarrhoea
  - bruises, lacerations or cuts that are infected
  - untreated illnesses
  - physical complaints not responded to by parent.

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Medical neglect encompasses a parent or guardian’s delay or denial of the need to seek the necessary health care for a child.

Denial of health care is the failure to provide or to allow needed care as recommended by a competent health care professional for a physical injury, illness, medical condition, or impairment. There may be a need to consider the best way forward if that treatment is against the parent’s religious beliefs.

Delay in health care is the failure to seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention. Examples of a delay in health care include not getting appropriate preventive medical or dental care for a child, not obtaining care for a sick child, or not following medical recommendations. Not seeking adequate mental health care also falls under this category.

See more at [www.childwelfare.gov/pubs/usermanuals/neglect/chaptertwo.cfm](http://www.childwelfare.gov/pubs/usermanuals/neglect/chaptertwo.cfm)

**Mental Health**

- Neglected children have an increased risk of developing PTSD.
- BUT other variables also play a part.
- Neglected children are at increased risk for early behavioural problems and conduct disorder.
- Effects on lifestyle and behaviour may expose individuals to higher risks.

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In Widom's study (1999) 30.6% of victims of childhood neglect met DSM-III-R criteria for lifetime post-traumatic stress disorder (PTSD, which is the standard textbook definition used for mental health. The relationship between childhood victimization and number of PTSD symptoms persisted despite the introduction of covariates associated with risk for both. Victims of child abuse (sexual and physical) and neglect are at increased risk for developing PTSD, but childhood victimization is not a sufficient condition. Family, individual, and lifestyle variables also place individuals at risk and contribute to the symptoms of PTSD. Thus, the general effects of other family variables (such as poverty, parental alcoholism or drug problems or other inadequate social and family functioning) need to be disentangled from specific sequelae associated with childhood abuse or neglect.

Long-term mental health effects of neglect are inconsistent. Effects of neglect can range from chronic depression to difficulty with relationships; however, not all adults neglected as children will suffer from these difficulties. First, some individuals are more resilient than others and are able to move beyond the emotional neglect they may have experienced. Characteristics of resilient individuals include an optimistic or hopeful outlook on life and feeling challenged rather than defeated by problems. Resilience is also promoted by the existence of protective factors around the individual at family and wider community levels.

A second reason is that previous research has suggested that abused and neglected children are at increased risk for early behaviour problems and conduct disorder. Behaviour problems in childhood or adolescence may be associated with increased risk for engaging in risky behaviours. In turn, it may be those behaviours that lead to increased risk of exposure to traumatic events and to subsequent PTSD.

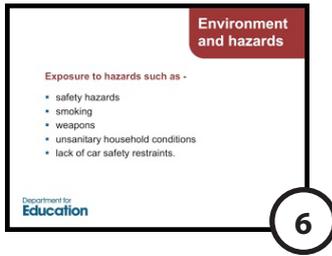
A third possibility is that childhood victimization may be associated with PTSD through its effect on a person's lifestyle, which places the person more or less at risk for exposure to traumatic events and, ultimately, PTSD. For example, Breslau and Davis (1987) have identified a set of risk factors for PTSD, such as low levels of education and extraversion, which is characterised by positive emotions and seeking out stimulation that serve to expose individuals to social roles and environments associated with high risk for victimization.

The present examination of PTSD is part of a prospective study of the long-term consequences of early childhood victimization that used documented and substantiated cases (Widom 1999). It offers an opportunity to determine whether PTSD is one of the sequelae of early childhood maltreatment (physical and sexual abuse, and neglect). Widom's article (1999) presents findings from a study in which abused and neglected children were followed up into adulthood and compared with a matched group.

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### Environmental Neglect

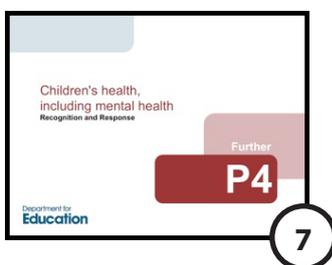
Some of the characteristics affecting the health of neglected children can be seen as stemming from environmental neglect, which is characterised by a lack of environmental or neighbourhood safety, opportunities, or resources. While children’s safety and protection from hazards are major concerns for practitioners, most attention focuses on the conditions in the home and parental omissions in care. A broad view of neglect incorporates environmental conditions linking neighbourhood factors with family and individual functioning, especially since the harmful impact of dangerous neighbourhoods on children’s development, mental health and child maltreatment has been demonstrated. Practitioners should be aware of this impact on the family when assessing family and environmental factors. For example, practitioners can help parents find alternative safe play areas in a neighbourhood where there are significant levels of substance misuse rather than have their children play on the streets.

### Exposure to hazards

Examples of exposure to in- and out-of-home hazards include:

- Safety hazards - poisons, small objects, electrical wires, stairs, drug paraphernalia;
- Smoking - second-hand smoke, especially for children with asthma or other lung problems;
- Guns and other weapons - guns that are kept in the house that are loaded and not locked up or are in reach of children;
- Unsanitary household conditions - rotting food, human or animal faeces, insect infestation, or lack of running or clean water;
- Lack of car safety restraints.

<http://www.safechild.org/childabuse4.htm>



One large-scale study undertaken in the United States (Sullivan and Knutson 2000) found that disabled children were 3.4 times more likely to be abused than non-disabled children. They were:

- 3.8 times more likely to be neglected
- 3.8 times to be physically abused
- 3.1 times more likely to be sexually abused
- 3.9 times more likely to be emotionally abused.

**Disability and neglect**

- There is a lack of general awareness of disabled children's vulnerability.
- Growth, behaviour and other problems may be seen to be the result of the disability.
- Professionals need to be vigilant about feeding regimes.

(Sullivan and Knutson 2006)

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In relation to disabled children, Kennedy and Wonnacott (2005) identified the ways their needs may be neglected:

- **Feeding may be withdrawn to allow a child to die**
- **Children are not fed enough to keep them 'light' for carrying purposes**
- **Feeding may be too difficult, and parents 'give up'**
- **Parents may not allow gastrostomy tubes (feeding tubes that directly enter the stomach, used to supplement feeding in those who have difficulties swallowing or to give high protein etc diets) even in the face of severe malnutrition**
- **Parents may insist on gastrostomy tubes despite them not being medically necessary**
- **Food may be used as a reward or denied as punishment**
- **Parents may fabricate illnesses by the judicious use/non-use of food.**

Whilst highlighting the range of ways in which disabled children's needs may be neglected by parents, Kennedy and Wonnacott also stress the importance of assessing whether parents are themselves receiving sufficient support and resources to enable them to meet their children's developmental needs.

**Weight faltering**

Previously known as Failure to thrive (FTT)

- Organic/nonorganic debates.
- Failure to meet expected weight and growth norms or developmental milestones.
- 5% of all children have faltering growth; 25% of children who are abused or neglected have faltering growth.
- Routine growth monitoring is important: height, weight, BMI and head circumference.
- Health visitors are the crucial first link. Dietetic and paediatric assessment next.

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The majority of children with slow weight gain will have no underlying organic disease. Despite this, much emphasis by professionals and parents has been placed on the possibility of organic disease. This is probably because it is not clear why children sometimes do not gain weight. The term 'non-organic failure to thrive (FTT)' has now been almost eradicated, and more recently even FTT has been dropped in favour of the more accurate 'weight faltering'.

All young children are at very high risk of under-nutrition; they have very high-energy requirements. Pre-verbal children are entirely dependent on parents to recognise their feeding needs and quite a small problem can lead to weight faltering. A mother or carer only needs be slightly pre-occupied by family stress, or offer a well-meaning but inappropriate diet (for example, high fibre meant for adults) for it to impact on weight gain.

Where weight faltering is apparent it is essential that the child be examined by an appropriate health professional. Parents and carers are highly likely to be as concerned to know the reason for the problem as professionals and, as far as possible, parents and carers should be involved at all stages. If a parent appears not to accept the potential dangers of faltering weight, or is resistant to the child receiving health care then it will be important to undertake further assessment of the extent to which the child may be experiencing neglect and whether a section 47 enquiry may be required.

**Child death related to neglect**

- Lack of supervision (most deaths occur from this category).
- Malnutrition or poor care can lower resistance to infection.
- Failure to respond to illness in child - sudden infant death.
- Failure to use preventive health care, for example, immunisation.
- Parental use of drugs - intoxicated adult/lack of supervision, accidental ingestion.

(Brandon, Bailey and Bellerose 2010)

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**NB under-reporting and under-recognition of neglect in child death are both common**

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From the previous slides, it becomes clear that neglect is a health issue that can cause death. Wilson and Mullin (2010) summarise the particular reasons why death may occur related to neglect. Key things to emphasise here are that most deaths occur where there has been a lack of supervision, yet this is something often underemphasised; and that both under-reporting and under-recognition are common.

**Clinical presentation**

- Severe and persistent infestations (for example, scabies or lice).
- Consistently inappropriate clothing.
- Persistently dirty and smelly.
- Faltering growth because of inadequate or inappropriate diet.

(NICE 2009)

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A systematic review by Connell-Carrick (2003) indicates that children under three suffer neglect more than any other age group, with children under one suffering neglect twice that of other ages.

Recently published guidelines from the National Institute for Health and Clinical Excellence (NICE 2009) provide an evidence based overview of the features associated with maltreatment that may be observed when a child presents to healthcare professionals. Clinical presentation which should give rise to concern about neglect among health professionals relevant to neglect include the list on the slide.

Chester et al. (2006) undertook a retrospective study of 440 hospitalised paediatric burns patients during 2000-2002. A multidisciplinary team investigation of suspicious cases was used. This included a home assessment. There were 41 cases of neglect (9.3%) and 395 cases of accidental burning (89.8%). Parental drug abuse, single parent families, delay to presentation and a lack of first aid were statistically more prevalent in the 'neglect' group than in the 'accidental' group. Children in the 'neglect' group were also statistically more likely to have deeper burns and require skin grafting. 82.9% of children whose burns were deemed to be due to neglect had a previous entry on the child protection register. 48.8% were transferred into foster care. The authors advocate a multidisciplinary investigation coupled with the use of home assessments to aid diagnosis. It may be possible to target preventative strategies on the children with the above risk factors.

**Clinical presentation**

- Home reports which indicate a poor standard of hygiene which affects the child's health; inadequate provision of food and living environment unsafe for child's developmental age.
- Parent/carers fail to seek medical advice for their child to the extent health and wellbeing are compromised, including if the child has ongoing pain.

(NICE 2009)

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**Clinical presentation**

- If explanation of injury suggests a lack of appropriate supervision (for example, sunburn, ingestion of harmful substance).
- Repeated failure by parents/carers to administer essential prescribed treatment.
- Repeated failure by parents/carers to attend essential follow-up appointments.

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**Clinical presentation**

- Repeated failure by parents/carers to engage with relevant health promotion programmes; for example, immunisation, screening and health and development reviews.
- If parents/carers have access to, but persistently fail to obtain NHS treatment to their child for dental tooth decay.

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**The ACE study**  
Adverse Childhood Experiences

- Adverse Childhood Experiences and their relationship to Adult Health and Wellbeing.
- Child abuse and neglect.
- Growing up with domestic violence, substance abuse, mental illness, crime.
- 18,000 participants.
- 10 years.

(Anda et al. 2008)

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The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and wellbeing. It is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego. Participants underwent a comprehensive physical examination and provided detailed information about their childhood experience of abuse, neglect and family dysfunction. Over 17,000 people chose to participate. To date, over 50 scientific articles have been published.

Adverse Childhood Experience was defined as:  
Experiences that represent medical and social problems of national importance:

- childhood abuse and neglect
- growing up with domestic violence, substance abuse or mental illness in the home, parental loss, or crime.

The largest study of its kind ever done:

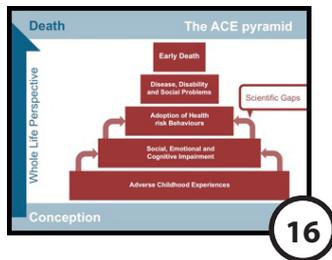
- 18,000 participants
- followed for 10 year period.

See <http://www.acestudy.org/>  
And <http://www.cdc.gov/nccdphp/ace/index.htm>

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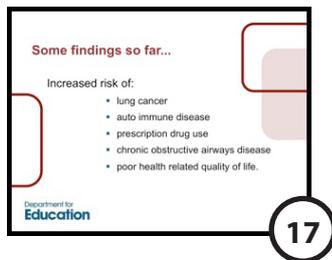


The ACE Pyramid represents the conceptual framework for the study. During the time period of the 1980s and early 1990s, information about risk factors for disease had been widely researched and merged into public education and prevention programs. However, it was also clear that risk factors for many common diseases - such as smoking, alcohol abuse and sexual behaviours - were not randomly distributed in the population. In fact, it was known that risk factors for many chronic diseases tended to cluster, that is, persons who had one risk factor tended to have one or more.

Because of this knowledge, the ACE Study was designed to assess what were considered to be “scientific gaps” about the origins of risk factors. These gaps are depicted as the arrows linking Adverse Childhood Experiences to risk factors that lead to the health and social consequences higher up the pyramid. Specifically, the study was designed to provide data that would help answer the question: “If risk factors for disease, disability, and early mortality are not randomly distributed, what influences precede the adoption or development of them?”

The ACE Study takes a whole life perspective, as indicated by the arrow leading from conception to death. By working within this framework, the ACE Study began to progressively uncover how childhood stressors (ACE) are strongly related to development and prevalence of risk factors for disease and health and social wellbeing throughout the lifespan.

<http://www.acestudy.org/>  
 And <http://www.cdc.gov/nccdphp/ace/index.htm>



To date, the ACE study has found a range of statistically significant findings that, in essence, say the more ACEs, the more likely you are to have increased chances of developing all sorts of other conditions.

Whilst the increases in lung cancer or chronic obstructive airways disease (COAD) might be explained by ACEs having caused increases in risk taking behaviours (such as smoking), the findings show that there is an even greater risk if it is ACEs PLUS smoking (albeit the smoking may have been related to the ACEs; people with fewer or no ACEs, who smoke the same amount, have a lower risk of developing these diseases). Similar associations have been found with autoimmune diseases (such as rheumatoid arthritis), and overall health related quality of life.

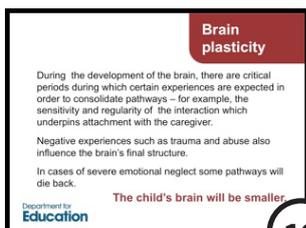


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At birth the infant brain contains millions of neurons, but most are not yet developed. Two processes use experience in different ways to build these connections. The first is experience-expectant development: experiences from the environment (light, sound, social contact and so on) help to organise synapses by stabilising some and letting others die. Almost half will be pruned during normal development: first in the visual and auditory centres, then in the language centres and finally in the prefrontal cortex; an area that continues to develop until early adulthood. The experience-expectant development phase involves very sensitive periods, times when areas of the brain are highly responsive to particular types of experience. The most discussed example is usually the formation of the ocular dominance columns: which are crucial for normal eyes control. The space between holding a baby and eye contact with the mother is the perfect distance for allowing normal development here.

The second process, experience-dependent development, is thought to be completed by early adulthood. This is where individual experiences are encoded in the brain through learning and memory. Rather than pruning unused connections, experience-dependent development involves generating new connections or modifying existing ones. Animal studies have revealed how important early stimulation is.

The diagram on the slide shows the proliferation in synaptic connections in children at birth, age 6 and at 14 (Seeman 1999).



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The brain is programmed to try to make sense of whatever experiences come its way.

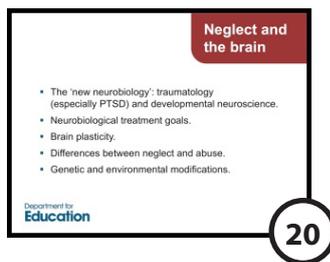
Acquisition of language is a good example. If this is not achieved by about the age of 8, that particular door or window of opportunity is closed forever. It becomes much, much harder to acquire language later on in life, as the necessary synaptic connections are no longer direct but are more likely to require a number of connections.

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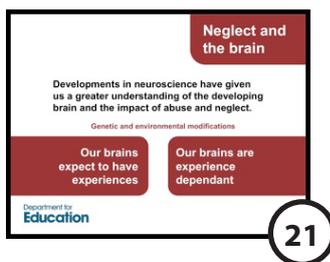
Recent years have seen mental health professionals from clinical perspectives consider psychiatric treatment approaches for childhood post-traumatic stress disorder (possible result of child abuse), weaving this with developmental neuroscience research on the biological aspects of attachment theory. One objective is to attempt to reverse some of the brain impairments that may have resulted from chronic stress by providing positive experiences. Thus in addition to psychological and family treatment goals, there are psychobiological goals such as decreasing stress reactivity and modifying brain connections through new experiences.

Glaser’s review (2000) is very important. The review emphasises that different types of abuse and other types of trauma may affect development of brain systems that regulate responsiveness to stress in ways that may be maladaptive to mental health. In addition, some types of maltreatment, most especially neglect, result in a lack of experiences required for typical brain development.

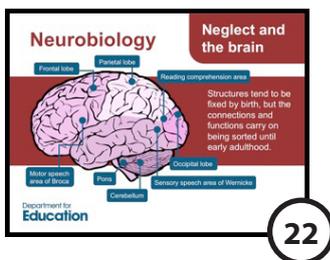
Brain plasticity: the ability of the brain to respond to experience by modifying its structure and function, both during development and throughout life. MRI (magnetic resonance imaging), and glucose tolerance tests using PET (position emission tomography) scans can both be used to demonstrate the concept.

Retrospective studies of adults, who were abused or neglected as children are fairly common, but are prone to categorisation and recall bias. Studies with children are less common, but a well designed one by Teicher et al. (2004) with adolescent children used regression analyses to show that neglect was associated with size differences in four different regions of the corpus callosum (a bunch of nerve fibres that connect the two halves of the brain, unifying perceptions and memories) – especially noted in the boys in the study.

For an excellent overview, see Twardosz and Lutsker (2010)



Biological approaches must encompass psychosocial influences; people are thinking beings and they are heavily influenced by the way they process the experiences that they undergo (Rutter 1991 in Howe et al. 1999, p14).



**Neglect and the brain**

Chugani *et al.* (2001)

- Romanian Orphans.
- Persistent specific behavioural and cognitive deficits.
- Brain glucose metabolism.
- Significantly decreased metabolism.

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Social policies and economic problems in the early 1980s resulted in early global deprivation for thousands of children. Chugani *et al.* (2001) undertook a study of children in Romanian orphanages. Over 65,000 children were placed in orphanages during this time, over 80% of them within first month of life. Caregiver ratio was usually 1:10 up to age 3, 20:1 thereafter. Infants spent up to 20 hours per day in their cribs.

Chugani and colleagues compared 10 orphans with 17 normal young adults and 7 children with epilepsy. The orphans often continued to cry in fear and did not use carers as a secure base. This alternated with indiscriminate friendliness. Most remained shorter in stature than their peers. There were continued deficits in fine motor skills, sensory difficulties (especially loud noises); behavioural (acts without thinking, hoards food); language (needs instructions over and over). Although there is much recovery by age 4, there remain significant deficits, thought to be associated with early global deprivation. Early deprivation appears to cause early damage in development to the limbic brain regions known to be associated with prolonged stress. Altered functional connections in these circuits may represent the underlying persistent disturbances in these children.

**Discussion point:** If you want to see more about Romanian orphanages, there is a good video on YouTube: <http://www.youtube.com/watch?v=VDR5xpLEx-U>

**Health brain**      **An abused brain**

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Bruce Perry and colleagues have established the Child Trauma Academy as a centre of excellence. A very readable book from Perry and Szalavitz (2006), *The Boy who was Raised as a Dog*, is aimed at the general public and includes a selection of case studies where children had witnessed abuse, neglect or witnessed family violence. The thread throughout the book is how maltreatment may change brain function. A very moving account of Perry's involvement with the Branch Davidian compound in Waco, Texas is given. These children had lived in constant fear, isolation, food deprivation and abuse, yet powerful therapeutic experiences can still occur.

**Child Trauma Academy**

- The Child Trauma Academy (Perry *et al.*)
- *The Child who was Raised as a Dog* (Perry & Szalavitz 2007)
- Neglect: the absence of critical organising experiences at key times during development.
- Non-human animal studies.
- Institutional deprivation.
- Recovery after safe placement.
- Corroboration: Romanian orphans.
- Brain scans.

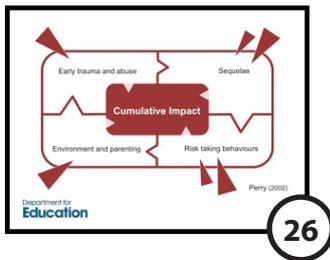
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see [www.childtrauma.org](http://www.childtrauma.org)

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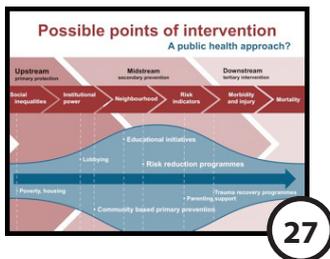
Perry has conducted animal studies on deprivation and enrichment, clinical studies on institutional deprivation and the extent of recovery after placement in safe and nurturing environments, plus similar work with children in foster care. Perry concluded that decreased sensory input results in cortical atrophy, enlarged ventricles, and small head size. Corroborative evidence of this is provided by Chugani *et al.*'s studies of Romanian orphans.

For more information see [www.childtrauma.org](http://www.childtrauma.org)



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Intergenerational cycles are clear in neglect: each life stage has moments where effective interventions can take place, but also where things can be made worse. Risk taking behaviours as a result of early neglect can impact on subsequent parenting behaviours of that individual and their social environment, which can in turn lead to neglect of their own children. Early interventions are crucial given the developing brain.



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Public health approaches to child neglect may be useful. For example, a public health approach to lung cancer has been to introduce a smoking ban in public places, and a public health approach to cot death has impacted on infant sleeping arrangements. The life continuum is commonly presented as a river. We have become very good at rescuing children and families from the river as they float past, we even save some from drowning. But do we need to also consider going up river, and targeting interventions there. For example, reviews of child death data has led to a number of initiatives to reduce deaths in particular geographical locations: traffic calming, smoke alarms and child safety locks on windows in social housing schemes.

**Discussion point:** So if we are looking at a public health approach, we might see a range of interventions that help us reduce child maltreatment. Some of these will be at a very upstream end (for example global policy); others will be at the very downstream end of the river. Ideally, there should be a range of interventions along the continuum, rather than a clustered effect at one end or another. Using the river analogy, think about the range of interventions you use in your area, and try to locate them on the continuum. Are there any surprises?

Notes