

### Childhood Neglect: Improving Outcomes for Children

#### Learning Outcomes

To identify concerns about parenting capacity that may contribute to neglect.

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

**Time** 30 minutes

#### Key Reading

Aldridge, J. and Becker, S. (2003) Children Caring For Parents With Mental Health Illness: perspectives of young carers, parents and professionals. Bristol: The Policy Press.

Cleaver, H., Unell, I. and Aldgate, J. (2011) Children's Needs – Parenting Capacity. Child Abuse: Parental mental illness, learning disability, substance misuse and domestic violence (2nd edition). London: The Stationery Office.

Falkov, A. (ed.) (1998) Crossing Bridges: Training resources for working with mentally ill parents and their children. Reader for Managers, Practitioners and Trainers. Brighton: Pavilion Publishing.

Royal College of Psychiatrists (2008) Mental Health Information For All. Available: ([www.rcpsych.ac.uk/mentalhealthinformation.aspx](http://www.rcpsych.ac.uk/mentalhealthinformation.aspx)) Accessed 4 May 2011.

Weir, A. and Douglas, A. (1999) Child Protection and Adult Mental Health: conflict of interest. Oxford: Butterworth Heinemann.

#### Links to Common Core

**Common Core 1** Effective communication and engagement with children, young people, their families and carers (skills: listening and building empathy). Develop and use effective communication systems appropriate to the audience.

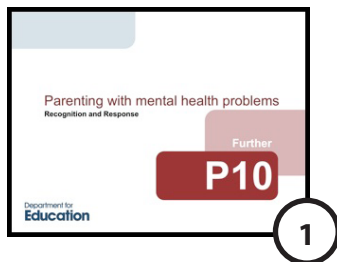
**Common Core 2** Child and young person development (knowledge: understand how babies, children and young people develop). Know that development includes emotional, physical, intellectual, social, moral and character growth, and know that they can all affect one another.

**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.

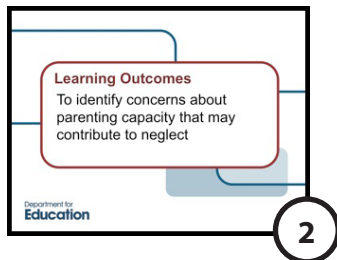
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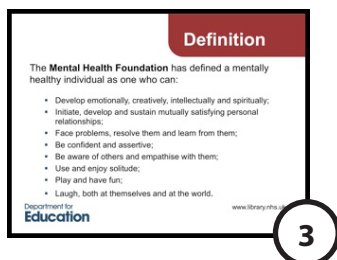


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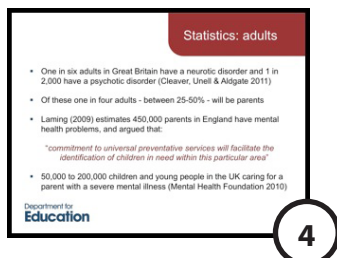


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Learning outcome.



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Cleaver, Unell and Aldgate (2011) have examined much of the published literature on parental mental ill-health and cite that 30% of adults with a mental disorder have dependent children and 7% live in lone-parent households (Falkov 1998; Melzer 2003). More recently, the Mental Health Foundation (2010) has estimated that 50,000 to 200,000 children and young people in the UK are caring for a parent with a severe mental illness.

The OPCS survey (Office of Population and Censuses and Surveys 1996), which breaks down the data by type of family unit, showed a higher rate of mental illness for lone parents than for adults living as a couple with children. Cleaver, Unell and Aldgate (2011) suggest that children may be more vulnerable to harm and neglect when living with a lone parent who suffers from mental illness; because when the parent is experiencing the disorder there is likely to be no other caring adult living in the home to take on the parenting role.

Statistics: children

- Re-analysis of Cleaver and Walker with Meadows' (2004) study of 2,248 referrals to children's social care found that parental mental illness was recorded in 10.4% of referrals
- Following an initial assessment, parental mental illness is recorded in 16.9% of cases
- Parental mental illness was identified in 25% of cases coming to a child protection conference (Farmer and Owen 1995) and in some 43% of cases where children are the subject of care proceedings (Brophy et al. 2003).
- Children of parents with mental health difficulties are at greater risk of experiencing health, social and/or psychological problems

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Research: children

- Research (Kaslow 1994; Ferro et al. 2000) identified that a significant number of parents of 'depressed children' had themselves increased levels of depression, anxiety, substance misuse and antisocial behaviour
- Combined issues such as genetic inheritance, social adversity and psychological factors may lead to an increased chance of children experiencing mental health issues

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Effects on parenting capacity

Parental Mental Illness	Parental Symptoms	Effect on Parenting/Parent-child relationship
DEPRESSION Major depressive disorder	Lack of energy, lethargy & low mood, disturbed sleep, appetite loss, concentration becomes difficult and decisions impossible	Physical and/or emotional neglect (inconsistent involvement), inability to focus (negative involvement), lack of communication & emotional support for child, inconsistent parenting (over & under involvement)
Bipolar affective disorder	Extreme physical and mental energy, argumentative, dictatorial and haughty	
Depressive disorder	Guilt, despair, hopelessness, self-blame, worthlessness, hopelessness	Mother seeks comfort from child, inconsistent parenting (over & under involvement)
Psychotic depression	Delusions of guilt, despair, hopelessness, suicidal and/or homicide thoughts or plans	Severe neglect, involvement in delusions

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## Unipolar affective disorder (depression)

Cleaver, Unell and Aldgate (2011) report that those who are depressed experience a pervasive and sustained change in mood, which leaves them feeling persistently sad, worthless and helpless. Depression is often cyclical and in most cases will resolve or improve with time. Often there is no clear single cause. Without treatment the symptoms can last for weeks or even years.

People who suffer from depression find it affects all aspects of their life: sleep is disturbed; appetite lost; thoughts are heavy, slow and gloomy; concentration becomes difficult and decisions impossible; actions slow down; and many sufferers are overwhelmed with feelings of exhaustion and worthlessness.

Finally, depression can deprive the suffering parent of the capacity to care about themselves or about those whom they love.

## Bipolar affective disorder (manic-depression)

About a quarter of people with major depression will also experience a manic episode. Although the depression is similar to that in the unipolar affective disorder, manic episodes are experienced as overwhelming surges of physical and mental energy. As a result, sufferers become over talkative, frequently to the point of incoherence. Others can become argumentative, dictatorial and haughty as a result of inflated self-esteem or grandiosity. The feeling of extreme physical energy can result in restlessness and excitability, and the manic depressive feels driven to continual activity. When in this state sleep appears unnecessary and for some, impossible. Eating an inconvenience that can be dispensed with.

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Effects on parenting capacity		
Parental Mental Illness	Parental Symptoms	Effect on Parenting/Parent-child relationship
<b>BORDER PERSONALITY DISORDER</b>	Unstable relationships, hostility & suspicion, impulsiveness, mood swings, associated alcohol & substance misuse, lack of empathy, self-harm, symptoms associated with other mental illnesses	Over involvement (obusive interactions, positive or negative), for example, harsh discipline & criticism, lack of empathy, modelling antisocial behaviour Exposure to discordance Inconsistency Inappropriate expectations for self care by child Comfort seeking from child Neglect (emotional and/or physical) and intolerance of child's need for care

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Research by the Royal College of Psychiatrists (2008) has shown that personality disorders tend to fall into three groups:

- **Suspicious – sufferers often experience feelings of deep suspicion and paranoia, are emotionally cold and have inappropriate emotional reactions.**
- **Emotional and impulsive – sufferers do not care about the feelings of others, tend to be aggressive and have a strong sense of their own self-importance.**
- **Anxious – sufferers tend to be perfectionists, rigid, judgemental, extremely sensitive to criticism, and feel insecure and inferior.**

Adult personality and borderline personality disorders are thought to be influenced in early attachment relationships and the impact of early negative childhood experiences including emotional, physical and sexual abuse. Personality disordered parents frequently have coexisting physical and mental health problems (Cleaver, Unell and Aldgate 2011).

Effects on parenting capacity		
Parental Mental Illness	Parental Symptoms	Effect on Parenting/Parent-child relationship
<b>SCHIZOPHRENIA</b>	<b>Positive Symptoms</b> (hallucinations & delusions)  <b>Negative Symptoms</b> (apathy & withdrawal)	Inconsistency Over involvement (positive or hostile) involvement in delusions  Neglect (consequence to child's needs) physical and/or emotional

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Positive symptoms highlight a change in the usual thinking process and can include:

- **Hallucinations – hearing, smelling, feeling or seeing something that isn't there. Voices which appear utterly real; although they can be pleasant, they are more often rude, critical, abusive or annoying.**
- **Delusions – totally believing things that others find strange, unrealistic and unbelievable.**
- **Difficulty in thinking clearly – concentration is hard and there is a tendency to drift from one idea to another.**
- **Feeling controlled – feeling psychologically and/or physically controlled by someone else.**

Together these symptoms are called psychosis.

Negative symptoms show a reduction or absence of usual mental functions and can include:

- **Loss of interest, energy and emotions**
- **Social withdrawal, not bothering to get out of bed or go out of the house**
- **Lack of motivation, not getting round to routine jobs like washing, cleaning or tidying**

(Royal College of Psychiatrists 2008)

Effects on parenting capacity		
Parental Mental Illness	Parental Symptoms	Effect on Parenting/Parent-child relationship
ANXIETY DISORDERS	Poor concentration, irritability, agitation, over-protective control, tension, aggression, avoidance. Physical symptoms (e.g. sweating, tremor, speech)	Irritability, criticism (negative involvement), increased parenting (over and under involvement), Comfort seeking from child

(Hood College of Pharmacy)

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There are various types of anxiety disorder and sufferers of anxiety disorders experience a range of fear symptoms in the absence of a dangerous situation, including increased arousal, restlessness, sweating, heart palpitations and shortness of breath, trembling and difficulties in concentration. They may experience chest pains and fear that they are dying or having a mental breakdown.

The different disorders include (Cleaver, Unell and Aldgate 2011):

- **Generalised anxiety disorder:** characterised by long-lasting unrealistic or excessive worries that are not focused on any particular object or situation. The constant fear and inability to control their worries may result in sufferers experiencing heart palpitations, dizziness, insomnia, and chest pain. Generalised anxiety disorder affects more women than men. A review of 41 prevalence studies on anxiety disorders in the adult population found a lifetime prevalence of 18.5% for women compared with 10.4% for men.
- **Panic attacks:** usually brief recurrent attacks of terror and apprehension which has no identifiable cause. It is often accompanied by physical symptoms such as shortness of breath, trembling and shaking, confusion, dizziness, nausea, feelings of impending doom, fear of losing control, of going crazy, of having a heart attack or even of dying and commonly last 15–30 minutes although on rare occasions they may last for some hours.
- **Phobias:** can be classified into three categories: social phobia, specific phobia and agoraphobia. Sufferers of social phobias fear or are acutely embarrassed about performing everyday actions such as eating in public. The triggers for specific phobias are more precise such as spiders, lifts or flying. Sufferers of agoraphobia experience anxiety about being in a place or situation where escape is difficult or embarrassing.
- **Obsessive-compulsive disorder:** characterised by the need to repeatedly do certain things, such as hand washing or cleaning the house, in order to relieve anxiety. Obsessions are distressing, repetitive, intrusive thoughts or images that the individual often realises are senseless. However, affected people cannot control their thoughts or actions.
- **Post-traumatic stress disorder:** results from a traumatic experience, such as being involved in warfare, rape, a hostage situation or a serious accident. The sufferer may experience flashbacks, avoidant behaviour, depression, anxiety, irritability and other symptoms.

Impact on the unborn child	
<ul style="list-style-type: none"> <li>• Exposure to high levels of stress and adversity increases the likelihood that a child born with a genetic predisposition to mental illness will develop symptoms at an early age (summarised by Cleaver, Unell &amp; Aldgate 2011).</li> <li>• "...maternal depression is a potent but malleable risk factor for child psychopathology, and there is reason to believe that early detection of depression in mothers, along with short-term support for their children, may prevent the development of disorders before they begin" (Reiss 2008, p.1084).</li> <li>• Mothers suffering from schizophrenia, anxiety and depression find it more difficult to keep medical appointments</li> </ul>	

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Prior to starting primary school many children attend nursery. However, some children will not experience nursery because of the mental health problems of their parent and the first opportunity to mix with their peer group will be at primary school.

Impact on children 1-12 months	
<ul style="list-style-type: none"> <li>• Babies may be neglected physically and emotionally</li> <li>• Cognitive development and learning may be delayed through parents' inconsistent, under-stimulating and hostile behaviour</li> <li>• Insensitivity and emotional unavailability in parents may result in inappropriate responses which causes poor bonding and insecure attachment</li> <li>• A baby's health and development may be exacerbated by living in an impoverished physical environment</li> </ul>	

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(Cleaver, Unell & Aldgate 2011)

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Impact on children  
1-4 year olds

- Illness and injury are not recognised and adequate and timely medical help not sought
- Risk of accidents, injuries and abuse may be increased because parental awareness and supervision is inadequate
- Diet may be inadequate and unsuitable
- Health problems can be exacerbated by living in impoverished physical environments
- Cognitive and language development may be delayed
- Insecure attachment and longer-term emotional and behavioural problems may arise as a result of unpredictable and frightening parental behaviour

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Impact on children  
5-10 year olds

- Increased risk of physical injury; children may show symptoms of extreme anxiety and fear
- Academic attainment may be negatively affected and child's behaviour in school can become problematic
- Boys more quickly exhibit problematic behaviour but girls are also affected if parental problems endure
- Poor self-esteem; children may blame themselves for their parents' problems

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Having a parent with mental ill health can lead to a number of concerns.

**Discussion point:** What might these concerns be?

- **Medical neglect** – for example, not attending for inoculations, untreated health problems, lack of dental care.
- **Nutritional neglect** – poor eating habits leading to poor health and affecting healthy development.
- **Physical neglect** – basics in life: food, warmth, clothing, shelter including lack of supervision and children may be placed in a high-risk environment compromising their safety.
- **Emotional neglect** – lack of interaction (withdrawal and attachment), or negative environment such as aggression reducing self-esteem. Emotional warmth. Parents react inappropriately or inconsistently.

These all affect the school-age child and may contribute to educational neglect.

Children already living with a parent with mental ill-health may be vulnerable to any or all of the factors stated above. All these factors whether through commission or omission will impact on the child's development.

Parents' with mental ill-health may be all a child has ever experienced or the parent's ill-health may occur whilst in the "school years." However, the later in a child's life a parent develops mental health issues, the greater coping mechanisms the child has.

### The risk of physical injury

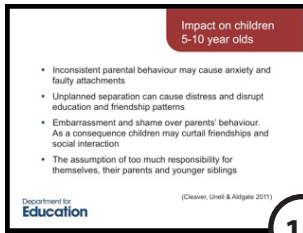
Child may be subject to physical injury due to an abusive parent or through the parents' inability to foresee dangers and risks. Many young people are involved in "significant" caring risks. This can lead to displays of extreme anxiety and fear.

### School behaviour and academic attainment

This may be impaired due to poor concentration, poor or sporadic attendance, or unmet health needs which means that the child is unable to function as effectively in school. This may lead to low self-esteem, which may cause disruptive behaviour.

### Self-blame

The parents may not have the capability of organising the child for school or consider its value. The difficulties for the child may be increased if the parent has agoraphobia. Some children may blame themselves for their parents' behaviours; some children feel responsible for their parent's ill health.



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### Unplanned separations

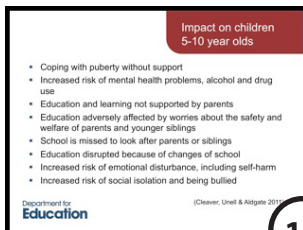
If the parent requires hospitalisation or if the child has to go to alternative accommodation, this can interrupt the child's education and friendships with peer groups.

### Stigma

The stigma of mental health in the family particularly when or if the child becomes aware of bizarre behaviour.

### Responsibility

Child finds themselves with responsibility for the parent's needs and demands and also younger siblings above and beyond normal expectations. Responsibility could be unfair and dangerous. For single children they may have all the caring on their shoulders. For older children with one or more siblings they have perhaps both the parent and the siblings to care for.



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### Coping with puberty

Coping with puberty without support. Young person may not get factual information about puberty, sex and contraception

### Denial

A young person may deny their own needs and feelings. Young people may internalise anxiety and concerns, affects concentration and general health. Research by Barnardo's indicated that 72% of children do not tell their teachers and 75% do not tell their friends.

### Problems and behavioural disorders

Mental health difficulties in parents may lead to increased risk of psychological problems and behavioural disorders. This could lead on to suicidal tendencies or offending behaviours.

### Poor school attainment

Compounded by difficulties in concentration, poor attendance in order to look after parents or younger siblings. Difficulties can be seen in punctuality, extra curricular activities or anxiety and fatigue.

Less attendance – less academic achievement – lowers self-esteem – less friendships. And eventually unacceptable behaviour that could lead to exclusion.

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**Impact on children 11-15 year olds**

- Increased risk of conduct disorders including bullying
- Increased risk for adolescent boys of being sexually abusive
- Poor or ambivalent relationships with parents
- Lack of positive role models
- Poor self-image and low self-esteem
- Friendships restricted or lost
- Feelings of isolation and having no one to turn to
- Increased responsibilities of being a young carer
- Denial of own needs and feelings

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(Cleaver, Unell & Aldgate 2011)

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### Fear

Young people may fear that revealing family problems may lead to the family being broken up resulting in increased isolation from friends and adults outside the family.

### Increased risk of abuse

Due to parent's diminished quality of care or psychotic state, the young person may be at risk of increased abuse.

### Poor role model

Parents may react with inappropriate responses and this poor role model makes child vulnerable.

**Vulnerability and adversity**

- Chaotic, disorganised household and routines
- Poverty
- Isolation – geographically and socially
- Substance misuse / domestic violence
- The parent's "need" – physically & psychologically
- Poor role model
- Sibling interaction
- Inappropriate responsibility

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Parents may find it difficult to organise themselves and provide little structure for the child.

Research shows that assessments tend to be incident-focused and thus fail to take into account both the children's developmental needs and parents' capacity to respond to these appropriately.

In rural areas, families can be distant from agencies. Isolation through missed opportunities to mix with peer groups.

Parenting skills today impact on child for future both as an adult, and also as a parent.

Sibling may not be properly managed leading to one child being more domineering, bullying or other siblings being bullied.

The need to look after a parent may result in decreased opportunities for a child or young person to mix with their own peer group; being placed in the position of being the carer is not easy.

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**Protective and resilience factors**

- Sufficient income support and good physical standards in the home
- Practical and domestic help
- Regular medical and dental checks including school medicals
- Regular attendance at school with sympathetic, empathic and vigilant teachers
- A mentor or trusted adult with whom the child is able to discuss sensitive issues
- An adult who assumes the role of champion
- The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated

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**Discussion point:** What factors might help protect the child?

Protective factors may include:

Other adults looking to the child and parent. Good location. Alternative support from adults with whom child has true and trusting relationship

Agencies are able to provide attention. Discrete episodes of parental illness, with good return of skills/abilities between episodes

School sympathetic and aware of child's situation. Greater cognitive abilities

Experience of success outside home (educational, social, sporting)

Age plays a major factor in the severity of harm experienced by a child. The older the age of a child at the onset of their parents' illness often means that the child is more sociable, able to engage with adults and has an easier 'temperament'

**Children's understanding**

- Understanding parent's mental illness:
  - personal concerns
  - attributions as to the cause of the illness
  - quest for information
- Recognising 'the signs' of mental illness
- Impact of hospitalisation
- Managing mental illness:
  - coping with impact of parents' illness on self
  - coping with the impact on their parent
  - perceptions of what is helpful for parent

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**What to do?**

- Awareness by professionals
- Clear treatment plans
- Timescales
- Evidence-based assessment frameworks
- Assessment and education of carers both kinship and foster

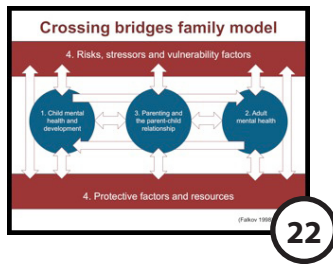
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An approach based on the Crossing Bridges Family Model (Falkov 1998) enables staff to:

- Know what to look for that indicates neglect.
- Take a holistic approach to assessment and consider the environment, family, cultural and social systems within which individuals live (e.g. housing, finance, employment, relationships).
- Gain a better understanding of the links and relationships between risk of poor outcomes and resilience, adult and child, symptoms and parenting, the changing pattern over time, and what to do with the information they gather.
- Understand the risks to health and wellbeing as a result of neglect that occur across generations and manage these risks to reduce their impact.

All have implications for the frontline practitioner working with neglect.

Adopting this approach requires a change in attitude and practice which includes:

- Switching from a focus on diagnosis or pathology to concentrate on individual strengths and interventions that are strongly associated with promoting mental health and recovery, sustaining families and promoting inclusion.
- Raising the expectations of people who use mental health services who are parents and taking seriously their views of their resource needs.
- Looking at the family as a unit and focusing on positive interdependency and supportive relationships.
- Helping parents to understand their mental health problems, their treatment plan, and the potential impact of mental health problems on their parenting, the parent-child relationship and the child.
- Working with parents and children to enable the child to have age-appropriate understanding of what is happening to their parent and information about what services are available for them in their situation and how they can access these.

At the same time, practitioners need to remain aware and be prepared to intervene when there is evidence that the child is suffering, or is likely to suffer, significant harm.

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