

Childhood Neglect: Improving Outcomes for Children

Learning Outcomes

To assess parents' capacity to respond to the child's needs.

Audience Groups 1-8 (Working Together 2010)

Time 30 minutes

Key Reading

Crittenden, P.M. (1993) 'An information-processing perspective on the behavior of neglectful parents'. *Criminal Justice and Behavior* 20(1): 27-48.

Donald, T. and Jureidini, J. (2004) 'Parenting Capacity'. *Child Abuse Review* 13(1): 5-17.

Horwath, J. and Morrison, M. (2000) 'Assessment of Parental Motivation to Change.' In J. Horwath (ed) *The Child's World: Assessing Children in Need and Their Families*, pp.77-90. London: Department of Health, NSPCC and University of Sheffield.

Horwath, J. (ed) (2009) *The Child's World. The Comprehensive Guide to Assessing Children in Need*. London: Jessica Kingsley Publishers.

McGhee, J. and Hunter, S. (2011) *SCCPN Briefing - Involving parents in assessment and decision-making*. Stirling: Scottish Child Care and Protection Network.

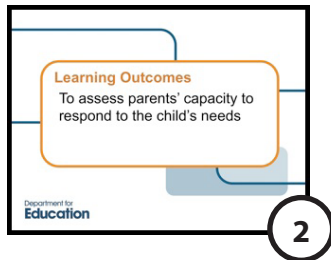
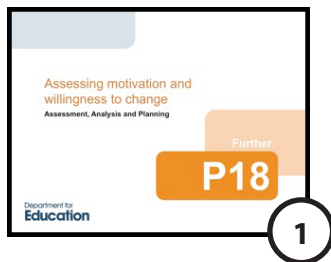
Links to Common Core

Common Core 1 Effective communication and engagement with children, young people, their families and carers (skills: consultation and negotiation). Understand the key role and value of parents and carers; know when to refer them to further sources of information, advice or support.

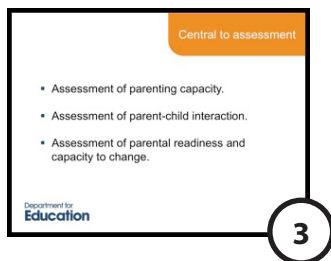
further

Assessing motivation
and willingness
to change

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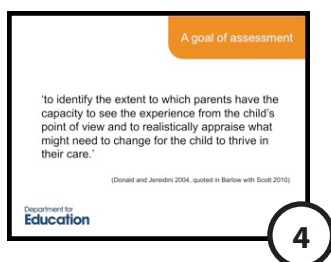
Learning outcomes.



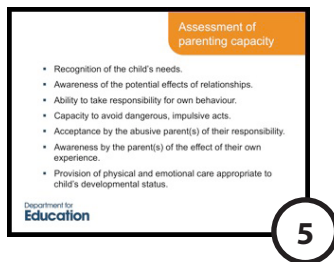
It is important to understand that assessing the child and family over time will greatly increase our understanding of the parents' capacity to change. Consideration should be given to a model of change focusing in detail on the stages of the change process (Howarth and Morrison 2000). Donald and Jurendi (2004) adopted an approach to assessment built on the Assessment Framework, which focuses on three key areas:

- parenting capacity
- parent-child interaction
- parental readiness and capacity to change.

The authors argue that attention should be given to parenting capacity independent of how challenging the child's behaviour may be.



Reflect on quote.

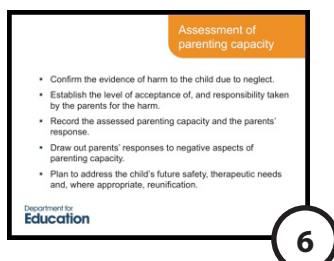


In understanding what needs to change, it is helpful to reflect on some characteristics of parenting capacity:

- **Recognition of the child's needs and to put them before parental needs/wants.**
- **Awareness of the potential effects of relationships stresses (between parents' and parent-child) on children.**
- **Ability to take responsibility for own behaviour.**
- **Capacity to avoid dangerous, impulsive acts.**
- **Acceptance by the abusive parent(s) of their primary responsibility for providing a safe environment for their child.**
- **Awareness by the parent(s) of the effect of their own experience or their parenting capacity.**
- **Provision of physical and emotional care appropriate to child's developmental status.**

However, capacity in terms of parenting may be influenced by the experiences of the adult themselves, and the child. Several factors impact on parenting capacity: this includes knowledge and experiences of parenting, and the ability to form relationships; the support or distress from extended family and other networks such as other parents; financial stress; alcohol and drug misuse; and other factors such as domestic violence and parental mental health difficulties.

A child's disability, illness or emotional disturbance prior to, or as a result of, maltreatment, and developmental age of child at the time of the abuse will impact on the parent-child relationship and capacity to parent the child.



Assessments should confirm the evidence of harm to the child, and clearly state the level of responsibility taken by the parents for the harm done.

The assessment should also record the assessed parenting capacity and the parents' response to this. It should then consider the level of responsibility taken by the parents and state the optimal plan in relation to the child's future safety, therapeutic needs and reunification, based on assessed parenting capacity, responsibility taken by the parents and their preparedness to address identified concerns.

The final assessment should restate the evidence of harm to the child.

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N18 ³

Assessment of parent-child interaction

- Sensitivity of parent towards the child.
- Control of parent's emotions, for example, covert or overt hostility.
- Responsiveness of the adult towards the child.
- The infant's cooperativeness.
- The infant's compulsivity.
- The infant's 'difficultness' and passivity.

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7

Barlow with Scott (2010) comment that parent-infant/child interaction should be assessed routinely by social workers who have received training, or by a specialist professional.

It is important to understand that assessments of the parent-child interaction is not an individual characteristic; it is characteristic of a specific relationship. The same adult could display different degrees of sensitivity with different children.

Assessment of willingness to change

- Capacity has two elements: ability and motivation.
- Each parent is an individual with different motivation and ability to change. It is crucial that assessment involves both, as one parent could negatively influence and undermine change in the other.
- Intentions to change are complex and should not be confused with willingness to work with a particular practitioner or particular programme.
- Professionals need to recognise the changing context in which assessment takes place. It is only by assessing the family over time that it is possible to discover the parental and familial capacity to change.

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8

In the Child's World (2000; 2009), Howarth and Morrison discuss how capacity has two elements: ability and motivation; a parent may have the knowledge and ability to change, but not the motivation or have the motivation, but not the ability.

Each parent is an individual with different motivation and ability to change. It is important to take this into account during an assessment, and for professionals to recognise. Also, the changing context in which assessment takes place. It is only by assessing the child and family over time that it is possible to discover the parental and familial capacity to change.

However, Littell and Girven (2005) cited in Barlow with Scott (2010) point to the need for caution. Constructs such as the capacity for change are helpful, but, as yet, there is no causal association between intentions or readiness to change and later outcomes for the child and family.

Steps in assessment

- Assessment of parents' functioning including an assessment of their interaction and relationship with their child(ren).
- Specification of targets for change that should include the unique problems facing the family.
- Implementation of interventions that addresses all aspects of family functioning with goals tailored to address specific areas of family functioning.
- Objective measures of changes over time including standardised tests pre- and post-intervention and evaluation of parents' willingness to change.

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9

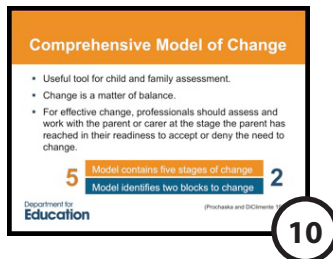
Having looked at the elements to consider during an assessment, it is then useful to explore the steps in assessments and the different models and tools of assessment that can contribute.

Clear steps include an assessment of parents' functioning and an assessment of their interaction and relationship with their child(ren). Targets should be identified and set for the members of the family that are specific to the unique problems facing the family. Subsequent measures of change over time include standardised tests pre- and post-intervention and evaluation of parents' willingness to change.

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and willingness
to change

N18 4



One useful model is Prochaska and DiClemente's Comprehensive Model of Change (1982) for child and family assessment. It can be applied to any family where change is required at personal and relationship levels, especially where there may be a need for external sanctions via court orders and where the parents' engagement in the system is involuntary at the outset at least. Equally it applies to situations in which the parent has sought advice and support about problems within the family.

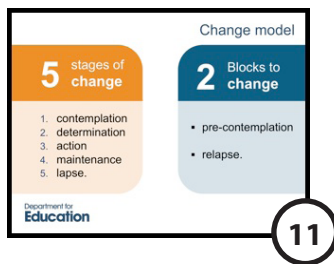
The model's basic premises are:

- **that change is a matter of balance, and that people change their behaviour when there are more motivational forces in favour of change than in favour of the status quo**
- **for the process of change to be effective, professionals must assess and work with the parent or carer at the stage which the parent has reached in terms of their readiness to accept or deny the need to change.**

The model contains five stages of change:

- **contemplation**
- **determination**
- **action**
- **maintenance**
- **lapse.**

There are also two blocks to change: pre-contemplation and relapse.



Contemplation

As Howarth and Morrison (2000; 2009) write, this is the stage when parents begin to consider the possibility that there is a problem and explore whether or not they are able to tackle it. The assessment process is essential to address some of these possibilities, but can take time. This is why it is essential to ensure that the needs of the child remain central and parents may be ambivalent and feel anxious about what change will mean. Part of parents' very early motivation may come from outside the family as agencies may have some concerns about the family, or the child is subject to a child protection plan.

However it is important that motivation also comes from within parents and families and not only in response to external pressures. Therefore, the ability of workers to develop a relationship with the family, which allows parents to reflect on their behaviour, understand the needs of their children and begin to consider what needs to change, is crucial if intervention is to lead to change.

Workers must also recognise that individual parents may be at different stages in the change process. In addition each parent may need to make a different type of change. Consideration should also be given to the part that can be played by the extended family in terms of positive and negative influences for encouraging and supporting change.

Steps in the contemplation stage include:

1. I accept there is a problem: 'I accept my child is underweight.'
2. I accept I have some responsibility for the problem: 'I never have enough time to feed her as she's such a slow eater.'
3. I have some discomfort about the problem: 'I feel bad when I see how thin she is.'
4. I believe that things must change: 'She really needs to put on weight.'
5. I can see that I can be part of the solution: 'I managed to feed the other one so I am capable.'
6. I can make a choice: 'If I don't do something about this she could be taken away.'
7. I can see the next steps toward change: 'I think I will go to that family centre.'

Determination

Determination is found when parents make a more formal expression of the real nature of the problems they face and how these affect their children, the changes they wish/should make and what specific goals are to be achieved.

Clear agreements for work towards change need to be agreed among parents, children and professionals. These agreements should include specific detail about who does what, when and how. For parents the agreements can reinforce the fact that progress will be incremental and achieved in small stages. Parents are more likely to be motivated to change if they receive early support services as part of the assessment process and any agreements need to make explicit what the parents can expect from professionals.

Action

At this stage, a parent has made a decision to change and is attempting to use the services and interventions provided to put the change into practice. If parents are not properly prepared, they may find it difficult to engage in the process of change. Specific interventions for specific problems may be useful to let parents work in organized incremental steps, rather than being overwhelmed by all that is required.

Maintenance

Maintenance emphasises moves to consolidating changes already made. This may be achieved through rehearsal and testing of newly acquired skills and coping strategies, over time and under different conditions. At this point, it is important to understand the need to give specific attention to relapse-prevention work to anticipate unexpected stresses and triggers that are likely to occur and can result in parents reverting to past patterns of behaviour. Good examples are those parents recovering from addictions. It is particularly important to recognise the impact of stresses on the parents when one parent changes while the other is left out of that process. The abandonment of one parent can occur if the focus of professional involvement centres on the other parent, frequently the mother, who is prepared to work with the professionals.

This stage also requires good professional judgement and understanding of how far the family has progressed. Decisions about the level and extent of supports or service provided may be subject to external economic or organisational pressures. If services are withdrawn too early, families and parents specifically, may find it too difficult to maintain progress and revert to the previously concerning behaviours.

Further complications arise if parents are unable to internalise the changes required of them. Change can only be maintained through the use of external resources, for example family and community networks. Some parents with learning disabilities, for instance, are able to meet the developmental needs of the child with support from family and the community. Therefore, part of the assessment process needs to include an evaluation of both the effectiveness and viability of maintaining a support network as a long-term arrangement, in the event of the parents' present inability to internalise the required changes.

Lapse

In reality few people who are trying to change behaviours succeed the first time. We often use the term 'two steps forward, one step back' - change requires commitment and is often incremental.

This model allows for both lapses and relapse. Lapses occur when individuals/families get themselves into difficult situations. In this case, it is vital that families recognise what is happening, and put into action their plan to avoid a difficult situation becoming more high-risk.

The two blocks to change are:

Pre-contemplation

The parents who are in pre-contemplation are unaware, or have a vague recognition of concerns, but at this stage they have not considered that their behaviour needs to change. Parents may respond in a variety of ways to the initial social work contact ranging from anger to anxiety when faced with the concerns of professionals and may be defensive, and deny difficulties. Alternatively, there may be a helpless, passive response in which parents seemingly do not react to the professionals' concerns.

At this stage the agencies' concerns to protect the child may involve practitioners in planning interventions to safeguard the welfare of the child. However, workers need to be aware that parents at the pre-contemplation stage are unable to make a full commitment to plans for change as they have not yet come to terms with the need to change.

Relapse

A relapse occurs with a return to the unwanted behaviour – in this case neglect of a child – for which there may be serious consequences for the family's future.

Lapses are therefore, part of the process of change - the two steps forward, and one step back. A relapse, where the risks to the child of suffering neglect are high, further action may be required that includes the child being looked after for a specific period of time.

Information processing

- This model evolved from research on neglectful parents to develop theory on how and why neglectful behavior occurs.
- Identifies 4 stages at which parents could fail to respond to signals of children's needs.
- Failure at each stage represents a different type of neglect.

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12

Engagement with parents is core to the possible success of interventions by agencies in cases of neglect. Being forced to engage in change is likely to increase the parents' sense of failure, uncertainty and low self-efficacy. In turn, this means that parents are likely to respond negatively to agencies (Howarth and Morrison 2009), so it is of critical importance to involve the parents as much as possible in decision making.

Parents may feel disempowered and marginalised in formal decision-making arenas. They can form the impression that decisions have already been made and that there is little scope for influencing them. This resonates particularly in child protection proceedings and those involving parents with learning disabilities.

Using cognitive theory on information processing, Crittenden (1993) identified four stages at which parents could fail to respond to signals of children's needs. It is proposed that failure at each stage represents a different type of neglect. Moreover, each stage is hypothesized to be associated with different types of parental developmental history and to call for different types of intervention.

Information processing

Parents could fail to respond to children's need for care because:

- did not perceive the signal
- interpreted the signal as not requiring a parental response
- knew that a response was needed but did not have a response available or
- selected a response but failed to implement it.

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13

Specifically, parents could fail to respond to their children's need for care because they:

- did not perceive the signal
- interpreted the signal as not requiring a parental response
- knew that a response was needed but did not have a response available
- selected a response but failed to implement it.

This model hypothesizes that different types of parental development history results in different types of neglect, with implications for how practitioners should interact with parents and families.

In practice: disorganised neglect

- Confusion for engagement:
- Reduced ability to express empathy, be
- Inappropriate of the child's needs
- Refusal to meet the child's needs
- Denial that some or all of the needs have not been met

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14

Slides 14-18 discuss different types of neglect and the implications for engagement.



Please Note Thumbnails of slides shown with a split screen indicate that the slide contains an animated sequence.

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N18 8

**In practice:
emotional neglect**

- Opposite of 'disorganised' families.
- Materially advantaged but failure to connect emotionally.
- Children know their roles, respond to clear rules, often do well at school - physical needs are met but not emotional needs.
- Absence of feelings - lack of empathic responses from parents.
- Results in children learning to block expression of feelings and awareness of feelings.
- Children may appear falsely bright, self-reliant but have poor social relationships.
- Children may become carers - role reversal.

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15

**In practice:
emotional neglect**

Implications for engagement:

- Families appear superficially successful – but do not require less professional involvement.
- Help parents learn to use other sources of support.
- Teach parents to engage with children emotionally.
- Provide structured support with clear rules and roles.

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16

**In practice:
depressed neglect**

- Classic neglect: parents appear withdrawn with dull affect.
- Uninterested in professionals, appear unable to understand and unmotivated.
- Love their children - but do not perceive their needs or believe anything will change.
- Present as passive and helpless.
- Parents have shut down both cognition and affect.
- Parents may feed, change and move children but rarely respond to signals from the them.
- Children may give up when there are no responses - become silent, limp, dull and depressed.

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17

**In practice:
depressed neglect**

Implications for engagement:

- Children benefit from access to responsive and stimulating environments, for example, day care.
- Parents need to learn to express feelings - practice smiling, laughing, soothing.
- Parent education unlikely to be successful if backed by threats or punitive strategies.
- Medication may help but beware side-effects.
- Needs a longer term, supportive approach.

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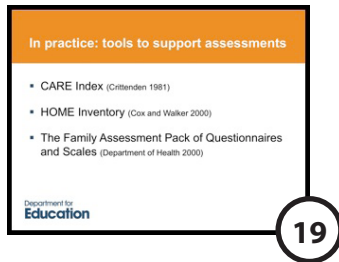
18

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to change

N18₉

Standardised tools – such as the CARE Index (Crittenden 1981) - can be used to support assessments and includes assessments or observations of:



- **sensitivity of parent towards the child**
- **control of parent's emotions: covert or overt hostility**
- **responsiveness of the adult towards the child**
- **the infant's cooperativeness**
- **the infant's compulsivity**
- **the infant's difficultness and passivity.**

Other tools include the HOME Inventory (Department of Health, Cox and Walker 2002) and the Family Pack of Questionnaires and Scales (Department of Health, Cox and Bentovim 2002).

The HOME Inventory enables the practitioner to assess the quality of parenting and the home environment provided for a child. The HOME (Home Observation and Measurement of the Environment) is user-friendly and is well received by families. It involves an hour long semi-structured interview in the home with the main caregiver and child to collect information about the nature and variety of the child's day-to-day experiences and the parenting capacity of the caregivers, and to explore a range of other aspects of the child's world and the life of the family. The HOME has been shown to be a good predictor of outcomes for children.

The Family Pack of Questionnaires and Scales provide a means of gathering information about key personal and parenting issues. They are tools for screening for emotional and behavioural difficulties in both children and adults, parenting problems and other family and environmental factors including recent life events, mental health difficulties and alcohol problems as well as the quality of family life.

Developed by Mary Main and her colleagues (1993), the Adult Attachment Interview (AAI) is a quasi-clinical semi-structured interview that takes about one hour to complete. It involves about twenty questions and has extensive research validation to support it. The interview taps into adult representation of attachment (i.e. their own internal working models) by assessing general and specific recollections from their childhood.

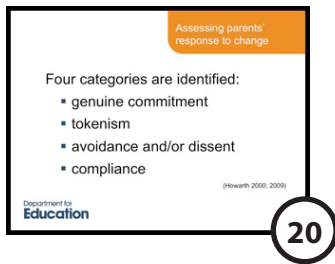
Parental AAI Attachment includes:

Autonomous: adults value attachment relationships, describe them in a balanced way and as influential. Their discourse is coherent, internally consistent, and non-defensive in nature.

Dismissing: adults show memory lapses. Minimize negative aspects and deny personal impact on relationships. Their positive descriptions are often contradicted or unsupported. The discourse is defensive.

Preoccupied: adults experience continuing preoccupation with their own parents. Incoherent discourse. Have angry or ambivalent representations of the past.

Unresolved/Disorganized: adults show trauma resulting from unresolved loss or abuse.



One of the crucial assessment tasks for the social worker is not only to understand how best to engage with parents, but also to assess the parents' commitment to engaging and implementing change. As Horwath (2000) has written 'effective change occurs when individuals are in agreement with the change and are prepared to put in effort to effect change.

As indicated, some parents may have difficulty in engaging with the change process and their responses may indicate whether the issue lies with acknowledgement of the need to change or the effort they are prepared to put into either the change or their capacity to change' (p84). Horwath developed a model to provide a framework for assessing parents' responses to change, which identifies four possible types of response:

- **genuine commitment**
- **tokenism**
- **avoidance and/or dissent**
- **compliance.**

Genuine commitment: the parent recognises the need to change and makes real efforts to bring about these changes. These parents are the ones who are most likely to maximise the use of resources provided to support change.

Tokenism: the parent agrees with the professionals regarding the required changes but will put little effort into making change work.

Dissent and/or avoidance: dissent can range from dissent to bring about change to disengaging from the process. One of the most difficult forms of dissent to assess and manage, are those of parents who do not admit their lack of commitment to change but work subversively to undermine the process. This is especially likely in cases involving perpetrators of sexual abuse and Fabricated or Induced Illness by Proxy (also known as Munchausen Syndrome by Proxy).

Compliance: in this situation the parents will do what is expected of them because they have been 'told' to do it. Change may occur but has not been internalised because the parents are doing it without having gone through the process of thinking and responding emotionally to the need to change.

Very few people can both agree to change and implement it by changing their attitudes and behaviour without any lapses. It is most likely that commitment and effort will vary not only from individual to individual but at different stages of the change process. For example, parents may make a genuine commitment to change at the start of the process because they are frightened of losing their children. However, as a care plan is created and implemented, this fear may subside and levels of commitment may waver as ambivalence returns. Practitioners need to be keenly aware of where such lapses are genuine lapses or a relapse into previous behaviours.

further

Assessing motivation
and willingness
to change

N18 11