

# PRACTICE NOTES

For North Carolina's Child Welfare Workers

From the NC Division of Social Services and the Family and Children's Resource Program

Volume 18, Number 1  
January 2013

This publication for child welfare professionals is produced by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families within the School of Social Work at the University of North Carolina at Chapel Hill.

*In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.*

**Let us hear from you!**

To comment about something that appears in Practice Notes, please contact:  
John McMahon  
Jordan Institute for Families  
School of Social Work  
UNC—Chapel Hill  
Chapel Hill, NC 27599-3550  
jdmcmaho@unc.edu

**Newsletter Staff**

Mellicent Blythe  
John McMahon  
Laura Phipps  
Tiffany Price

**Visit Our Website**

www.practicenotes.org

## Child Neglect: Impact and Interventions

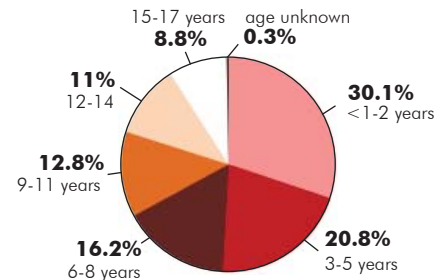
We know a fair amount about child neglect. For example, we know it is the main reason families come to the attention of Child Protective Services in North Carolina (Duncan, et al., 2012). As the figure below illustrates, that's also true across the United States.

We also know that neglect disproportionately affects younger children. In federal fiscal year 2011, 50% of child neglect victims were five years old or younger; 30% were age two or younger. The statistics for medical neglect were quite similar (USDHHS, 2012).

This, of course, is not good. As the National Scientific Council on the Developing Child (2012) points out, significant neglect—especially early in life—can hurt children's physical and mental development, impair their ability to cope with adversity, compromise their immune systems, and put them at risk for emotional, behavioral, and interpersonal relationship difficulties later in life.

Unfortunately, we know less about the most effective ways to help families struggling with neglect. At present the California Evidence-Based Clearinghouse for Child

**Age of U.S. Neglect Victims, 2011**



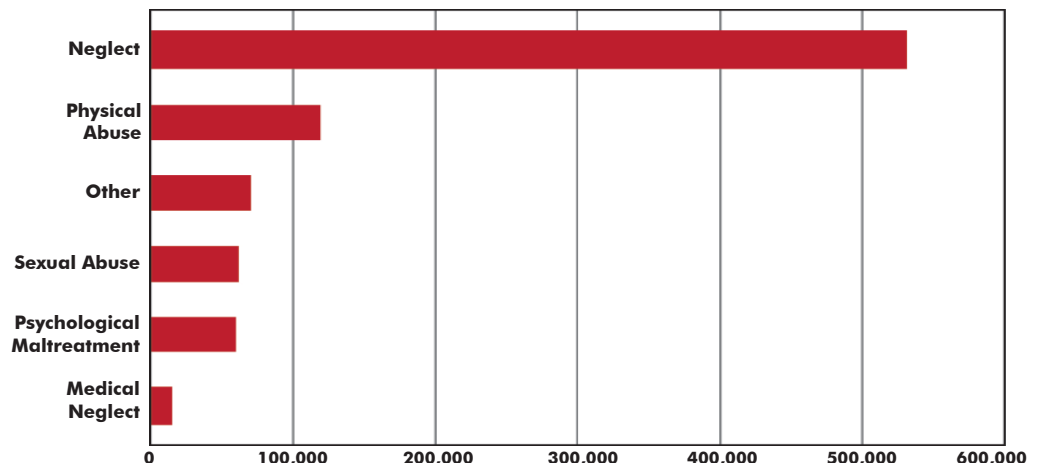
Source: USDHHS, 2012

Welfare ([www.cebc4cw.org](http://www.cebc4cw.org)) lists just four programs as having adequate evidence to prove their effectiveness with neglect. We profile one of these, SafeCare, in this issue.

But we're learning more all the time. Researchers are working hard to ensure that in the future we will be better able to respond to—and prevent—neglect. In the meantime, child welfare professionals continue to do all they can to address this daunting challenge.

We hope this issue of *Children's Services Practice Notes* will help them with this important work. ♦

**Child Maltreatment in the United States Oct. 1, 2010–Sept. 30, 2011**



Reflects total number of victims (defined as a child for whom the state determined at least one report of maltreatment was found to be substantiated or indicated) as reported by 50 states, the District of Columbia, and Puerto Rico. "Other" includes abandonment, threats of harm, and drug addiction. Source: USDHHS, 2012

## Impact of Neglect on Brain Development and Attachment

Neglect is sometimes considered less severe than other forms of maltreatment. However, a study comparing developmental repercussions for four types of child maltreatment—neglect, physical abuse, sexual abuse, and psychologically unavailable parents—concluded that neglected children suffer the worst consequences (Gaudin, 1993).

Why would neglect have such an impact? Two big reasons: brain development and attachment.

### Neglect and Brain Development

Because development begins *in utero*, neglect can affect the brain even before a child is born. For an illustration of the impact environmental conditions can have on children before they are born, consider Charil's study (2010), which found reduced brain size and impaired development in children whose mothers had high levels of stress hormones during pregnancy.

The ongoing nature of chronic neglect significantly impacts the brain in infancy and early childhood. According to Perry (2002), neglect at this phase impedes formation of neurological pathways essential to communication in the brain. In particular, neglect has been shown to harm the frontal cortex, the area of the brain responsible for planning, decision making, and memory (Perry, 2002; DeBellis, 2005). Extreme neglect can actually make children's brains smaller.

There are many outcomes related to this disruption in brain development, including lowered IQ, cognitive delays that impact learning, and difficulty with behavioral inhibitions (Wilkinson, 2009; Barkley, 1997).

### Neglect and Attachment

A secure attachment to a primary caregiver is the foundation that allows

children to learn to trust others and explore the world around them. This foundation is crucial for healthy development. The degree to which children are attached to their caregivers depends on how well their needs were responded to in early life. Because neglect by definition means needs are not met in some significant way, we would expect higher rates of attachment problems in neglected children.

That's just what we find: up to 85% of children in out-of-home placement have some disruption in attachment (Perry, 2002). Attachment difficulties caused by neglect affect every aspect of children's development, especially their ability to relate to others. Studies have repeatedly shown that children with disrupted attachment who have experienced neglect have problems coping and managing emotions, are more hopeless, and have a poor self-concept (Hildyard, 2002; Erickson & Egeland, 2002; Shipman, 2005).

According to Erickson and Egeland (2002):

Emotionally neglected children expect not to get what they need from others, and so they do not even try to solicit care and warmth. They expect not to be effective and successful in tasks, and so they do not try to succeed. Or perhaps, these children's dependence needs are so overwhelming that they are barely able to concern themselves with being motivated and task-oriented.



### Neglect: Is it Trauma?

Neglect is a form of trauma because the stress responses that occur in the brain from a lack of care are the same as those that occur when a physical threat occurs (DeBellis, 2005). Neglect puts children at risk for other forms of trauma. Neglected children often need more medical attention and may have trauma related to medical procedures. In addition, neglected children often have more behavior problems, which can lead to a greater risk of physical abuse.

For all these reasons, we must include neglect in our ongoing dialogue about trauma and ensure that neglect is considered as we build a more trauma-informed child welfare system.

### Learn More

Want to learn more about how neglect disrupts the developing brain and how best to respond? Read the clear, accessible Working Paper #12 from the National Scientific Council on the Developing Child. You can find it at [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).



### Other Learning Resources

- *Understanding the Effects of Maltreatment on Brain Development*. <http://1.usa.gov/UJj3Jj>
- *Trauma, Brain and Relationship: Helping Children Heal* (video). <http://bit.ly/OR2JUF>

Given neglect's impact, we must address the gap between what we know and what we do. The phrase "neglect of neglect" has become a common saying regarding what has been referred to as "the absurd paradox" of our field: although neglect is the most common form of maltreatment with the most significant impacts, it is also the least understood and often the least addressed (McSherry, 2007). We need to focus more on understanding the complex factors that contribute to neglect and developing strategies for intervening as early as possible. ♦

## What We Know about Neglect: Key Points from the Research

The latest science about the negative effects neglect can have on children is compelling. For those who must intervene, it can also be overwhelming.

**The good news: there are effective interventions to help caregivers meet the needs of children who've been neglected.**

The following information, drawn from a working paper by the National Scientific Council on the Developing Child (2012), summarizes key points from the research to keep in mind when working with children and families touched by neglect.

### Children Can Recover

Neglect's negative effects can be reduced or reversed. Children can recover if they are removed from neglectful conditions and placed in nurturing environments.

### Intervention Is Often Necessary

Simply ending the neglect usually isn't enough. Children who've been neglected often need appropriate, timely interventions before they can get better. To heal, children often require systematic, empirically supported, long-term (6 – 9 months or longer) interventions involving skilled, supportive caregiving.

The research also tells us that if severely neglected children don't get therapeutic, supportive care, they "remain at increased risk for a host of problems that have been found to continue through adolescence and into the adult years" (p. 9).

### Recovery Speeds Vary

Many factors influence recovery from neglect. These include the severity, duration, and timing of the deprivation and the timing and type of intervention provided. Severe neglect, especially in early childhood, makes children more likely to withdraw when stressed and to show more anxiety and difficulty regulating their mood than children who experience less severe deprivation. Longer periods of neglect are associated with greater deficits in brain activity, attention and

cognitive control, and academic achievement (p. 9).

### Early Intervention Is Best

Children who get appropriate intervention for neglect are less likely to demonstrate long-term, adverse effects.

This is particularly true for "extreme deprivation," which is rare.

If appropriate intervention occurs very early—in various studies the benchmark age for removal from extreme deprivation has been identified as 6, 12, or 24 months—substantially improved functioning in cognition, attention, memory, and executive functioning can be achieved. . . . Generally speaking, it appears that the more profound and pervasive the deprivation, the earlier the child needs to be removed in order to facilitate the greatest recovery (p. 9).

### There Are Effective Approaches

Thankfully, there are interventions for neglect that work. The table on the next page describes some of the programs that have been proven to help caregivers respond to the needs of neglected children. Child welfare agencies and their partners—the courts, community-based programs, health and mental health professionals, schools, and others—should make a concerted effort to make these and other evidence-based interventions available in their communities.

Project Broadcast, a federally-funded effort to disseminate trauma-informed practices to child welfare-involved children in North Carolina, is an example of how state and federal agencies are contributing to the effort to expand the availability of effective programs. Among its other activities, Project Broadcast is training clinicians in Attachment and Biobehavioral Catch-up (*described next page*) in 9 demonstration counties. The goal is to eventually expand ABC and three other evidence-based interventions (Structured Psychotherapy for Adolescents Responding to Chronic Stress, Trauma-Focused Cognitive Behavioral Therapy, and Parent-Child Interaction Therapy) to all 100 North Carolina counties.

### Don't Forget Prevention

The authors of the working paper conclude with a call for more effective outreach to families facing the kind of adversity that puts their young children at risk for significant neglect. They urge us to think broadly about prevention, noting that even programs that don't focus specifically on children can build caregiver capacities and family resources that can prevent neglect from occurring in the first place (p. 13). This, of course, can have a big, positive impact on child and family outcomes. ♦

## Chronic Neglect Resources

The American Humane Association offers online resources child welfare professionals can use to broaden their knowledge of chronic child neglect. They include:

### Basic Overviews

- *Chronic Neglect Primer*  
<http://bit.ly/RJztGp>
- *National Efforts to Address Chronicity and Cumulative Harm*  
<http://bit.ly/WiF6bN>
- *Chronic Families, Chronic Neglect*  
<http://bit.ly/UdShvC>
- *Chronic Neglect: Multiple Views*  
<http://bit.ly/100qtz3>

### Presentations & Articles

- *Chronic Neglect: Assessment and Decision-Making*, by Diane DePanfilis  
<http://bit.ly/UiKlop>
- *Introduction: Shining Light on Chronic Neglect*, by Caren Kaplan, Patricia Schene, Diane DePanfilis and Debra Gilmore <http://bit.ly/QubiE7>
- *Chronic Neglect Practice with St. Louis Families*, by Frances A. Johnson <http://bit.ly/Zp0D8U>

To access these and other resources visit <http://www.americanhumane.org/children/professional-resources/program-publications/chronic-neglect.html>

## Promising Evidence-Based Interventions for Children Who Have Experienced Neglect

Adapted from National Scientific Council on the Developing Child, 2012; California Evidence-Based Clearinghouse for Child Welfare, 2012

### Attachment and Biobehavioral Catch-Up (ABC)

Short-term, in-home intervention to improve attachment regulation and bio-behavioral regulation in maltreated children.

**DURATION.** Ten, 1-hour sessions that rely on video-feedback and homework.

**TARGET POPULATION.** Infants and toddlers placed in foster care, relative care, or living with their birth parents.

**PROGRAM GOALS AND INTERVENTION STRATEGIES.** Strengthen parents' or caregivers' sensitivity and responsiveness to infant's cues and help them provide an environment in which they are able to cultivate a young child's regulatory abilities.

**EVIDENCE OF EFFECTIVENESS.** Young children who received the ABC intervention developed more secure attachments to their caregivers more frequently, showed more normative patterns of cortisol production (indicative of improved stress regulation), and demonstrated better behavioral regulation than children who received a control intervention.

### AVAILABILITY IN NC

The Center for Child and Family Health offers ABC in the Durham County area and is bringing it to *Project Broadcast* counties; the ABC contact at CCFH is Ashley Alvord (ashley.alvord@duke.edu). Others interested in ABC should contact ABC's creator, Dr. Mary Dozier (mdozier@psych.udel.edu).

### Child-Parent Psychotherapy (CPP)

Trauma treatment model for improving social-emotional, behavioral, and cognitive functioning in children exposed to interpersonal violence and other traumas.

**DURATION.** One year. Involves fifty-two, 60- to 90-minute sessions conducted in the family's home or in a community agency, or outpatient clinic.

**TARGET POPULATION.** Children aged 0-5 who experience mental health, attachment, and/or behavioral problems as a result of traumatic events.

**PROGRAM GOALS AND INTERVENTION STRATEGIES.** Helps the parent and child co-create a trauma narrative and make positive meaning of traumatic events. Enhances parent's capacity to provide physical and emotional safety for the child through a focus on attachment and affect regulation. Treatment also focuses on contextual factors that may affect the parent-child relationship, such as cultural norms and socioeconomic stressors.

**EVIDENCE OF EFFECTIVENESS.** Compared to control groups, after CPP: children who witnessed domestic violence showed greater reductions in behavior problems and traumatic stress symptoms; the rate of secure attachment in maltreated infants improved significantly; maltreated preschoolers showed better self-esteem and attitude towards the mother; toddlers of depressed moms showed more secure attachment and improved cognitive functioning.

### AVAILABILITY IN NC

There are clinicians trained in CPP in Chatham, Durham, Orange, Person, Mecklenburg, and Wake counties. Groups interested in a CPP learning collaborative should contact Donna Potter (donna.potter@duke.edu); right now she's the only endorsed CPP trainer in North Carolina.

### Homebuilders

Intensive family preservation services treatment program for preventing unnecessary placement of children in foster care, group care, psychiatric hospitals, or juvenile justice facilities.

**DURATION.** An average of 4-6 weeks. Three to five sessions/week; an average of 8-10 hours/week of face-to-face contact, with phone contact between sessions.

**TARGET POPULATION.** Families with children 0-18 at imminent risk of placement into foster care, group, or residential treatment, psychiatric hospitals, or juvenile detention.

**PROGRAM GOALS AND INTERVENTION STRATEGIES.** Reduce abuse and neglect, family conflict, and child behavior problems and teach families to prevent placement. Engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners.

**EVIDENCE OF EFFECTIVENESS.** Compared to control group, children in Homebuilders spent more time in their own home during the 6-month and 12-month follow-up periods. At the end of the 15-month study period, 70% of children who were in the program remained home, compared to 47% of children in the control group.

### AVAILABILITY IN NC

Available in all counties as part of NC's Intensive Family Preservation Services Program. To find the Homebuilders/IFPS provider in your county, contact the NC Division of Social Services' Michelle Reines (Michelle.Reines@dhhs.nc.gov 919/334-1089).

## Promising Evidence-Based Interventions for Children Who Have Experienced Neglect

Adapted from National Scientific Council on the Developing Child, 2012; California Evidence-Based Clearinghouse for Child Welfare, 2012

### Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)

Early intervention model that aims to promote healthy self-regulation, positive relationships with caregivers and peers, and school readiness in vulnerable young children.

**DURATION.** Six to nine months. Foster parents receive at least seven contacts per week. Each week children in treatment receive a 2-hour therapeutic playgroup and a 2-hour skills training session. Biological families or other long-term placement resources receive a weekly 1-hour skill-building session.

**TARGET POPULATION.** Children in foster care aged 3-6.

**PROGRAM GOALS AND INTERVENTION STRATEGIES.** Help caregivers provide and maintain a positive, responsive, and consistent environment for young children through the use of concrete encouragement to reinforce positive behaviors and effective limit-setting to reduce problematic behaviors. Children also receive support through behavioral therapy in a preschool setting and a weekly playgroup that promotes positive socialization.

**EVIDENCE OF EFFECTIVENESS.** Compared with children who received a control intervention, preschoolers in MTFC-P showed improvements in attachment-related behaviors, fewer behavior problems, and improved cortisol rhythms.

### AVAILABILITY IN NC

Currently MTFC-P is not available in NC. However, Alexander Youth Network offers a version of MTFC for adolescents. Those interested in bringing MTFC-P to their communities should contact Rena Gold, [www.mtfc.com](http://www.mtfc.com), [renag@mtfc.com](mailto:renag@mtfc.com), 541/343-2388.

### SafeCare

See next page for profile of SafeCare.

## Evidence-Based Intervention Lowers Cortisol Levels in Maltreated Preschoolers

Adapted from National Scientific Council on the Developing Child (2012)

### Why Cortisol Matters

Regulation of the key stress hormone cortisol is altered in children who experience severe neglect. This can lead to greater risk for anxiety, depression, and, later in life, heart problems.

In typically developing children, cortisol levels increase in the morning (to get the body going for the day), and then steadily decline. Significantly neglected children have cortisol levels that are lower in the morning and flat across the day.

### MTFC for Preschoolers

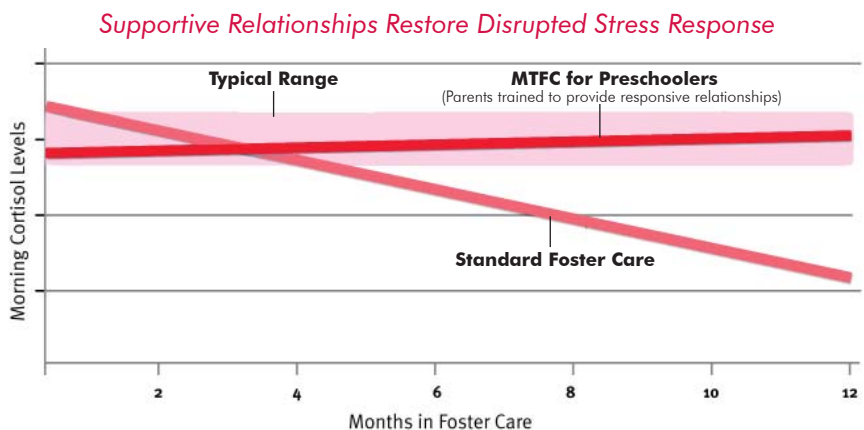
A study by Fisher et al. (2007) found **Multidimensional Treatment Foster Care for Preschoolers** to be better than traditional foster care at restoring stress hormones to typical levels.

As the figure at right shows, children in traditional family foster

care showed suppressed cortisol levels, which worsened the longer they were in care. Foster parents trained to provide responsive relationships through MTFC-P restored children's stress hormones to typical levels, as measured in a control group of children from the same community who were not in foster care.

Conclusion: MTFC for Preschoolers improved children's stress-regulatory capabilities, as indicated by patterns of cortisol production indistinguishable from those of non-neglected, healthy children.

See above to learn more about MTFC for Preschoolers.



## SafeCare: An Evidence-Based Intervention for Child Neglect

More and more, child welfare agencies are turning to empirical research to help them select the most effective ways to help families struggling with child maltreatment. Current evidence suggests that of the programs that address child neglect, SafeCare is one of the best.

**Of the evidence-based programs that address neglect, SafeCare is one of the best.**

### SafeCare

SafeCare is a parenting program in which professionals provide weekly in-home, direct skills training to parents in the areas of infant and child health care, home safety, and parent-child interactions.

**Target Population:** Parents of children ages birth to 5 at risk or reported for child maltreatment, including young parents; parents with multiple children; parents with a history of depression or other mental health problems, substance abuse, or intellectual disabilities; parents being reunified with their children; parents recently released from incarceration; parents with a history of domestic violence or intimate partner violence; and parents of children with developmental or physical disabilities.

#### Essential Components

- *Health Module.* Targets risk factors for medical neglect. Teaches parents to use health reference materials to prevent common childhood illnesses and injury, identify symptoms, and provide and seek appropriate treatment.
- *Home Safety Module.* Targets environmental neglect and unintentional injury. Includes childproofing the home and eliminating safety and health hazards.
- *Parent-Child/Parent-Infant Interactions Module.* Targets risk factors for neglect and physical abuse. Includes skill development in child behavior management.

**Intensity and Length.** SafeCare home visitors conduct weekly or biweekly home visits for approximately 90 minutes each over 18–20 weeks, depending on parents' progress and whether other services are integrated into SafeCare delivery. Home visitors work with parents until they meet a set of skill-based criteria established for each of three program modules.

### Evidence of Effectiveness

The California Evidence-based Clearinghouse for Child Welfare ([www.cebc4cw.org](http://www.cebc4cw.org)) rates SafeCare as "2-Supported by Research Evidence," a relatively high rating indicating that SafeCare has been shown to be effective in at least one rigorous randomized controlled trial with a sustained effect of at least 6 months.

In fact, SafeCare continues to be the subject of considerable study; at least five papers have been published about it since 2008. This includes a 10-year Oklahoma-based study which found SafeCare reduced child abuse and neglect recidivism in very challenging families (Chaffin, et al., 2012). The 2,175

families in this study averaged five prior encounters with CPS. Over 90% of the referrals included neglect, and 70% were exclusively neglect. Of the families included in the study, 82% lived below the poverty line.

This study found that families who received standard home visiting services plus SafeCare were 26% less likely to experience CPS reports than families who received home visiting services alone.

### Support for Implementation and Fidelity

As part of its effort to disseminate the SafeCare model nationwide, the National SafeCare Training and Research Center (NSTRC) pays special attention to issues of implementation, fidelity, and sustainability. Agencies considering SafeCare are asked to complete a readiness assessment. The NSTRC uses a variety of means to support agencies as they develop the capacity to faithfully implement SafeCare.

### To Learn More

Additional information, including contact information, can be found at the National SafeCare Training and Research Center website (<http://publichealth.gsu.edu/968.html>). ♦

### SafeCare in NC

SafeCare is available in 15 states and several international locations. Currently two agencies in North Carolina are doing SafeCare with child welfare-referred clients:

- Exchange Clubs' Family Center of Durham County (*Durham*)
- Children's Center of Surry and Yadkin (*Dobson*)

In addition, the National SafeCare Training and Research Center has worked with several agencies to integrate SafeCare with another evidence-based early childhood parent education, family support, and school readiness home visiting model, *Parents As Teachers* (PAT). This is part of a research project in which they will compare the results of PAT+SafeCare with the results of PAT alone. North Carolina agencies involved in this study are:

- Rockingham Co. Partnership for Children (*Reidsville*)
- Children and Family Resource Center (*Henderson*)
- Kids Advocacy Resource Effort (*Waynesville*)
- Beaufort-Hyde Partnership for Children (*Washington*)
- Sampson Co. Partnership for Children (*Clinton*)

# Using Strategies from Relapse Prevention to Help Families Address Substance Abuse and Neglect

Families struggling to care for their children also often struggle with substance abuse. Indeed, studies say 40–80% of families involved with the child welfare system have substance abuse problems (NCSACW, n.d.).

**The goal is to improve people's coping skills and control behaviors that put children at risk.**

## A Definite Connection

Studies suggest there is a direct association between child neglect and substance abuse (Dunn, et al., 2002). In one study, substance abusing parents were more than *three times* more likely to neglect their children than other parents, even when researchers controlled for things such as social support, depression, and antisocial personality disorder (Chaffin, et al., 1996). Other studies have shown that substance-abusing parents are likely to provide less supervision, spend less time with their children, and express greater dissatisfaction with their children (sources in Dunn, et al., 2002).

## States, Not Traits

It can be helpful to remember that even if they are chronic, substance abuse and child neglect are both **states**, not **traits**. In other words, both conditions are fluid, changing over time in response to the family's internal dynamics and the larger environment. Both substance abuse and neglect depend in part on parents' ability to cope with stress and maintain their role as caregiver (Larimer, et al., 1999; Dunn, et al., 2002).

## Relapse Prevention

In trying to figure out how to assist families experiencing chronic neglect, it can be helpful to look to the field of substance abuse for models that have been shown to improve people's coping skills and control behaviors that put the user and their children at risk.

One such approach is **Relapse**

**Prevention.** First implemented in 1977, there has been significant research to support the effectiveness of this method (SAMHSA, 2012).

Relapse Prevention is a cognitive-behavioral approach: the goal is to help people change how they think about and behave in relation to substance use in order to improve their coping skills and minimize the risk of relapse. Cognitive-behavioral approaches have been shown to be particularly effective with substance use disorders (McKellar, et al., 2010).

While Relapse Prevention is a treatment intervention, it has key components child welfare workers can adapt to help families create realistic plans. In fact, these key components are part of what child welfare workers already do every day, though they may not see it as relapse prevention.

## Relevant Components

### 1. Identify and prepare for high risk situations.

A basic tenet of Relapse Prevention is that people abuse drugs and alcohol in the context of a few high risk situations. A key task is to help clients identify their personal triggers: to get them to ask, "What are the situations in which I am most likely to use or be tempted to use?" Often those situations involve negative emotional states, especially those related to interpersonal conflict or social pressure (Marlatt, 1996). When someone has a positive plan for handling a given situation, they are more likely to get through it without using (Larimer, et al., 1999).

Child welfare workers can help parents move in this direction by reviewing recent episodes of drinking or drug use to identify the people, places, emotions, or other charac-

## Risk Factors for Relapse

- Have co-occurring mental illness (depression, bipolar disorder, PTSD)
- Live with a partner who is still using
- Have frequent exposure to high risk situations
- Have frequent reminders of use (paraphernalia, drug friends, places)
- Want to test their control over drug/alcohol use
- Have inadequate avoidance/refusal skills
- Have inadequate skills to deal with conflict or negative emotions

Source: Peters, 1993

teristics involved. Then, parents can be coached with solution-focused, open-ended questions to plan specific responses for those situations. For example, if spending time with particular friends usually leads to drug use, what can the parent realistically do the next time one of those friends tries to include them in something?

The connection to North Carolina's Principles of Partnership is clear. Parents will be much more willing to explore these situations when the child welfare worker has approached them in a collaborative way, offering to partner in problem-solving.

### 2. Identify and reinforce successes.

To avoid relapse, people with substance abuse disorders must have two things: a clear plan of action for dealing with high-risk situations, and the confidence to carry out that plan (Larimer, et al., 1999). Actually, this is true for anyone trying to change behavior: we must have skills needed to make the change *and* we must believe we can really change.

Child welfare workers ask parents about their successes all the time to encourage and reinforce positive choices and a sense of accomplishment. In the area of sub-

*continued next page*

# Relapse Prevention and Neglect

continued from previous page

stance abuse, this involves asking parents about times when they have not been using, or when they successfully managed a high risk situation without a lapse or relapse. Helping parents make a realistic plan and build their confidence in carrying it out are critical components in maintaining sobriety.

### 3. Don't let lapses turn into relapses.

In Relapse Prevention, one of the most critical steps is re-framing how people think about relapse. A lapse in sobriety should not be seen as a personal failure that immediately sets off a string of catastrophic consequences and shameful reactions. Instead, a single lapse must be understood as a chance to learn from mistakes and figure out how to do better next time. By reducing the punitive response and the resulting shame, small lapses can be prevented from turning into a complete relapse (Marlatt & Gordon, 1980 & 1985, cited in Larimer, et al., 1999).

Compare it to dieting. Just because you treat yourself to that bowl of ice cream one night doesn't mean you need to give up on dieting and over-indulge all week. In cognitive-behavioral terms, people who view a lapse as a personal failure ("I am a terrible parent and will never be sober") are more likely to progress to full-blown relapse than people who view the lapse as "a failure to cope effectively with a specific high-risk situation" (Larimer, et al., 1999).

In the child welfare world, some visitation plans stipulate that parents will lose visits with their children if they use drugs or alcohol at any time. Unfortunately, this can mean that even if a parent uses a small amount away from their children, they can become so ashamed and depressed that they are more likely to fall into a full relapse. If instead parents are encouraged to share with their social worker

## Phases and Warning Signs of Relapse

- 1. Return of Denial.** Becomes unable to recognize and honestly tell others what he or she is thinking or feeling.
- 2. Avoidance and Defensiveness.** Doesn't want to think about anything that will cause painful feelings to come back, so avoids anything or anybody that will force an honest look at self. Defensive when asked directly about well-being.
- 3. Crisis Building.** Begins experiencing life problems caused by denying feelings, isolating self, and neglecting recovery. Wants to solve the problems and works hard at it, but new problems pop up to replace every problem that is solved.
- 4. Immobilization.** Totally unable to initiate action; goes through the motions of living but is controlled by life rather than controlling life.
- 5. Confusion and Overreaction.** Can't think clearly, upset with self and those around her, irritable, overreacts to small things.
- 6. Depression.** Depression so severe and persistent that it cannot be ignored or hidden from others. Difficulty keeping normal routines. Thoughts of suicide, drinking, or drug use as a way to end the depression.
- 7. Behavioral Loss of Control.** Unable to control or regulate behavior and daily schedule. Heavy denial and no full awareness of being out of control. Life becomes chaotic and problems are created in all areas.
- 8. Recognition of Loss Control.** Denial breaks and suddenly he recognizes how severe the problems are, how unmanageable life has become, and how little power and control he has to solve the problems. Awareness is extremely painful and frightening. Has become so isolated that it seems that there is no one to turn to for help.
- 9. Option Reduction.** Feels trapped by pain and inability to manage life. Seems to be only three ways out—insanity, suicide, or drug use. No longer believes anyone or anything can help.
- 10. Relapse Episode.** Begins to use again, struggling to control or regain abstinence. Shame and guilt when the attempt fails. Eventually all control is gone and serious bio-psycho-social problems develop and continue to progress.

Source: Miller & Harris, 2000

that they have had a lapse, the two can work together to figure out what the high risk situation was and how to manage it better next time. An approach that encourages learning and self-awareness is much more useful for long-term outcomes than the avoidance and power struggles involved in trying to hide or prove a single episode of use.

### 4. Create a more balanced lifestyle.

People with substance abuse disorders often have little genuine pleasure in their lives. They tend to have a lot of things they *must* do, but not many they *want* to do (Larimer, et al., 1999). To maintain sobriety, parents must find healthy things they enjoy and ways to take care of themselves in spite of other obligations.

In many ways, most of us share this struggle. Because of their histories and coping skills, parents with substance abuse issues tend to need specific support and coaching to find

"healthy addictions" to fill some of the time and replace some of the pleasure that drug or alcohol use provided.

One strategy used by treatment providers can be adapted easily by child welfare workers. Parents can be encouraged to keep a log for just a few days, noting what they do and whether it is a "should" or a "want to." Simply raising their awareness of how they spend their time, and of their power to make different choices, can help adjust the balance between the two.

Since substance abuse is a common factor in situations of chronic neglect, it makes good sense to consider how managing one can help improve the other. Fortunately, many of the specific steps of Relapse Prevention are familiar to child welfare workers. Improving parents' self-awareness and ability to cope with risky situations can help increase both their chances for maintaining sobriety and their opportunities for positive parenting. ♦



## References in this Issue

- Barkley, R. A. (1997). Attention-Deficit/Hyperactivity disorder, self-regulation, and time. *Journal of Developmental & Behavioral Pediatrics, 18*(4), 271-279. doi:10.1097/00004703-199708000-00009
- California Evidence-Based Clearinghouse for Child Welfare. (2012). Accessed December 21, 2012 from <http://www.cebc4cw.org/>.
- Chaffin, M., Hecht, D., Bard, D., Silovsky, J., & Beasley, W. H. (2012). A statewide trial of the safe care home-based services model with parents in child protective services. *Pediatrics, 129*, 509-515.
- Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse and Neglect, 20*, 191-203.
- Charil, A., Laplante, D., Vailancourt, C. & King, S. (2010). Prenatal stress and brain development. *Brain Research Reviews, 65*(1), 56-79.
- DeBellis, M. D. (2005). The psychobiology of neglect. *Child Maltreatment, 10*(2), 150-172. doi:10.1177/1077559505275116
- Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J., Bauer, R., & You, A. (2012). *Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in NC*. Retrieved December 21, 2012 from [ssw.unc.edu/ma/](http://www.ssw.unc.edu/ma/)
- Dunn, M. G., Tarter, R.E., Mezzich, A.C., Vanyukov, M., Kirisci, L. & Kirillova, G. (2002). Origins and consequences of child neglect in substance abuse families. *Clinical Psychology Review, 22*(7), 1063-1090.
- Erickson, M. F., & Egeland, B. (2002). Child neglect. In J.E.B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 3-20). Thousand Oaks, CA: Sage.
- Gaudin, J. M. (1993). *Child neglect: A guide for intervention*. USDHHS, Administration for Children and Families.
- Hildyard, K. L., & Wolfe, D. A. (2002). Child neglect: Developmental issues and outcomes. *Child Abuse & Neglect, 26*(6-7), 679-695. doi:10.1016/S0145-2134(02)00341-1
- Larimer, E., Palmer, R., & Marlatt, G. A. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioral model. *Alcohol Research and Health, 23*(2), 151-60.
- Marlatt, G.A. (1996). Taxonomy of high-risk situations for alcohol relapse: Evolution and development of a cognitive-behavioral model. *Addiction, 91*(suppl): 37-49.
- McKellar, J., Finney, J. W., & Moos, R. H. (2010). Psychosocial treatments for addictive disorders: Models, settings, and important roles for referring physicians. In N. S. Miller and M. S. Gold (Eds.), *Addictive disorders in medical populations* (Chap. 34, pp. 525-530). New York: John Wiley & Sons.
- McSherry, D. (2007). Understanding and addressing the neglect of neglect: Why are we making a mole-hill out of a mountain? *Child Abuse & Neglect, 31*(6) (2007), 607-614.
- Miller, W. R. & Harris, R. J. (Sept. 2000). Simple scale of Gorski's warning signs for relapse. *Journal of Studies on Alcohol, 61*(5), 759-765.
- National Center on Substance Abuse and Child Welfare. (n.d.) *Fact sheet 3: Research studies on the prevalence of substance use disorders in the child welfare population*. Accessed December 21, 2012 from [http://www.ncsacw.samhsa.gov/files/Research\\_Studies\\_Prevalence\\_Factsheets.pdf](http://www.ncsacw.samhsa.gov/files/Research_Studies_Prevalence_Factsheets.pdf)
- National Scientific Council on the Developing Child. (2012). The science of neglect: The persistent absence of responsive care disrupts the developing brain [Working Paper 12]. Accessed December 21, 2012 from <http://www.developing-child.harvard.edu>

## Understanding and Intervening in Child Neglect An ONLINE TRAINING



Child welfare social workers and supervisors employed by North Carolina county DSS agencies are encouraged to take this interactive, self-paced online course. The course helps participants understand neglect, its effects on children and families, and innovative interventions. Offered by the NC Division of Social Services, in partnership with the UNC-Chapel Hill School of Social Work.

**10 Contact Hours.** Counts toward the annual 24-hour continuing education requirement for NC child welfare staff.

### Course Components:

**1. Self-Paced Online Session.** Participants have two weeks to complete this session.

**2. Online Discussion Forum.** As part of the self-paced session, participants must interact through an online discussion forum, reflecting on their learning and exploring how they will apply it to their practice.

**3. Knowledge Assessment.** Participants take a Knowledge Assessment at the end of the course.

For class times or to register, log in to your account on [www.ncswlearn.org](http://www.ncswlearn.org).

Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind, 3*(1), 79-100. doi:10.1023/A:1016557824657

Peters, R. H. (1993). Relapse prevention approaches in the criminal justice system. In *Relapse Prevention and the Substance-Abusing Criminal Offender: An Executive Briefing* [Technical Assistance Publication Series 8]. Rockville, MD: Center for Substance Abuse Treatment.

SAMHSA. (2012). National registry of evidence-based programs and practices. Accessed December 21, 2012 from <http://www.nrepp.samhsa.gov/>.

Shipman, K., Edwards, A., Brown, A., Swisher, L., & Jennings, E. (2005). Managing emotion in a maltreating context: A pilot study examining child neglect. *Child Abuse & Neglect, 29*(9), 1015-1029. doi:10.1016/j.chiabu.2005.01.006

TFC Consultants. (2013). *Current sites*. Retrieved January 3, 2013 from <http://www.mtfc.com/currentsites.html>.

U.S. Department of Health and Human Services. (2012). *Child maltreatment 2011*. Washington, DC: Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Accessed January 4, 2013 from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

Wilkerson, D., Johnson, G. & Johnson, R. (2009). Children of neglect with attachment and time perception deficits: Strategies and interventions. *Education, 129*(2), 343.