

Treatment of Child Neglect: A Systematic Review

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Objective: Child neglect is the most common type of child maltreatment. Our objective was to systematically evaluate the available evidence regarding the effectiveness of child neglect treatment programs, including those focused on victims of childhood neglect and (or) their caregivers.

Method: We comprehensively searched the Medline, Psycinfo, and Eric databases from January 1980 to May 2003. Two authors independently reviewed 54 studies that met inclusion criteria. Fourteen articles met our design criterion and were assessed for their methodological quality according to guidelines developed by the US Preventive Services Task Force.

Results: Of the 14 studies included in the review, 2 were rated as good, and 3 were rated as fair. We found evidence that 2 specific types of play therapy and a therapeutic day treatment program had beneficial effects for children. Further, parents and children in families where neglect had occurred showed improvement with multisystemic therapy.

Conclusions: Rigorous studies of treatments for neglected children and their families are lacking. Well-designed and well-conducted evaluations are urgently required to identify effective treatments, which should then be made available to children and their caregivers. (Can J Psychiatry 2005;50:497–504)

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Clinical Implications

- Few evidence-based treatments are available. There is some support for the effectiveness of resilient peer treatment and imaginative play training, for multisystemic therapy, and for a specific therapeutic day treatment program to increase neglected children's self-concept.
- Interventions that focus either on reducing the recurrence of child neglect or on treating the impairment associated with exposure to neglect require evaluation.
- Clinicians need to address a broad range of factors when working with children exposed to neglect. Taking into account the family system and contextual issues is important in implementing treatment programs.

Limitation

- Defining child neglect has been difficult, and there is currently no consensus on its definition. This has led to challenges in measuring neglect and associated outcomes.

Key Words: *child neglect, treatment, child maltreatment, systematic review*

Child neglect is the most prevalent type of child maltreatment (1–3), yet it has often been overlooked in the literature on child victimization. In the Canadian Incidence Study of Reported Child Abuse and Neglect, child neglect was the most common reason for child welfare investigations, accounting for 40% of an estimated 135 573 maltreatment investigations in 1998 (1). The health and social sciences liter-

ature does not reflect growing awareness of the prevalence and implications of child neglect: most studies continue to focus on sexual or physical abuse of children (4). Further, the existing research generally lacks methodological quality (4). This may in part be because child neglect is difficult to define and measure and there is no consensus regarding specific types of neglect. One commonly used approach to categoriza-

tion includes physical, emotional, medical, and educational neglect (see 5,6). Others have included such subtypes as supervisory and nutritional neglect (see 5,7). A recent investigation of a general definition of neglect and of the relations among 3 subtypes found that, although these subtypes are related, physical, psychological, and environmental neglect are unique phenomena and that specific subtypes may be better measures than simply assessing “general neglect” (8). Since each subtype may be associated with different risk indicators, and therefore responsive to specialized intervention programs, each should be studied as a separate construct (8,9).

Another challenge for research in the area of child neglect is to access study samples in which exposure to neglect and exposure to abuse do not overlap (10). Most studies are conducted with children who have experienced several types of maltreatment. This makes it difficult to determine how child neglect differs from other types of maltreatment with respect to etiology, prevention, and treatment.

Risk indicators for child neglect include individual factors (for example, such parenting characteristics as low parental warmth and the use of physical discipline) and characteristics of the social context of the child and family (for example, poverty) (11,12). When creating intervention programs, it is important to consider the influence of both social and individual factors associated with neglect. However, our review focused on interventions directed at the child and family, rather than on their social context, because these were the only studies that met the study design inclusion criterion.

The challenge of defining neglect affects the classification of maltreatment cases as such (13) and has limited our knowledge about effective interventions. This situation causes concern because the consequences of neglect can be severe, potentially affecting many areas of child development and often resulting in long-standing impairment (2). Although the ultimate goal would be to prevent neglect before it occurs, it is important that effective interventions exist to assist neglected children. To our knowledge, there are no current systematic reviews of child neglect interventions. Therefore, the objective of this systematic review is to examine available evidence for the effectiveness of child neglect treatment interventions, make practice recommendations, and provide direction for future research.

Method

We searched the Psycinfo, Medline, and Eric databases from January 1980 to May 2003, using the key words child neglect, child maltreatment, treatment, therapy, and intervention. Two authors independently reviewed all citations and abstracts retrieved from the databases, using the following content-specific selection criteria: target population—children and families who had experienced neglect; intervention—any

therapeutic manoeuvre aimed at treatment (prevention programs were excluded); and outcome—occurrence of neglect or any associated physical, emotional, or cognitive outcome. The articles were obtained in full and independently reviewed to determine whether they met the methodological criterion of having an observational or experimental design that included a comparison group.

Many authors fail to precisely define neglect within their study. Most descriptions cite an absence of care or inadequate care resulting in harm. For this review, we adopted a definition suggested by Dubowitz and colleagues, whereby neglect is an act of omission rather than commission that occurs when children’s basic needs are not adequately met (14). This definition is broad and encompasses many areas in which neglect commonly occurs. Treatment of failure to thrive was not considered relevant in this review unless it had occurred specifically as a result of neglect.

We included any treatment studies involving samples of children and (or) families exposed to neglect, even if it was not possible to separate out results for those exposed to neglect from those exposed to abuse. The cooccurrence of abuse and neglect is high (15). Although it is often difficult to differentiate treatment effects for neglected, compared with abused, children, it is nonetheless important to examine the treatment effects separately; however, the paucity of studies that focused exclusively on children exposed to neglect meant that we needed to include samples with overlap.

Outcome measures included the evaluation of parental behaviours commonly associated with child neglect (for example, method of child discipline, quality and type of parent–child interactions, and quality of family functioning); recidivism and incidence rates of substantiated cases of child neglect; family reunification; and other areas related to improved parent and child functioning (for example, child’s self-concept, aggressiveness, and play behaviour; parental social support, knowledge of child development, and parental stress). Therefore, incidents of neglect were not necessarily measured in each study. Sometimes, treatment programs focused on addressing the consequences of child neglect and (or) the family and parental problems contributing to the neglect.

The literature search yielded 697 citations related to child neglect treatment or therapy. Of this total, 54 studies met the content-specific eligibility criteria, and of these, 14 met the design criterion. Two reviewers (Note 1) independently assessed the quality of these studies for internal validity and gave a rating of good, fair, or poor, according to the methods of the US Preventive Services Task Force (16). Specifically, studies with a randomized controlled trial (RCT) design or a prospective or retrospective cohort design were rated as good if they met all criteria for their study design, as fair if they did

not meet all criteria but had no fatal flaw that invalidated the results, and as poor if they had a fatal flaw or an accumulation of important threats to internal validity.

Results

The studies varied considerably. Five studies evaluated treatments for victims of child neglect (that is, children or adults exposed to neglect during childhood); 8 evaluated treatments for neglectful families, including parents and child victim(s); and one evaluated a treatment designed specifically for neglectful parents. Note that many outcome measures may not appear to relate directly to neglect per se; however, they are thought to be important consequences for neglected children. These measures include low self-esteem (17), poor peer relationships (18), and withdrawal (19), among others.

In total, we rated only 2 studies as good, 3 as fair, and 9 as poor. We provide descriptive information only for those studies rated as good or fair (Table 1) (20–24), although we describe the methodological limitations of studies rated as poor (Note 2). The 5 studies with good or fair ratings all assessed treatment effects on combined samples of children or families wherein the child had experienced neglect, abuse, or both. Although one study sample did comprise children who had experienced abuse or neglect (but not both for the same child), we only assessed treatment effects for the combined group (20). Only one study assessed treatment effects for both a combined sample of children who had been maltreated (as defined by the experience of either neglect or physical abuse) and for each subsample of children (21). Therefore, the effectiveness of treatment for children exposed to neglect alone (that is, without cooccurring abuse) cannot be determined from the existing literature.

Treatment Protocols for Victims of Childhood Neglect

Four studies (20,22–24) evaluated treatment programs for neglected children, and one (25) evaluated a treatment for adult survivors of childhood neglect. Treatment programs for child neglect victims included the evaluation of a day treatment program (20), play therapy or play training (22,24), specialized nursery care (23), and group therapy (25). Of these studies, we rated 2 as good (22,24), 2 as fair (20,23), and 1 as poor (25).

The 2 studies rated as good provide support for the effectiveness of 2 specific programs of play therapy as treatment for children who have been neglected. The RCT by Fantuzzo and colleagues (22) evaluated resilient peer treatment. Participants included African-American children exposed to physical abuse and (or) neglect. Children in the experimental group received this treatment, which involved pairing a resilient peer with a target child for 15 play sessions supervised by an adult assistant, with the goal of improving the withdrawn

child's social interactions and increasing positive interactive peer play. At 2 weeks posttreatment, children in the treatment group showed significantly more positive play and less solitary play, compared with control subjects. At 2 months posttreatment, gains in social interactions and fewer internalizing and externalizing behaviour problems were present among children in the treatment group.

Udwin's study, also rated as good, evaluated the effectiveness of imaginative play training for emotionally deprived preschool children removed from their families because of abusive or inadequate care (24). Children were randomly assigned to an experimental or control group; treatment included group training sessions in imaginative play over 5 weeks. After treatment, children in the experimental group were found to have increased levels of imagination, increased cooperation and interaction with peers, and less aggressive play, compared with control subjects. Younger children with a greater predisposition toward fantasy and with higher non-verbal IQs responded more positively to the training.

We rated 2 studies of treatment programs for neglected children as fair. In the first, Reams and Friedrich conducted an RCT evaluating play therapy with maltreated children attending a specialized nursery and receiving milieu therapy (23). The experimental group received weekly individual play therapy sessions with a trained therapist in addition to the milieu therapy. Sessions included affective exploration, encouraging the expression of sensitive material, and teaching coping strategies. At posttreatment, children in the experimental group differed from the control group only in their degree of isolated play, which was significantly lower; however, this result was not maintained at a 10-week follow-up. There were no significant findings with respect to the 12 additional outcome measures. It appears that this play therapy program did not result in sustained improvement for neglected children.

The second study, by Culp and colleagues, also rated as fair, evaluated a centre-based therapeutic day treatment program for maltreated children that extended, on average, for 9 months (20). An additional treatment component was included for parents, but it was not evaluated. The primary goal of the program was to increase the self-concepts of neglected children through group milieu therapy and individual treatment. After treatment, the perceived competence of subjects in the experimental group was significantly higher than both their pretreatment levels and the control group's perceived competence. Specifically, children reported greater cognitive competence, peer acceptance, and maternal acceptance, but not greater physical competence. Further, their teacher, who was involved in the group milieu program, reported that they were more cognitively and physically competent and more accepted by their peers. Children in the experimental group also had higher developmental levels

Table 1 Summary of child neglect treatment studies rated as good or fair

Study description and participants	Treatment protocol	Outcome measures	Results	Strengths and (or) weaknesses
<i>Udwin (24) (RCT): Quality rating, Good</i>				
Emotionally deprived preschool children who had experienced parental neglect, abuse, or both placed in institutional care (<i>n</i> = 34) Experimental group: imaginative play training (<i>n</i> = 17) Control group: play sessions (<i>n</i> = 17)	Experimental group: ten, 30-minute training sessions with facilitator in small groups for 5 weeks, plus exercises and games Control group: small groups exposed to 10 play sessions; provided verbal input but no active training in make-believe	Observation of free play activity of two, 10-minute periods; assessment of fantasy predisposition, imaginative predisposition, intelligence (verbal and nonverbal IQ); postintervention follow-up evaluation at 4 weeks	Experimental group: improved peer interactions and cooperation, imagination, positive affect, divergent thinking; decreased aggressive play; no change in concentration, interaction or cooperation with adults, or in aggression or anxiety; most gains maintained at follow-up	Equivalence of groups demonstrated Raters blind to hypotheses and treatment conditions Multiple, valid measures used Reliability of observational data measure Randomization not described
<i>Fantuzzo and others (22) (RCT): Quality rating, Good</i>				
Socially withdrawn African-American children exposed to physical abuse, physical neglect, or both from 10 Head Start centres in northeastern US (<i>n</i> = 46) Experimental group: resilient peer treatment (<i>n</i> = 10) Control group: attention control (<i>n</i> = 10) Nonmaltreated control (<i>n</i> = 11) and experimental groups (<i>n</i> = 15)	Experimental group: resilient peer treatment involved dyadic pairing of resilient peer-play buddy with target child for play sessions; parent volunteers trained as play supporters; 3 play sessions weekly spread over 2 months for a total of 15 sessions Control group: attention control program paired target child with classmate of average interactive play ability; met in same play corners for same number of sessions	Observational measure of amount and quality of peer social interactions; teacher ratings of social skills (at 2-month follow-up); peer-play interactive checklist; family cohesion	Pretreatment, socially withdrawn maltreated children more isolated and interacted less with peers during play; both maltreated and nonmaltreated socially withdrawn children benefited from resilient peer treatment (decreased solitary play, increased positive interactive peer play); gains in social interactions still present in experimental group 2 months posttreatment; fewer internalizing and externalizing behaviour problems	No significant demographic differences between experimental groups Blinding of teachers, data collectors, and play supporters to maltreatment status and treatment conditions Reliability data on observational rating measure Multiple informants and approaches to evaluation using validated instruments and methods Randomization not described
<i>Reams and Friedrich (23) (RCT): Quality rating, Fair</i>				
Preschool children, who were victims or siblings of a victim of physical, sexual, or emotional abuse and (or) physical or emotional neglect, in therapeutic nursery (<i>n</i> = 41) Experimental group: play therapy plus milieu therapy (<i>n</i> = 26) Control group: milieu therapy only (<i>n</i> = 15)	Experimental group: directive individual play therapy (50-minute sessions for 15 weeks) and milieu therapy Goals were to create a safe environment, encourage expression of sensitive topics through play and role-play, and to teach coping strategies	2 weeks prior, 2 weeks after, and 2 months following therapy measured intellectual ability and development; observed classroom behaviour in areas of play, aggression, attentiveness, obedience; also, parental and teacher measures of child behaviour	Experimental group: less isolated play, no other differences; at follow-up, no significant differences; post hoc analyses indicated that more time in therapeutic preschool was associated with decreased depression and acting-out scores, increased compliance	Observers and raters blind to treatment status Equivalence of groups demonstrated Reliable, valid measures including observational approaches Extent of attrition and missing data unclear Randomization not described

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posttreatment, as assessed by a multidisciplinary team. It is not known whether these effects were maintained over time. Further, although the sample involved mutually exclusive groups of children who were physically abused or neglected, the results were presented for the combined sample. Therefore, treatment effects for the subsample of neglected children are not known.

We rated the final study evaluating an intervention for children exposed to neglect as poor (25). The treatment under evaluation differed from those previously discussed in that it was a group therapy program for adult survivors of childhood maltreatment, including neglect. Methodological limitations, such as ambiguity regarding the sample size, use of only one self-report measure to assess outcome, and lack of a

Table 1 continued

Study description and participants	Treatment protocol	Outcome measures	Results	Strengths and (or) weaknesses
<i>Culp and others (20) (prospective cohort): Quality rating, Fair</i>				
Maltreated preschool children (physically abused or neglected, but not both) under authority of state protective services ($n = 34$) Experimental group: therapeutic day treatment program ($n = 17$) Control group: nontreatment ($n = 17$)	Experimental group: therapeutic day treatment program of group milieu therapy 6 hours daily, 5 days weekly, for average of 9 months (teacher-child ratio, 1:4); individual treatment with speech, play, and physical therapy; counselling and education services for parents; family support group, parent aides, family therapy, crisis phone line, and emergency financial aid Control group: met criteria for admission but not enrolled because of space limitations	Children's self-concept scale (child and teacher reports); developmental profile (test administered by multidisciplinary team); administered pretreatment and approximately 9 months into treatment	Experimental group: significant improvements in perceived cognitive competence, peer and maternal acceptance, but not physical competence; posttreatment, children in experimental group rated as having greater cognitive and physical competence, greater peer acceptance, and higher developmental quotients	No significant differences between groups in age, sex, intake category, ethnicity Multiple informants on measures Only pretest-posttest comparisons for treatment group No obvious masking of outcome assessment
<i>Brunk and others (21) (RCT): Quality rating, Fair</i>				
Families where one or more incidents of abuse or neglect, or both (combined cases were categorized as abusive families) had occurred, based on investigation by state social service investigative team ($n = 33$) Multisystemic therapy group ($n = 16$; neglect cases only, $n = 8$) Parent training group ($n = 17$; neglect cases only, $n = 7$)	Multisystemic therapy group: individually in home or clinic with each family; covered family interaction, education on child management, expectations of child behaviour, and other topics as necessary (for example, marital therapy, peer relationships) Parent training group: in groups at clinic; covered human development, child management techniques, parent-child interaction skills Both treatment groups had eight, 1.5-hour sessions weekly	Observational measures to examine parent-child interactions; self-report measures of parental psychiatric functioning, child behaviour problems, family functioning, parental stress; perceived problem ratings by parents and therapist; measures collected pretreatment and 1 week posttreatment	Both treatments effectively decreased parent-reported psychiatric symptoms and stress; improved identified individual and family problems; Multisystemic therapy was more effective at improving parent-child interactions (that is, parents better able to control and more responsive to child's behaviour; children showed less noncompliance; parent training was more effective at decreasing social problems; 23% attrition	Blinding of research assistants to hypotheses and treatment condition Reliable, valid measures including observational approaches Multiple measures and informants Groups not equivalent in some characteristics Nonrandom assignment of therapists Comparison rather than control group used Randomization not described No intent-to-treat analysis

pretreatment group comparison of demographic characteristics precluded conclusions about the effectiveness of this program.

Treatment Protocols for Neglectful Families

Eight studies (21,26–32) evaluated treatments for neglectful families. These treatments included multisystemic therapy (21), multifamily group therapy (26,27), ecobehavioural programs (Project 12-Ways and Project SafeCare; 28,29), family reunification services (30), Project Respite and Remediation (31), and a social network intervention (32). Most programs focused on improving parent-child interactions as well as on providing parent training. We rated none of

these studies as good and only one as fair; the remaining studies were rated as poor.

In the study rated as fair, Brunk and colleagues evaluated multisystemic therapy with neglectful and abusive families as a group and independently (21). Where the children had experienced both abuse and neglect, they were categorized in the abuse subsample. Therefore, the subsample of abused children also included children who had been neglected. The hypothesis underlying this type of therapy is that behaviour problems are multidimensional, and therefore, treatment must target several systems. Treatment was individualized with the general goal of improving family interaction patterns. Additional therapy components included parent education, marital

therapy, and coaching and emotional support for both parents and children. The comparison group received parent training only. At postintervention, parents in both groups were found to have decreased psychiatric symptomatology, decreased stress levels, and fewer individual and family difficulties. Compared with parent training, multisystemic therapy appeared to more effectively ameliorate negative parent-child interactions. However, parent training more effectively reduced social problems. These effects were similar when assessed separately for abusive and neglectful families. It is not known whether these effects were sustained over time.

The remaining studies in this group received a quality rating of poor (26–32). Their methodological limitations included a lack of information regarding randomization procedures or a lack of random assignment, no masking of outcome assessment, insufficient information on group assembly or retrospective sample selection, use of self-report measures only, inadequate retention rates, and selective sample loss.

Treatment Protocols for Neglectful Parents

Another study rated as poor evaluated a treatment for neglectful parents (33). Emotionally abusive and neglectful parents received either individual parent training plus 10 weekly group sessions or individual parent training alone. Methodological limitations included a lack of group comparison on demographic characteristics, a primary measure that had not undergone psychometric testing, and a small sample size with no power analysis.

Other Interventions

Most studies excluded from this review evaluated treatments that did not target victims of child neglect. Study samples often focused on children who were abused but not neglected. In other cases, we could not determine whether neglect was included in the category of child maltreatment, and studies often lacked a comparison or control group. We excluded additional studies because they did not separate prevention effects from treatment effects in the intervention assessment. These samples included both children at risk for neglect and those who had experienced neglect.

Discussion

This systematic review evaluated treatment programs for childhood neglect. We assigned a quality rating of good (2 studies) or fair (3 studies) to only 5 (36%) of the 14 studies included in the final review. Most treatments targeted children and (or) their families; only one study, with a comparison group rather than a control group, evaluated a treatment protocol for neglectful parents.

Overall, we found some evidence for effective treatments of child neglect. A few specific programs of play therapy may be beneficial for children exposed to child neglect. The 2 studies

rated as good showed positive effects: group play training improved neglected children's cooperation and interaction with peers (24), and withdrawn children exhibited more interactive play after receiving resilient peer treatment (22). However, Reams and Friedrich did not find support for individual play therapy in their study, rated as fair (23). Because the children in this latter study were already receiving milieu therapy, it could be that play therapy did not provide any additional advantages. Further, the play therapists in this study did not have a great deal of experience, which might also have affected the results. We note that Fantuzzo and colleagues included peers in their intervention (22); perhaps the use of peers had a more powerful effect than did therapists. We also suggest that children's IQ should be considered in treatment, since Udwin found effects of age and IQ on treatment gains (24). Specifically, older children with lower nonverbal IQs did not respond as well to play training as did younger children with higher nonverbal IQs. Reams and Friedrich did not consider IQ in their study (23).

Play therapy programs that have demonstrated positive results would be important to replicate to determine the extent to which the findings can be generalized. It would also be useful to determine what specific aspects of programs might help children exposed to neglect. It is generally unknown whether treatment gains as a result of play therapy or play training are sustained beyond 2 months posttreatment.

A therapeutic day treatment program may be beneficial for the self-esteem of neglected children (20). In another study, rated as fair, Culp and colleagues found that children perceived themselves as having greater cognitive competence, peer acceptance, and maternal acceptance after treatment. It is not known whether these effects were stable over time or which aspect of the program most effectively increased the self-concept of these neglected children. Parent services were offered as part of the treatment, but their influence on treatment gains was not evaluated.

Beyond the above-mentioned findings, we are unable to report on the effectiveness of other types of treatment protocols for neglected children. Further, no studies that met our criteria for critical evaluation involved treatment aimed specifically at neglectful parents.

One study evaluating treatment for neglected children and their families met inclusion criteria. Brunk and colleagues found multisystemic therapy to be effective, although their use of a treatment comparison group rather than a no-treatment control group made it difficult to determine the full extent of the intervention's effectiveness (21). However, this study (rated as fair) does provide preliminary evidence for the effectiveness of a multisystemic type of therapy in restructuring poor parent-child relationships. Since neglect often

involves the entire family, or at least one parent and one child, this treatment may reduce the recurrence of child neglect.

From the small number of studies reviewed, it is apparent that more investigation is required before we can draw conclusions about effective approaches to assisting children exposed to neglect. Treating a child for one or more impairments related to neglect is not necessarily helpful if the child remains in a family where neglect continues. Of the 5 studies that we rated as good or fair for internal validity, none evaluated treatments that aimed to reduce subsequent incidents of neglect and provide treatment for identified emotional, social, and physical problems (34). Clearly, this is not an issue if children are removed permanently from a neglectful environment. However, if children remain with the caregivers from whom they experienced neglect, reducing the recurrence of neglect is particularly important. Many neglectful families have chronic patterns of poor family functioning and poor parent-child interactions (10). In such environments, there is a high probability that neglect will continue.

Although play training may benefit neglected children, it may not target the root of the problem, which is often parental and family dysfunction (10). Such benefits are not a substitute for ensuring that a child is no longer exposed to neglect. All treatment approaches reviewed here targeted children and (or) their families directly in terms of individual characteristics, parent-child relationships, and parenting practices. Given the strong association between poverty (12) or other environmental factors (11) and neglect, it is also necessary to evaluate the extent to which provision of social supports or improvements in environments (such as neighbourhoods) reduces the likelihood of neglect persisting. Further, because most treatment research has been done with samples that combine children exposed to abuse and (or) neglect, future research should examine treatment effects independent of abuse.

Several treatment approaches did not meet inclusion criteria for this review. Some treatments differed in scope from the treatments reported here, including other types of child or family interventions, such as behavioural therapy, cognitive-behavioural therapy, and peer support therapy; residential treatment or home visitation programs; treatments targeting parents, such as parental education; and multidisciplinary treatment approaches. Therefore, we do not know the extent to which these other treatments are effective.

In summary, although primary prevention of child neglect should remain a key goal, the significant prevalence of neglect and associated impairment requires that interventions with proven effectiveness be available for neglected children. The mixed evidence to date and the relative lack of recent attention to this issue (4), as reflected in the few studies published since 2000 identified for this review, mean that more rigorous

research is necessary to evaluate the effectiveness of treatments for child neglect. Further research is needed to confirm the effectiveness and generalizability of multisystemic therapy in treating victims of neglect, as well as to determine what aspects of play therapy are most effective for these children. Also, as Slack and colleagues highlight, there is a need to create and evaluate intervention programs that target areas of concern other than parenting and family relationships, including poverty and other environmental factors (12).

Clinical Implications

Our review indicates that resilient peer treatment and imaginative play training produce positive effects for children exposed to neglect. A therapeutic day treatment program also showed benefit, and multisystemic therapy appears promising in improving family systems and relationships, which are often dysfunctional in cases of child neglect.

As we continue to learn more about effective programs for children exposed to neglect and for families with parents who have a history of neglectful behaviour, it is important that clinicians assess the risk for ongoing exposure to neglect. Treatment for the impairment associated with neglect is not a substitute for ensuring that neglect stops. Clinicians can also advocate for children and families to have access to adequate social and financial assistance. Although many children living in poverty are not neglected, the presence of low socioeconomic status and poor social supports increases the ongoing risk for neglect.

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Notes

1. In cases where there was disagreement, a third reviewer provided an independent assessment, and the ratings were discussed until a consensus was reached.
2. This is a truncated version. Full tables describing all studies can be obtained from the authors.

References

1. Trocmé N, MacLaurin B, Fallon B, Daciuk J, Billingsley D, Tourigny M, and others. Canadian incidence study of reported child abuse and neglect: final report. Ottawa (ON): Minister of Public Works and Government Services Canada; 2001. (Cat H49-151/200E).
2. Dubowitz H, Black M. Child neglect. In: Reece RM, editor. Child abuse: medical diagnosis and management. Philadelphia (PA): Lea & Febiger; 1994. p 279-97.
3. Sedlak AJ, Broadhurst DD. Third national incidence study of child abuse and neglect: final report. Washington (DC): US Department of Health and Human Services; 1996.
4. Anonymous. The neglect of child neglect. *Lancet* 2003;361:443.
5. Cowen PS. Child neglect: injuries of omission. *Pediatr Nurs* 1999;25:401-18.
6. de Jong AR. Do we neglect child neglect? *Del Med J* 1997;69:397-404.

7. Zuravin SJ. Research definitions of child physical abuse and neglect: current problems. In: Starr RH Jr, Wolfe DA, editors. *The effects of child abuse and neglect: issues and research*. New York: Guilford Press; 1991. p 100–28.
8. Dubowitz H, Pitts SC, Black MM. Measurement of three major subtypes of child neglect. *Child Maltreat* 2004;9:344–56.
9. Harrington D, Black MM, Starr RH Jr, Dubowitz H. Child neglect: relation to child temperament and family context. *Am J Orthopsychiatry* 1998;68:108–16.
10. Black MM. The roots of child neglect. In: Reece RM, editor. *Treatment of child abuse: common ground for mental health, medical, and legal practitioners*. Baltimore (MD): Johns Hopkins University Press; 2000. p 157–64.
11. Drake B, Pandey S. Understanding the relationship between neighborhood poverty and specific types of child maltreatment. *Child Abuse Negl* 1996;20:1003–18.
12. Slack KS, Holl JL, McDaniel M, Yoo J, Bolger K. Understanding the risks of child neglect: an exploration of poverty and parenting characteristics. *Child Maltreat* 2004;9:395–408.
13. Alter CF. Decision-making factors in cases of child neglect. *Child Welfare* 1985;64:99–111.
14. Dubowitz H, Black MM, Starr RH Jr, Zuravin S. A conceptual definition of child neglect. *Crim Justice Behav* 1993;20:8–26.
15. Scher CD, Forde DR, McQuaid JR, Stein MB. Prevalence and demographic correlates of childhood maltreatment in an adult community sample. *Child Abuse Negl* 2004;28:167–80.
16. Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow CD, Teutsch SM, and others. Current methods of the U.S. Preventive Services Task Force. A review of the process. *Am J Prev Med* 2001;20(Suppl 3):21–35.
17. Oates RK, Forrest D, Peacock A. Self-esteem of abused children. *Child Abuse Negl* 1985;9:159–63.
18. Asher SR, Parker JG. Significance of peer relationship problems in childhood. In: Schneider BH, Attili G, Weissberg RP, editors. *Social competence in developmental perspective*. New York: Kluwer Academic/Plenum Publishers; 1989. p 5–23.
19. Aber JL, Allen JP. Effects of maltreatment on young children's socioemotional development: an attachment theory perspective. *Dev Psychol* 1987;23:406–14.
20. Culp RE, Little V, Letts D, Lawrence H. Maltreated children's self-concept: effects of a comprehensive treatment program. *Am J Orthopsychiatry* 1991;61:114–21.
21. Brunk M, Henggeler SW, Whelan JP. Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *J Consult Clin Psychol* 1987;55:171–8.
22. Fantuzzo J, Sutton-Smith B, Atkins M, Meyers R, Stevenson H, Coolahan K, and others. Community-based resilient peer treatment of withdrawn maltreated preschool children. *J Consult Clin Psychol* 1996;64:1377–86.
23. Reams R, Friedrich W. The efficacy of time-limited play therapy with maltreated preschoolers. *J Clin Psychol* 1994;50:889–99.
24. Udwin O. Imaginative play training as an intervention method with institutionalised preschool children. *Br J Educ Psychol* 1983;53:32–9.
25. Nisbet Wallis DA. Reduction of trauma symptoms following group therapy. *Aust N Z J Psychiatry* 2002;36:67–74.
26. Meezan W, O'Keefe M. Evaluating the effectiveness of multifamily group therapy in child abuse and neglect. *Res Soc Work Pract* 1998;8:330–53.
27. Meezan W, O'Keefe M. Multifamily group therapy: impact on family functioning and child behavior. *Fam Soc* 1998;79:32–44.
28. Wesch D, Lutzker JR. A comprehensive 5-year evaluation of Project 12-Ways: an ecobehavioral program for treating and preventing child abuse and neglect. *J Fam Violence* 1991;6:17–35.
29. Gershater-Molko RM, Lutzker JR, Wesch D. Using recidivism data to evaluate Project SafeCare: teaching bonding, safety, and health care skills to parents. *Child Maltreat* 2002;7:277–85.
30. Walton E, Fraser MW, Lewis RE, Pecora PJ, Walton WK. In-home family-focused reunification: an experimental study. *Child Welfare* 1993;72:473–87.
31. Irueste-Montes AM, Montes F. Court-ordered vs voluntary treatment of abusive and neglectful parents. *Child Abuse Negl* 1988;12:33–9.
32. Gaudin Jr JM, Wodarski JS, Arkinson MK, Avery LS. Remediating child neglect: effectiveness of social network interventions. *J Appl Soc Sci* 1990–1991;15:97–123.
33. Iwaniec D. Evaluating parent training for emotionally abusive and neglectful parents: comparing individual versus individual and group intervention. *Res Soc Work Pract* 1997;7:329–49.
34. Howing PT, Wodarski JS, Gaudin Jr JM, Kurtz PD. Effective interventions to ameliorate the incidence of child maltreatment: the empirical base. *Soc Work* 1989;34:330–8.

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Résumé : Le traitement des enfants négligés : une étude méthodique

Objectif : La négligence envers les enfants est le type le plus répandu de violence faite aux enfants. Notre objectif consistait à évaluer les données probantes disponibles sur l'efficacité des programmes de traitement des enfants victimes de négligence, y compris ceux destinés aux victimes de négligence dans l'enfance et/ou à leurs soignants.

Méthode : Nous avons mené une recherche exhaustive dans les bases de données Medline, Psycinfo et Eric, de janvier 1980 à mai 2003. Deux auteurs ont mené un examen indépendant de 54 études qui satisfaisaient aux critères d'inclusion. Quatorze articles satisfaisaient aux critères de notre méthode, et leur qualité méthodologique a été évaluée selon les lignes directrices élaborées par le groupe de travail américain sur les services préventifs.

Résultats : Sur les 14 études comprises dans la recherche, 2 étaient cotées bonnes et 3 étaient acceptables. Nous avons trouvé des preuves que 2 types spécifiques de thérapie par le jeu et un programme de traitement de jour avaient des effets bénéfiques pour les enfants. En outre, parents et enfants de familles où il y avait eu de la négligence présentaient des améliorations grâce à la thérapie multisystémique.

Conclusions : Il n'y a pas d'études rigoureuses des traitements pour enfants négligés et leur famille. Des évaluations bien structurées et bien menées sont nécessaires de toute urgence pour discerner les traitements efficaces et les offrir à ces enfants et leurs soignants.