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Relevance of age and special needs in initial development phases of a child neglect scale

Stephanie Ann Stowman
University of Nevada, Las Vegas

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RELEVANCE OF AGE AND SPECIAL NEEDS IN
INITIAL DEVELOPMENT PHASES OF
A CHILD NEGLECT SCALE

by

Stephanie Ann Stowman

Bachelor of Science
Northern Arizona University
2002

A thesis submitted in partial fulfillment
of the requirements for the

**Master of Arts Degree in Psychology
Department of Psychology
College of Liberal Arts**

**Graduate College
University of Nevada, Las Vegas
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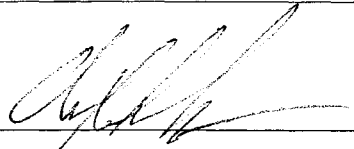

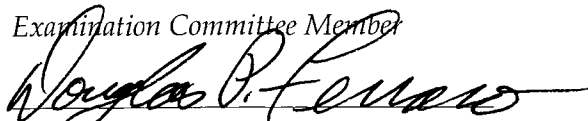
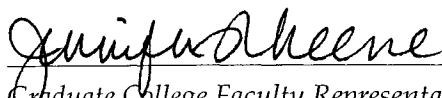
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Examination Committee Member
Graduate College Faculty Representative

ABSTRACT

Relevance of Age and Special Needs in Initial Development Phases of a Child Neglect Scale

by

Stephanie Ann Stowman

Dr. Christopher A. Kearney, Examination Committee Chair
Professor of Psychology
University of Nevada, Las Vegas

Currently, there is a lack of standardized procedures in Child Protective Services (CPS) agencies in regards to risk assessment for child neglect. Available child neglect assessment measures often lack empirical support or are limited by response bias due to the focus on parental responsibility. This study utilized interviews with CPS employees to obtain descriptions of child neglect situations. A questionnaire was then generated based on the interviews and distributed to additional CPS employees. The questionnaire examined respondents' likelihood to substantiate each item as neglect, the frequency each item occurred and the perceived level of harm for each item across multiple child age categories. Factor analysis was conducted to create an item pool for future development of tool that is sensitive to child age and special needs. Recommendations for future directions were also provided.

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CHAPTER 1

INTRODUCTION

Child maltreatment is increasingly receiving more attention in society, with child abuse receiving more focus and attention than child neglect, even though child neglect is the most prevalent form of child maltreatment (Berry, Charlson, & Dawson, 2003; Hildyard & Wolfe, 2002). Although child neglect affects children of all ages, children under three years of age suffer the most severe consequences and are at the highest risk of being victims of child neglect (Berry et al., 2003; Scannapieco & Connell-Carrick, 2002). In addition to age, other correlates of child neglect include single parent homes, poverty, substance abuse, and violence in the home (Berry, et. al., 2003).

There is not a single agreed upon definition of child neglect. However, there are some generally agreed upon aspects within varying definitions. Situations in which there is a lack of adequate nutrition, clothing, hygiene, health care, and supervision are generally agreed to constitute child neglect (National Clearinghouse of Child Abuse and Neglect Information, 2001). Although these aspects may generally be agreed upon as constituting child neglect, the terms are vague, and interpretations vary. Definitions of child neglect also vary with regards to the context in which the definition is intended to be used. Certain professionals in the areas of clinical psychology, psychiatry, social work, and other counseling professions are considered experts in the area of child neglect and impact varying definitions (Giovannoni, 1989).

Current child neglect assessment measures focus on a variety of aspects regarding neglect including the child's environment and parental behavior. Child Protective Services agencies are increasingly utilizing risk assessment tools to determine the likelihood a child will be maltreated at some future time, however, decision making procedures in many states are largely based on unstandardized processes (Camasso & Jagannathan, 2000; Lyons, Doueck, Wodarski, 1996). The requirement of structured assessment measures varies by state. There currently is a lack of consensus among states that use standardized assessment measures as to which are the best predictors of neglect and abuse.

The effectiveness of child neglect assessment measures are limited, in part, by the nature of child neglect itself. Child neglect is generally chronic and not traceable to a single incident. Additionally, multiple types of child neglect are often present and what constitutes neglect may vary by the age of the child. Therefore, it is hard for one measure to encompass all facets of child neglect. Moreover, effective child neglect measures should consider frequency, duration, and type of child neglect, age of the child, potential consequences to child's development, and degree of danger to the child (Cowen, 1999).

Social desirability bias also limits measures of child neglect that rely on information from self-report. The sensitive nature of the questions involved in the assessment of child neglect make self-report measures of this nature particularly susceptible to this bias. Some measures, such as the Child Abuse Potential Inventory (Milner, 1986), incorporate a lie scale to reduce the number of false negative classifications. Although these types of scales may alert a clinician to social desirability responding, the use of a lie scale does not reduce social desirability responding. Recent

research has suggested child neglect assessment measures move away from questions that focus on parental responsibility and blame and focus on the child in terms of risk exposure (Dubowitz, Black, Starr, Raymond, & Zuravin, 1993; Slack, Holl, Altenbernd, McDaniel, & Stevens, 2003). The use of blame reduction statements is one method to attempt to reduce blame and stigma inherent in many child neglect assessment measures. This method places a statement before the question in an attempt to reassure respondents there is not an underlying assumption (e.g. Some children are much more active than others, which can make it difficult to 'keep an eye' on them much of the time) (Slack et al., 2003).

The proposed study had two primary objectives. The first was to develop a pool of items for future use in the development of a child neglect assessment measure. The item pool was based upon child neglect situations identified in interviews with CPS employees. A questionnaire containing potential scale items was distributed to additional professionals in the area of child neglect. This questionnaire assessed professionals' likelihood to substantiate questionnaire items as neglect for four age categories and a special needs category as well as the perceived harm level and frequency of occurrence of each item. The second objective of this study was to examine the relevance of child age and special needs to CPS employees' questionnaire responses.

CHAPTER 2

LITERATURE REVIEW

Child Neglect Prevalence Rates

During the past 150 years child maltreatment has increasingly been recognized as a complex social problem (Giovannoni, 1989). Although child maltreatment has been an issue of much focus, child physical abuse has received more attention than child neglect. However, child neglect is the most common form of child maltreatment in the United States and the consequences and effects are more enduring than that of child physical abuse (Berry, Charlson, & Dawson, 2003; Hildyard & Wolfe, 2002). Indeed, more children suffer from child neglect than from physical and sexual abuse combined (National Clearinghouse on Child Abuse and Neglect Information, 2001; 2004). According to the National Clearinghouse on Child Abuse and Neglect Information (2004), in 2002 896,000 children were victims of maltreatment and 60% of those victims suffered neglect. Child neglect is the most prevalent reason for family intervention in CPS (Slack et al., 2003). In 2001, 3 million referrals concerning the welfare of approximately 5 million children were made to CPS agencies throughout the United States, of those 67% were screened in and 33% were screened out (National Clearinghouse on Child Abuse and Neglect Information, 2003). Some screened-reports were referred to other outside agencies depending on the level of perceived risk (National Clearinghouse on Child Abuse and Neglect Information, 2003). Some states such as

Washington divert “low risk” cases to community agencies for assistance rather than investigation them (Pecora, 1991). It is important to note that the aforementioned results only include children who have been reported to Child Protective Services (CPS) agencies and whose cases were substantiated. The preceding statistics, therefore, do not represent all children who are victims of child neglect.

The Third National Incidence Study of Child Abuse and Neglect (NIS-3) (Sedlack & Broadhurst, 1996) was based on data pertaining to children seen by community professionals, in which incidents of child neglect were not reported to CPS, or were screened out by CPS without investigation, as well as data pertaining to children investigated by CPS. Rates were reported using both the “harm standard” and the “endangerment standard”. Using the harm standard, children identified were considered maltreated only if they had already experienced harm from abuse or neglect. Using the endangerment standard, children who experienced abuse or neglect that put them at risk of harm are considered to be maltreated (Sedlack & Broadhurst, 1996). Sedlack and Broadhurst (1996), using the endangerment standard, reported that the number of children who were victims of neglect more than doubled from the NIS-2 (Sedlack, 1991) from 917,200 to 1,961,300 (114% increase). Sedlack and Broadhurst also reported that CPS investigated only 28% of children who were considered neglected under the harm standard and that only a minority of children who were abused or neglected by either standard received CPS attention.

Defining Child Neglect

Generally Agreed Upon Definitional Aspects

Child neglect is determined by factors operating at multiple levels of analysis, and is heterogeneous in behavior, outcomes, and situational factors (Belsky, 1993; Slack et al., 2003). Child neglect is considered an act of omission in contrast to child abuse, which is an act of commission (Giovannoni, 1989). For instance, child neglect is often indicated by inadequate nutrition, clothing, hygiene, supervision, medical, dental, or mental health care, unsafe environments, and abandonment or expulsion from the home (National Clearinghouse on Child Abuse and Neglect Information, 2001), and these neglect situations are influenced by the perpetrator's lack of caretaking behaviors. Indeed, there is considerable agreement that it is important for caregivers to provide for the physical needs of a child, including food, clothing, shelter, supervision, medical care and education (Slack et al., 2003).

Dubowitz, Klockner, Starr, and Black (1998) conducted a study to examine individuals' perceptions of child neglect across ethnic groups. The measure used in this study was an Adequacy of Care measure comprised of 45 vignettes that was derived from the Child Well-Being Scales (Magura & Moses, 1986). Dubowitz and colleagues (1998) found few differences among racial groups' perceptions but low socio-economic status (SES) African Americans rated physical care vignettes more serious than Caucasians. There was substantial agreement among low SES African Americans, middle SES African Americans, and middle SES Caucasian caregivers about neglectful situations in which young children were at risk of being harmed (i.e. a child is left home alone). This study also suggested that professionals have a significantly higher threshold for concern

regarding both physical and psychological care than the lay community. This may reflect professionals' experience with neglectful families, greater education about children's needs and development, and the more stringent criteria for child neglect required by CPS compared to standards for the general community. Although there is a difference in what level of behavior constitutes neglect between professionals and lay persons, there are still many similarities in what type of behaviors constitute child neglect (Dubowitz et al., 1998).

Varying Definitions of Child Neglect

Various professions and social institutions have emerged as concerned participants in the definition and management of child neglect, including judges interpreting the statutes, social workers intervening in the problem, medical practitioners managing a medical problem, and lawyers ensuring legal rights (Giovannoni, 1989). At one time, the primary profession involved in the examination of child neglect was social work. However, today professional boundaries are blurred. Certain members of clinical psychology, psychiatry, and other counseling professions are also considered experts in the area and impact the varying definitions (Giovannoni, 1989).

The Federal Child Abuse Prevention and Treatment Act (CAPTA) provided minimum standards for definitions of child abuse and neglect:

The term 'child abuse and neglect' means, at minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm (The Child Abuse Prevention and Treatment Act of 1996).

This definition, however, provides only minimum standards, and uses vague and broad terms. Each state establishes its own definition of child neglect but must adhere to the minimum standards set forth by CAPTA (National Clearinghouse on Child Abuse and Neglect Information, 2001).

About one-fifth of states do not define neglect separately from abuse, and of those that define it separately, some also specify particular subtypes of neglect such as abandonment and medical neglect (National Clearinghouse on Child Abuse and Neglect Information, 2001). Some state definitions of child neglect may address endangerment and harm, whereas others only address harm (Slack et al., 2003). Definitions of child neglect based on state statutes also vary due to interpretation of vague language. Statutes are vague, particularly about setting boundaries (Giovannoni, 1989; Portwood, 1998; Roscoe 1990; Barnett, Manly, & Cicchetti, 1993). Statutes tend to include phrases such as, “a home or suitable place of abode,” “an unfit place by reason of neglect, cruelty, depravity, or physical abuse,” “mental suffering,” “endangering health,” and “failure to maintain a reasonable degree of interest, concern, or responsibility for the child’s welfare” (Giovannoni, 1989; Portwood, 1998).

Different definitions for child neglect exist in different contexts, but these delineations are often not detailed enough for research, and definitions that are developed for research purposes may be useful in that context, but often do not generalize to non-research settings (Giovannoni, 1989; Slack et al., 2003). Definitions of child neglect will vary depending on the reasons they are needed, the purpose of the definition, and the professionals who developed and will use the definition (Giovannoni, 1989). Broad definitions are often found in the areas of social policy and education and tend to be

vague and difficult to implement (Hutchison, 1990). Broad definitions tend to focus on environmental conditions, not parental responsibility. The positive aspects of broad definitions provide judicial flexibility to individualize cases and greater sensitivity to local community standards (Dubowitz, Black, Starr, Raymond, & Zuravin, 1993). Narrow definitions, on the other hand, focus on parental omission in care and are most often used in the legal and CPS system (Dubowitz et al., 1993; Hutchison, 1990). Narrow definitions often imply parental responsibility and blameworthiness, and are specific with a goal to protect children from serious harm but avoid overloading the CPS system as broad definitions may do (Dubowitz et al., 1993; Hutchison, 1990). Narrow definitions are often easy to operationalize and implement.

Definitions of child neglect vary because there are dilemmas in the recognition and reporting of neglect, as well as a lack of professional training and guidelines of what constitutes neglect (Cowen, 1999). Definitions of child neglect have been criticized as imposing middle-class values as interpreted by professionals on lower class families (Dubowitz et al., 1998). Other criticisms of definitions involve a lack of cultural considerations reflected in the definitions (Cowen, 1999). Definitions should take into account how the culture of the client would view the behavior and whether the given behavior is an idiosyncratic departure from one's cultural practice (Cowen, 1999).

Consequences of Child Neglect

Although child neglect has not received as much attention as child physical abuse, its effects are more enduring than child physical abuse (Berry et al., 2003). Indeed, the consequences of neglect in general may be as severe as, or more damaging than, other

forms of maltreatment (Berry et al., 2003). Neglect is associated with malnutrition, accidents, injuries, untreated health conditions, and developmental delays (Slack et al. 2003).

The specific consequences of child neglect vary depending on the age of the child. The likelihood of child neglect decreases as the child gets older (Jones & McCurdy, 1992). For instance, child neglect affects children of all ages, however, children under three are the most vulnerable and suffer the most devastating consequences (Scannapieco & Connell-Carrick, 2002; see also Berrick, 1997). Children in this age category spend more time with caregivers, and are more physically and psychological dependent upon parents, which leaves them more vulnerable to injury (Belsky, 1993). Hildyard and Wolfe (2002) reported infants and preschoolers who were victims of neglect had lags in early cognitive development, and were more likely to have an insecure attachment style. They also stated that a history of neglect had been shown to be predictive of problems in expressive and receptive language, and that the problems are more severe than those associated with child physical abuse. Poor social adaptation and negative mental representation of self and others were also consequences of child neglect identified in infants and preschoolers. Emotional neglect over the course of several months was linked to the decline in performance on the Bayley Scales of Infant Development (Hildyard & Wolfe, 2002).

Hildyard and Wolfe (2002) indicated that school aged children and adolescents who were victims of neglect also suffered from cognitive developmental problems. The authors also reported neglected children scored lower on achievement tests, were more socially withdrawn and had an elevation in internalizing problems (See also Kurtz,

Gaudin, Wodarski, & Howing, 1993). Hildyard and Wolfe (2002) stated that school aged children and adolescents also had negative mental representation of self and others. However, some consequences of child neglect may not appear until late adolescence or early adulthood. Johnson, Smailes, Phil, Cohen, Brown, and, Bernstein (2000) indicated that childhood emotional, physical, and supervision neglect were associated with increased risk for personality disorders and elevated symptom levels during adolescence and early adulthood.

Children were more likely to die from chronic neglect than a single incident of physical abuse (Berry et al., 2003). Margolin (1990) examined fatal child neglect in Iowa and found that the typical neglect fatality was a male child under the age of three years. The majority of neglect fatalities occurred due to the caregiver not being present at a critical moment, with the home, and in particular the bathroom, being the most common setting where the fatalities occurred (Margolin, 1990). Children who died from neglect were substantially younger than those who sustained nonfatal neglect and young children who survive near neglect fatalities suffer long term consequences (Margolin, 1990; Scannapieco & Connell-Carrick, 2002).

Characteristics of Child Neglect

The contexts of child maltreatment include parental and child characteristics, parent-child interactions, community and societal support, and the societal-cultural context (Belsky, 1993; Dubowitz, Black, Starr, Raymond, & Zuravin, 1993; Slack et al., 2003). Neglect is typically chronic and not traceable to a single incident, and most children who have been found to be neglected experience multiple types of neglect

(Cowen, 1999). Child neglect occurs on a continuum from mild to severe, and the risk and protective factors vary depending on the age and developmental abilities of the child (Cowen, 1999; Slack et al., 2003).

Important differences exist among neglectful parents (Belsky, 1993). There are general characteristics that are correlated with the presence of neglect, but not all families will share the same characteristics and even those that do will vary in degree. Relative to child physical abuse, child neglect is more strongly associated with poverty, few social networks, single parenthood, and parental age under 30 (Berry et al., 2003). Emphasis on caregiver behavior is often complicated by environmental constraints that the caregiver may or may not be able to control such as insufficient income, abusive spouse, and limited access to medical care (Slack et al., 2003). Characteristics that are typically identified as related to child neglect include single parenthood, economic hardship, lack of social support, strained parent-child interactions, mental health issues, substance abuse, and domestic violence (Belsky, 1993; Dubowitz, Black, Starr, Raymond, & Zuravin, 1993; Slack et al., 2003).

Single parenting is strongly correlated with child neglect, and families reported for neglect are more likely to be headed by a single parent (Cowen, 1999; Slack et al., 2003). NIS-3 data indicated that children of single parents are at greater risk of experiencing, and being harmed by emotional neglect (Sedlack & Broadhurst, 1996). Sedlack and Broadhurst (1996) also reported that children of single parents have a 220% greater risk of being educationally neglected and an 87% greater risk of being harmed by physical neglect.

Research involving the correlation between single parent homes and neglect often focuses on mothers. Often, child neglect research focuses on mothers because mothers more often care for children than fathers, and therefore children are more often neglected by females (Belsky, 1993; Sedlack & Broadhurst, 1996). Berry and colleagues (2003) reported that mothers found to have neglected their child or children experienced much higher levels of stress in their parenting role than non-neglectful mothers. Few mothers found to have neglected their child or children are over 34 years of age, with most between the ages of 20 and 34 years (Jones & McCurdy, 1992). Jones and McCurdy (1992) also reported that fewer mothers founded for emotional maltreatment held full time employment than mothers found for physical abuse or sexual abuse.

Poverty and unemployment are also strongly correlated with child neglect (Berry et al., 2003; Cowen, 1999). Families in which child neglect is founded have the largest percentage of families with low income, in comparison to families where physical or sexual abuse are founded (Jones & McCurdy, 1992). Sedlack and Broadhurst (1996) reported that children in families with annual incomes below \$15,000 were more than 44 times more likely to be neglected, and more likely to experience physical, emotional, and educational neglect than physically abused children. Reliance on public income is also a characteristic common to many families founded for child neglect. Jones and McCurdy (1992) stated that in comparison with physical and sexual abuse, families founded for child neglect had the largest percentage of children receiving Aid to Families with Dependent Children (AFDC), with 43% receiving the aid. Most state laws exclude omissions in children's care related to poverty in defining neglect, but in some cases the state law may be interpreted to view the parents as sharing responsibility due to such

reasons as poor management skills (Dubowitz et al., 1993). Families who neglect their children are in need of continuing financial assistance, current US policy directives are placing limits on the length and financial assistance to families in poverty (Berry et al., 2003). In addition to the aforementioned economic conditions that are found in neglectful families, Belsky (1993) reported neglectful families are more likely to be transient, live in isolation, and have a lack of social support (See also Berrick, 1997).

Patterns of parent-child interactions can also be characteristic of neglectful families. Families who are found to be neglectful have fewer significant parent-child interactions, more unresolved conflict, fewer positive communications within the family, and less empathy and warmth toward family members (Berry et al., 2003). Burgess and Conger (1977) found neglectful parents have more negative emotional interactions than abusive parents (the behavior involved in interactions was coded as neutral, positive, or negative). Burgess and Conger also noted neglectful mothers are more unresponsive to the child's initiatives and needs. Difficult and strained parent-child interactions can be characteristic of families founded for child neglect.

Although it is generally acknowledged that few abusing parents are psychotic or otherwise mentally disturbed to a clinical degree, there is disagreement regarding the personality or psychological attributes of maltreating parents (Belsky, 1993). Mental state alone, or in combination with other factors, can influence the likelihood of neglect occurring. Parents less able to manage negative emotions and who feel badly about themselves seem to be at most risk of mistreating their children and child neglect will most likely occur when age, health and behavioral aspects of the child make child rearing

more of a challenge (Belsky, 1993). Berrick (1997) stated that neglectful parents have been identified by their significant social isolation, poor self-concept, and depression.

Substance use may also be a characteristic of neglectful families. Children whose parent(s) abuse drugs or alcohol are approximately four times more likely to be neglected (Berry et al., 2003). Parental substance abuse has serious consequences for children, as parents may divert money needed for basic necessities to buy drugs or alcohol (National Clearinghouse on Child Abuse and Neglect Information, 2001). Parental substance use or abuse may interfere with a parent's ability to maintain employment and expose children to criminal behaviors and dangerous people. Substance abusing parents may also be emotionally or physically unavailable and not be able to properly supervise children leading to neglect situations (National Clearinghouse on Child Abuse and Neglect Information, 2001). McKeganey, Barnard, and McIntosh (2002) indicated that parental reports cited child neglect as associated with parental drug use, as well as putting the child at risk for violence, physical abuse, exposure to criminal behavior and family breakup.

Violence also contributes to child neglect. Domestic violence during the first six months of child rearing is significantly related to child neglect up to the child's fifth year (McGuigan & Pratt, 2001). Hartley (2002) examined differences in demographic characteristics for families involving neglect and woman battering compared to families with maltreatment but no known woman battering present. Hartley (2002) found partners in the co-occurrence group for neglect were less likely to be married, fewer fathers were biologically related to the neglected child in the co-occurrence group, mothers were more likely to have a known alcohol or drug problem in the co-occurrence group, as well as a

higher rates of history of mental problems, as compared with the neglect only group. Although violence may not be characteristic of all families who are neglectful, there are distinguishing characteristics between families with neglect and violence present and those with only neglect present.

Child Neglect Subtypes

Among neglectful families there are important differences in the types of neglect present (Belsky, 1993). Therefore, identifying subtypes is useful, as treatments should be focused on specific areas and skills (e.g., Project SafeCare focused on home safety, infant and child health care, and bonding) (Lutzker et al., 1982). The Second and Third National Incidence Studies of Child Abuse and Neglect (NIS-2 and NIS-3) described three categories of neglect (i.e., physical, educational, and emotional neglect). Among these three types of neglect, physical neglect is generally viewed as the most serious, most predictable, and most distinguishable (Jones & McCurdy, 1992). It is important to note that as with the general definition of child neglect, definitions of subtypes also vary as there is not a consensus as to what subtypes are present and what constitutes each.

Physical Neglect

Physical neglect is defined in the NIS-3 as harm or endangerment resulting from inadequate nutrition, clothing, hygiene, and supervision (Sedlack & Broadhurst, 1996). Signs of physical neglect include poor or inconsistent growth development, failure to thrive, consistent hunger, poor hygiene, constant fatigue, bald patches, apathy, and inappropriate dress for weather conditions (Berry et al., 2003). Some sources include more than the three subtypes identified by the NIS-2 and NIS-3. In general, these

additional subtypes still fall within the categories established by the NIS-2. For instance, abandonment, supervision neglect, health care neglect, and nutritional neglect are sometimes categorized as their own subtype but are types of physical neglect (Cowen, 1999).

Emotional Neglect

Emotional neglect is the most difficult child neglect subtype to detect and confirm, as emotional elements deemed essential for children's development are not readily agreed upon (Berrick, 1997). Although physical neglect is often accompanied by psychological neglect, the converse is not always the case (Glaser, 2002). Definitional problems are most pronounced in the area of psychological neglect (Brassard & Hardy, 1997). According to the NIS-3, emotional child neglect includes failure to provide adequate affection and emotional support and permitting a child to be exposed to domestic violence (Sedlack & Broadhurst, 1996). In cases of emotional neglect, parents may be providing adequate physical care but not adequate nurturing (Cowen, 1999). Emotional child neglect can occur in acute instances, or in a chronic pattern of interaction, and can occur in subtle behaviors or more extreme pronounced behaviors (Brassard & Hardy). Cases of emotional child neglect are often marked by parents who are detached and uninvolved with their children and seldom speak, cuddle, or hug their children (Cowen, 1999).

Educational Neglect

Educational neglect at its most severe level may include failure to comply with state laws requiring school attendance, failure to provide an approved home curriculum, consistently permitting truancy without reason or for nonlegitimate reasons, as well as an

inattention to a child's special education needs (e.g. failure to follow special interventions recommended by the school) (Cowen, 1999). Children experiencing any form of child neglect are at a significant risk for school failure and socio-emotional difficulties (Berry et al., 2003). Kurtz, Gaudin, Wodarski, and Howing (1993) found that both abused and neglected children scored significantly lower than nonmaltreated children on language and math portions of the Iowa Test of Basic skills, with deficits especially evident in neglected children. Moreover, children in the neglected group had a rate of absences nearly five times that of the comparison group, and parents of neglected children had lower educational aspirations for their children. Neglected children scored higher on the Internalizing scale of the Teacher Report Form of the Child Behavior Checklist (Reyome, 1993). Educational neglect is controversial because tardiness, lethargic behavior in the classroom, and delinquency are generally seen as issues that are more appropriately addressed by school systems and are not always reported to authorities as neglect (Berrick, 1997).

Child Protective Services

General Information

Child neglect is the most prevalent reason for family intervention in CPS (Slack et al., 2003). In 2001, 3 million referrals concerning the welfare of approximately 5 million children were made to CPS agencies throughout the United States. Of these, 67% were screened in or investigated, and 33 percent were screened out (National Clearinghouse on Child Abuse and Neglect Information, 2003). Screened in reports were investigated or assessed to determine if allegations could be substantiated, and 28% of children were

found to be maltreated, or at risk for maltreatment (National Clearinghouse on Child Abuse and Neglect Information, 2003). It is important to note that only a minority of children who are abused or neglected, by either the harm or endangerment standard, received CPS attention. Indeed, the NIS-3 study reported that CPS only investigates 28% of children who would be considered neglected under the harm standard (Sedlack & Broadhurst, 1996).

Risk factors for continued maltreatment play an important role in the determination of the level of case supervision necessary (Kaplan, Pelcovitz, & Labruna, 1999). Risk factors found to be predictors of future neglect are the youth being under three years of age, number of previous CPS referrals, and caretaker characteristics such as emotional impairment, substance abuse, and lack of social support (Kaplan et al., 1999). Due to overwhelming caseload sizes and limited resources, these factors are not always carefully assessed by CPS workers.

Procedures for investigating a report of child abuse or child neglect may be expedited in some instances. In the state of Nevada, upon receipt of a report of possible child abuse, CPS agencies may initiate an investigation immediately when the child is five years of age or younger, there is a high risk of serious harm to the child, or the child is seriously injured or deceased (State of Nevada Division of Child and Family Services [DCFS], 2001). Also in Nevada, after a report has been screened in and investigated, findings are classified into three main report outcomes (DCFS, 2001). Substantiated reports are those that investigation or assessment confirms reported abusive or neglectful situations or incidents. Unsubstantiated reports are investigations that fail to confirm that a neglectful situation was present. The third outcome possibility is “unknown or unable to

locate,” which indicates the receiving or investigating agency was unable to locate the alleged perpetrator and/or interview the child, there was insufficient information or evidence, or the information was too old to pursue (DCFS, 2001).

CPS Assessment Methods

Increasingly, CPS agencies are increasingly using structured risk assessment tools in their investigation to manage service demands due to shrinking resources and dramatic increases in maltreatment referrals. These tools are used to determine the likelihood that a child will be maltreated at some future time (Camasso & Jagannathan, 2000; Lyons, Doueck, Wodarski, 1996). Although risk assessment may be used to define a number of different assessment and decision making processes, it is essentially concerned with the prediction of whether or not a child will be maltreated at some future time (Pecora, 1991). Many states use formal risk assessment instruments to aid in case decision making, but most use them after substantiation of abuse or neglect to determine appropriate levels of service (Fluke, Edwards, Bussey, Wells, & Johnson, 2001). Many CPS agencies do not use structured assessment instruments. Of those that do, there is not consensus as to which instruments are the best to use, leading to variability among states and agencies within states in the investigative process (Lyons et al., 1996). Furthermore, few risk assessment models used by CPS are empirically based (Lyons et al., 1996). Despite the growing number of risk assessment instruments and models, CPS case decision making procedures in many states is limited to unstandardized processes structured more by practice than by empirical research (Pecora, 1991).

Child Neglect Assessment Measures

This review focuses on assessment measures that are pertinent to professional observation and interviewing methods of parents suspected of child neglect. Measures relying upon self-report of children, or adult self-report measures using retrospective data based on childhood neglect experienced by the individual are not included in this review. The types of child neglect measures to be examined include CPS risk assessment models, measures that focus on the environment of the child, parent self-report measures, and clinical interviews and subscales of measures that primarily assess for neglect.

CPS Risk Assessment Models

Increasingly, CPS agencies are using structured risk assessment tools in their investigation to manage service demands due to shrinking resources and dramatic increases in maltreatment referrals. These tools are used to determine the likelihood that a child will be maltreated at some future time (Camasso & Jagannathan, 2000; Lyons, Doueck, Wodarski, 1996). Although risk assessment may be used to define a number of different assessment and decision making processes, it is essentially concerned with the prediction of whether or not a child will be maltreated at some future time (Pecora, 1991). Many states use formal risk assessment instruments to aid in case decision making, but most use them after substantiation of abuse or neglect to determine appropriate levels of service (Fluke et al., 2001). Many CPS agencies do not use structured assessment instruments. Of those that do, there is not consensus as to which instruments are the best to use, leading to variability among states in the investigative process (Lyons et al., 1996). Furthermore, few risk assessment models used by CPS are empirically based (Lyons et al., 1996). Despite the growing number of risk assessment

instruments and models, CPS case decision making procedures in many states is limited to unstandardized processes structured more by practice than by empirical research (Pecora, 1991).

Risk assessment systems allow CPS workers to focus attention on the most critical risk factors, which is, of course, vital when resources are limited (Pecora, 1991). Assessment models can be particularly useful as they allow a small number of factors to be assessed over the phone as part of an initial investigation. These models also help to structure worker documentation and decision making, while reducing bias in the decision making process (Pecora, 1991). Although these risk assessment models have some utility, most do not explicitly help workers distinguish risk factors that may be unique to assessing the risk of future neglect (Pecora, 1991). There are five basic types of CPS risk assessment models (i.e., matrix model, empirical predictor model, behaviorally anchored items or scales, comprehensive ecologically structured scales, and computerized expert systems (English & Pecora, 1994; Pecora, 1991). The computerized expert systems combine CPS expertise and artificial intelligence to derive computer based decision rules. These models generally focus on the detection of both child abuse and neglect. The Ontario Child Neglect Index is one of the few CPS risk assessment measures used that focuses only on child neglect, which will be discussed in greater detail below. Although these models are currently used by various CPS agencies it should be noted that all these risk assessment systems lack validation and implementation, and many have been criticized for not being culturally sensitive (Pecora, 1991).

Matrix Model

The matrix model consists of assessment measures that have tables of risk factors that are rated in terms of severity by caseworkers (English & Pecora, 1994; Pecora, 1991). The Washington State Risk Assessment Matrix (WARM) is one specific measure that is encompassed in the matrix model.

Washington State Risk Assessment Matrix (Palmer, 1988). The WARM is a 32 item list of risk factors, and consists of seven subscales (i.e., child characteristics, severity of child abuse and neglect, chronicity of abuse and neglect, caretaker characteristics, parent/child relationship, and social and economic factors). Marks and McDonald (1989) found predictive validity for the predictors of “ability of child or age of child,” “perpetrator access to child,” “dangerous acts,” “provision for basic needs,” “protection of child or mother,” “sexual contact,” “adequacy of supervision,” and “lack of adequate care.” In contrast, Camasso and Jagannathan (1995) found little support for the severity, chronicity, parent/child and caretaker characteristics items on the WARM as predictors of alleged child neglect. One of the main criticisms of the WARM was that the long list of items should be truncated into more carefully measured indices of 8 to 10 items, and that items should have high reliabilities ($\alpha > .75$) and be stable in populations that do not receive CPS service (Camasso & Jagannathan, 1995). Other suggestions for improvement included risk items containing measures of chronicity, including caretaker characteristics such as alcohol and drug problems, and that the scale itself should be empirically linked to the labeling and decision processes that influence CPS workers to substantiate a case as child abuse or child neglect (Camasso & Jagannathan, 1995).

Empirical Predictor Models

Empirical predictor models contain small sets of factors found to be predictive of substantiation or reoccurrence of child abuse and/or child neglect (English & Pecora, 1994; Pecora, 1991). This type of model is considered the most concise approach to risk assessment, and generally focuses on identifying a small set of risk factors most predictive of child maltreatment (Pecora, 1991). These models do not include characteristics associated with child maltreatment in the final set of risk factors unless they actually predict the recurrence of one or more types of child maltreatment.

Child Endangerment Risk Assessment Protocol (Illinois Department of Children and Family Services, 1996). The Child Endangerment Risk Assessment Protocol (CERAP) is an example of an empirical predictor model. CERAP was developed by the Illinois Department of Children and Family Services in response to a legislative mandate in 1994. The development of this measure was a collaborative effort of professionals in the field of child neglect; these professionals included members from the Illinois Department of Children and Family Services, American Humane Association, University of Illinois, and specialists in law enforcement, mental illness, domestic violence and clinical practice (Fluke et al., 2001). The CERAP was adapted from a 160-item safety assessment tool measure used in New York's child protective services division, and has roots in the Child At Risk Field System. CERAP has 14 factors that are associated with immediate danger to children, followed by documentation of the decision about the safety of the child. The 14 factors focus on readily observable, immediate, and harmful behavior. If it is determined that any children are unsafe, documentation of the safety plan that was developed to protect the child is to be included (Fluke et al., 2001). Risk

factors such as parental history of abuse as a child, substance abuse, mental illness, and domestic violence are included only if they seriously affect the caretakers ability to supervise, protect, or care for the child (Fluke et al., 2001). The overall intent of CERAP is to address caretakers cooperation with the investigation and willingness to protect the child, current behavior, extent to which they describe children in negative terms, severity and chronicity of previous harm to children, the possibility of sexual abuse, and children's fear of people in the home.

Fluke and colleagues (2001) used data from Illinois's DCFS Child Abuse and Neglect Tracking System, which has detailed data on approximately 400,000 child records with reports of alleged maltreatment from December 1, 1994 to November 30, 1997, to determine the impact of CERAP. They found that the recurrence of indicated maltreatment for at risk children in Illinois was significantly reduced following the implementation of the CERAP, and that there was a significant reduction in the 2 years post-implementation. The authors state that these results suggest a coordinated effort by the state to design, train for, and implement a safety protocol could have a positive impact on the safety of children. It should be noted that the ex post facto design of this study makes it impossible to know and test all policies, historical changes, and factors that could affect child abuse recurrence rates. Further research on the psychometric properties of this assessment measure is needed to determine its true impact and utility.

Behaviorally Anchored Items or Scales

Behaviorally anchored items or scales assess levels of parent and/or parent functioning in order to identify areas of concern (English & Pecora, 1994; Pecora, 1991). These areas of concern could be focused on levels of parent, child, family and/or

household functioning. The Child Well-Being Scales (CWBS) is a prime example of a behaviorally anchored scale and has received more research attention than other CPS risk assessment measures. The Ontario Child Neglect Index (CNI) is an example of a behaviorally anchored scale that assesses specifically for the presence of child neglect.

Child Well-Being Scales (Magura & Moses, 1986). The CWBS were developed as an outcome measure for evaluating programs in child welfare services. The scales are scored for the family as a whole, and on some scales for each child in the family. There are 43 scales that cover a broad spectrum of content. The scales cover four main areas of functioning: parenting role performance, familial capacities, child role performance, and child capacities (Magura & Moses, 1986). A factor analysis performed on the 43 scales revealed that “household adequacy,” “parental disposition,” and “child performance” was measured by 28 of the 43 scales and accounted for 43% of the common variance of the individual scale scores (Magura & Moses, 1986). Each scale has anchoring points described with anchoring definitions to increase face validity. Each scale point is also weighted by a common dimension or the seriousness of the condition. The weightings for seriousness are based on opinions collected from practioners and administrators of child welfare services (Magura & Moses, 1986). The maximum score on weighted scales is 100. It is important to note that a high score does not imply superior performance but rather on most scales it signifies that the care is not problematic and is within acceptable limits. The scales themselves are asymmetrical, which affords them sensitivity to degrees of deficit or pathology, but not to degrees of goodness or competence.

Gaudin and Polansky (1992) found that the CWBS to discriminate neglect successfully and discriminant analysis scores on three of the combined factors identified

by Magura and Moses (1986) correctly classified 79% of neglectful families and 87% of control families. Gaudin and Polansky (1992) extracted 17 scales and used them to form a measure of physical and psychological care of children. Composite indices from the scales showed good internal consistency and concurrent validity of this segment was supported. The analysis of this modified form yielded three factors that reliably classified families externally verified as neglectful or nonneglectful control mothers. Indeed, the three combined factors correctly classified 79% of neglectful cases as neglectful and correctly classified 81% of the controls. Overall, Gaudin and Polansky (1992) found the CWBS to discriminate between neglectful and nonneglectful families with household adequacy as the strongest discriminant factor. Casady and Lee (2002) assessed low income families and found significant differences between means on the physical factor of the CWBS for families with substantiated child neglect and control families. Items indicating the physical factor involved adequacy of the physical environment, with included health care, diet, clothing, hygiene, sanitation, child supervision, utilities, and residence security (Casady & Lee, 2002).

One of the main criticisms of the CWBS is that although the scales incorporate measurement items for different domains of neglect, the assessment measurement itself is not intended for families not yet identified by CPS and this limits its application (Slack et al., 2003). Furthermore the CWBS are administered by child welfare professionals who are trained to identify problematic situations and are often familiar with the family and their history. Slack and colleagues (2003) suggested that future research examine the effectiveness of the CWBS with limited interviewer training to identify maltreatment without intrusive assessment of family members and their environmental contexts. The

scales have also been criticized because they do not adequately capture levels of extreme poverty (Seaberg, 1988; Fanshel, Finch, & Grundy, 1994). Seaberg (1988) cited a lack of clarity in the definition of child well-being, a lack of clinical cutoff points, and the lack of validity for indicators as limitations to the CWBS. The CWBS have also been criticized for a lack of scales based on measures of substance abuse or previous family history of maltreatment and a lack of allowance for any interaction of factors (Lyons et al., 1999).

The Ontario Child Neglect Index (Trocme, 1996). The CNI was designed to provide child welfare practitioners and researchers with a validated easy to use instrument that specifies type and severity of neglect. The CNI is a one page index with six scales for assessing neglect: supervision, nutrition, clothing and hygiene, physical health care, mental health care, and development/educational care. Each scale is rated on a four to five level severity scale with the ratings of “adequate,” “inconsistent,” “inadequate” and “seriously inadequate.” Rating instructions for the supervision scale require consideration of both the severity of harm and the potential for harm, whereas the physical care scales have an emphasis on evidence of actual impairment. For all six scales an “inadequate” or neglect rating requires either evidence of impairment, harm, or exposure to situations that could cause harm. Scores are calculated by combining the score from the scale receiving the highest severity rating and an age score calculated from a table with CNI scores ranging from 0 to 80. The scores are then interpreted as a rating of severity of neglect. Trocme (1996) examined concurrent validity by the comparison of CNI score to NIS maltreatment classification and scores on the CWB scales. The CNI scores were significantly related to NIS classifications and compared well with the CWBS. Predictive validity was examined by comparing CNI scores to the decision to provide ongoing child

welfare services, the mean CNI scores for cases kept open was significantly higher than mean CNI scores for closed cases.

The CNI is considerably shorter and requires less administration time than the CWBS. However, Trocme (1996) noted that the brevity of the CNI may not be as accurate and comprehensive as the CWBS. As with the CWBS, the CNI incorporates measurement items for different domains of neglect but the tool is not intended for families not yet identified by CPS. The CNI is also administered by trained child welfare professionals who have experience in identifying problematic situations (Slack et al., 2003). Slack and colleagues suggested that further research be conducted with the CNI that examines limited interviewer training to identify maltreatment as well as procedures that are less invasive to the family.

Comprehensive Ecologically Structured Scales

Comprehensive ecologically structured scales identify levels and sources of risk and facilitate identification of strategies to alter and measure risk reduction. These scales are based on the ecological approach to child neglect that views child neglect as an association with child, parent, community and societal factors (Dubowitz, Black, Starr, Raymond, & Zuravin, 1993). The Child at Risk Field (CARF) system is the most prominent approach used under this model.

Child at Risk Field System (Holder & Corey, 1987; Holder & Corey, 1989). The CARF uses 14 factors organized around five forces or categories which represent the child, parent, family, maltreatment, and intervention to predict maltreatment. The CARF was designed to enable caseworkers and other professionals to use risk as a basis for decisions regarding the family (Hansen & MacMillan, 1990). CARF is intended to

control subjectivity, increase uniformity and accountability, ensure decisions are based on sufficient data, and increase client involvement in problem solving. There are a series of 14 open-ended questions with anchored rating scales to identify risk influences. Answers to the open-ended questions constitute the influences that describe the family and child. Numerous influences can be identified, including danger loading influences, which refer to influences around the child and/or family that would be considered dangerous (Hansen & MacMillan, 1990).

Lyons et al. (1996) reports implementation problems with the CARF, as well as low internal consistency (Cronbach's $\alpha = .57$). Interrater reliability has been found to be good for the group mean, but single rater means were poor to moderate (Fluke et al., 1993). System effects, as well as service effects, were marginal (Fluke et al., 1993). As with other CPS risk assessment methods, the CARF lacks validation and implementation data (Pecora, 1991).

Environmentally Focused Assessment Measures

The environments of children who have been found to be maltreated are often not safe, particularly for toddlers (Donohue, Van Hasselt, Miller, & Hersen, 1997). Family members may be unaware of the potential hazards in their home, such as access to medications, toxins, and electrical outlets. Homes of maltreated children are often messy and may be unsanitary. Environmentally focused assessment measures have focuses that include assessing the home, access to dangerous material or weapons, and overall adequacy of the environment. The Home Accident Prevention Inventory (HAPI), Checklist for Living Environments to Assess Neglect (CLEAN), and the Home Safety

and Beautification Tour are examples of environmentally focused child neglect assessment measures.

Home Accident Prevention Inventory (Tertinger, Greene, & Lutzker, 1984)

The HAPI was developed in an attempt to assess the safety of home environments of families identified as abusive and or neglectful. The HAPI assesses 26 hazards in the home item categories of fire and electrical, suffocation by ingested object, suffocation by mechanical objects, firearms, and solid and liquid poisons. The total number of hazardous items as well as the type and number of categories under which these hazardous items are organized can be identified using this measure (Tertinger, Greene, & Lutzker, 1984). The HAPI-R is a revised version that has seven main categories of hazards: poisoning by solids or liquids, fire and electrical hazards, suffocation by mechanical objects, ingestible small objects, sharp objects, ingestible small objects, sharp objects, firearms, falling hazards and drowning hazards (Mandel, Bigelow, & Lutzker, 1998). Tertinger and colleagues (1994) found the HAPI to have adequate content validity indicated by all questions on the HAPI being considered at least a moderate threat my individuals associated with accident prevention research, safety commissions, and pediatric departments. The HAPI was also reported to be useful in the identification of home safety problems.

Checklist for Living Environments to Assess Neglect (Watson-Perczel, Lutzker, Greene, & McGimpsey, 1988).

CLEAN was designed to assess home cleanliness, and permits an examination of cleanliness of items in targeted rooms (e.g. sink, counter, table, and chairs in the kitchen) according to three dimensions (Watson-Perczel et al., 1988). The three dimensions are

presence of dirt or organic matter, the number of clothes or linens in contact with the item area, and the number of nonclothing items or other nonorganic matter in contact with the item area. The CLEAN produces a composite percentage score reflecting the condition of the home along the three aforementioned dimensions. Scores for all item areas in a particular room are added together, and then divided by the number of item areas, yielding a mean score for all item areas in that room and that number is divided by 20 (highest possible scores) and multiplied by 100 to yield a percentage score. Scores range from 0 to 100 with higher scores indicating more cleanliness. Watson-Perczel et al. (1988) reported that CLEAN has been shown to have adequate inter-rater agreement and is useful for evaluating the effects of home cleanliness training. The CLEAN requires a substantial period of time to complete, but has been reported to be well suited for the objective quantification of unhealthy or inadequate environments (Hansen & MacMillan, 1990).

Home Safety and Beautification Tour (Donohue, Van Hasselt, Miller, & Hersen, 1997)

The Home Safety and Beautification Tour is comprised of a tour of the home to examine 15 items in six rooms of the home. The 15 items examined are toxins, electrical hazards, sharp objects, heavy objects, small objects, weapons, home access, adequate temperature control, adequate food, cleanliness, household items, adequate toys, adequate children books, adequate clothing, and adequate décor. The Home Safety and Beautification Tour is intended to identify present or potential hazards and educate household members on the potential hazards that can lead to accidents and or injury. A tally is kept for each type of item that is found in the kitchen, bathroom, dining room, closet(s), and bedrooms. The psychometric properties of this instrument have yet to be

examined, and cut off points are not provided to indicate when child neglect is present. Nevertheless, the instrument appears to have good clinical utility.

Parent Self-Report Measures

Parent self-report measures provide an easy to administer and cost efficient method to assess for behavior and other factors related to child neglect (Howing, Wodarski, Gaudin, & Kurtz, 1989). Self-report measures, however, have the potential limitation of respondents answering in a socially desirable manner and thus underreporting neglectful or dangerous behaviors (Howing et al., 1989). Parent self-report measures such as the Child Abuse Potential Inventory (CAPI) and Conflict Tactics Scale parent to child version (CTSPC) do not focus specifically on child neglect but have subscales or items that relate specifically to child neglect.

Child Abuse Potential Inventory (Milner, 1986)

The original version of the Child Abuse Potential Inventory (Milner, 1980) was generated using an extensive review of child abuse and neglect literature, and revisions have occurred based on concurrent validation research. Milner and Wimberly (1980) found that 77 of the 160 items of the original Child Abuse Potential Inventory (CAP) significantly discriminated between a group of matched abusers and nonabusers. Although the CAPI, the revised version of the CAP, focuses on child abuse, there are some items that pertain to child neglect (i.e., I always try to check on my child when it's crying). The CAPI includes an Abuse Potential Scale and three validity scales (Random Responding, Inconsistency, and Lie), Distortion Indexes of Fake-Good, Fake-Bad, and Random Responding, which are derived from the validity scales (Milner, 1986). Upon extensive evaluation, Milner (1986) found the CAPI to have sound psychometric

properties (i.e. internal consistency, temporal stability, normative information, convergent, discriminant, and predicative validity) (see also Kaufman & Walker, 1986). Milner and his colleagues (1984) administered the CAP to 200 parents at risk for problems in parenting and found a significant correlation between abuse scores on the CAP and confirmed neglect reports. Kaufman and Walker (1986) reported the CAPI had great promise for screening but should not be used in isolation as a predictor of child abuse or neglect because of the possibility of misclassification.

Conflict Tactics Scale, Parent to Child Version (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

The CTSPC is an improved version of the Conflict Tactics Scale (CTS) in regards to the measurement of child maltreatment. The CTS was designed for use with partners in a marital, cohabitating, or dating relationship. The CTSPC changed the referent person from “your partner” to a specific child, and modified some items that were not appropriate in the examination of parent-child relationships. The CTSPC is intended to be used as a clinical screening tool that measures the extent to which a parent has carried out specific acts of physical aggression, regardless if acts resulted in injury to the child. The administration time is brief, requiring only six to eight minutes to administer the core scales. The CTSPC has a supplemental scale for child neglect that is intended to measure failure to engage in behavior that is necessary to meet the developmental needs of a child. Neglect is scored for failing to meet these needs regardless of whether the child is actually harmed by the neglect. The CTSPC also has a feature that many child neglect measures lack, statements preceding each scale and subscale that draw attention to factors that may increase the likelihood of child neglect such as money or personal problems.

Straus and colleagues (1998) reported low internal constancy reliability for the Neglect scale ($\alpha = .22$) but noted this does not necessarily mean the Neglect scale lacks validity. Further examination of the Neglect scale is needed to determine its utility in the measurement of child neglect. Overall, the CTSPC has been found to be a better measure of child maltreatment than the CTS (Straus et al., 1998).

Additional Measures and Techniques

Observation and clinical interviews may also be used to examine the presence of child neglect, but these measures are often used in conjunction with other assessment measures. In the assessment of child neglect, specific observation techniques may be used. Clinical interviewing allows a variety of information to be gathered in the assessment of child neglect and a widely used interview is the Child Abuse and Neglect Interview Schedule (CANIS). Service workers who are in close contact with a family suspected of child neglect can provide valuable information that can aid in the assessment process. The Childhood Level of Living Scale is an example of an assessment tool used service providers who know the family well.

Observation

Observation allows data to be gathered on what parents and children are actually doing in homes where child neglect is suspected (Burgess & Conger, 1977). Observation should occur in the home when possible, especially during periods of likely conflict such as mealtime, bedtime, and getting ready for school (Ammerman, 1989). During these periods, more conflict may be present in the parent-child interaction, but it is also important to consider the fact that the interactions may not be natural under the observation of a clinician. Burgess and Conger (1977) indicated that special attention

should be made when observing the patterns of interaction between parents and children, between parents, and between the child and siblings paying close attention to the reciprocal character of the interaction.

Burgess and Conger (1977) found that observation by caseworkers revealed distinct differences between neglectful and control families in which families where neglect was present showed less directed positive contact to each other, mothers responded positively at a significantly lower rate, mothers directed negative comments to other family members more often, and children directed fewer verbal responses to parent. Burgess and Conger (1977) identified important patterns that can be revealed through observation, but the method itself is time consuming and expensive, and did not yield information that alone could be used to determine the presence of or potential for child neglect. Rather it was shown to reveal behavior patterns present in families where neglect has already been identified. Costs can be high as observational procedures are more involved and unless sensitivity reaches 100%, which is unlikely, some families who need treatment will not be identified through assessment necessitating that the agency pay twice (i.e., first to administer the screening devices, and second to treat the abusive families and their victims who are not identified by the instruments (Caldwell, Bogat, & Davidson, 1988).

Child Abuse and Neglect Interview Schedule (Ammerman, Hersen, & Van Hasselt, 1988)

Interviewing is a common procedure for identifying circumstances around child maltreatment (Hansen & MacMillan, 1990). CANIS is a semi-structured interview that covers the areas of child care, child behavior problems, disciplinary practices, past history of family violence, sexual abuse, and drug and alcohol abuse (Ammerman, 1989).

The CANIS takes approximately 45 minutes to administer, but a portion of it can be used separately to obtain information solely related to the detection of child maltreatment. It is important to note that the CANIS was designed for families of disabled children but the interview may also be used with nondisabled populations (Ammerman et al., 1988). The psychometric properties of the CANIS have yet to be evaluated.

Childhood Level of Living Scale (Polansky, Chalmers, Bittenwieser, & Williams, 1981)

The Childhood Level of Living Scale was developed as a measure for scaling essential elements of child care and neglect. It is intended to capture child neglect, and does not assess physical or sexual abuse. The Childhood Level of Living Scale was designed for parents of children between four and seven years of age, although the authors suggest it may be appropriate for a wider age range (Polansky et al., 1981). The first version developed was intended for rural populations and the second version was developed for urban populations. The urban version has 99 items that assess nine factors, five of which are descriptive of physical care and four that are descriptive of emotional and psychological care. Physical and psychological care were shown to correlate highly (Polansky et al., 1981). Items include meal planning, sleeping arrangements, clothing, cleanliness, supervision, safekeeping of medicines, and similar domains. Service workers, who are in close contact with the family and know them well, rate the items on a scale ranging from “should be reported to legal authorities” to “excellent care.” Total scores can be derived with a range from “severely neglectful” to “good child care.” The Childhood Level of Living Scale scores have been shown to have construct and concomitant validity in several large studies (Polansky et al., 1981). Some, however, have questioned the relevance of some items as a measure of child neglect (i.e. child has

been taken by parents to a parade) (Gaudin & Polansky, 1992). Additional evaluation of quality and utility is needed but The Childhood Level of Living Scale is recommended as a measure that might reduce professional biases and errors in detecting neglect (Hansen & MacMillan, 1990).

General Critique of Current Assessment Measures

The nature of child neglect limits the effectiveness of assessment measures in general. Most children who suffer from child neglect experience multiple types of neglect, and child neglect is typically chronic, or not traceable to a single incident. Therefore, it is hard for one measure to encompass the various types of child neglect (Cowen, 1999). Cowen suggested that child neglect assessment measures should consider frequency, duration, and type of child neglect, age of the child, potential consequences to child's development, and degree of danger to the child.

Developmental Consideration of Child's Age

Child neglect assessment measures, due to variance of what constitutes neglect for different age categories, rarely can be used to assess for child neglect in all age ranges. Rather, contemporary assessment measures focus on specific age ranges, or only include items that could be considered neglect in all age ranges but exclude important items that would be specific to certain ages. Special needs of a child are also rarely taken into account by current neglect assessment procedures. An important innovation would be to develop measures that accommodate special needs and age diversity within child neglect.

Piaget's Developmental Stages. In developing an age-sensitive measure of child neglect, it is important to consider the child's cognitive development at the respective ages being assessed. Piaget's theory outlines four stages of child development:

sensorimotor, preoperational, concrete operational, and formal operational. Piaget recognizes that the timing of stages depends on a host of factors that vary among children. Indeed, development is a function of complex interactions among many factors, including social environment and rate of physical maturation (Ginsberg & Oppen, 1969). Behavior characteristics of a given stage do not disappear when the child attains the next stage; rather new abilities are added to the old ones. The sensorimotor stage occurs from birth to two years and is comprised of six stages. As the infant progresses through these stages, behavior and interactions become less focused on feeding activity and on the infant's own body and become more focused on the environment around the infant (Ginsberg & Oppen, 1969). Malnutrition is one consequence of child neglect that may be seen in children during the sensorimotor stage. At this stage, infants can also imitate models. Children in this stage probably are at an increased risk for neglect because they spend more time with caregivers, and are more physically and psychologically dependent on their caregiver (Hildyard & Wolfe, 2002). Indeed, infants and young children are the primary clientele of the welfare system as victims of child neglect (Berrick, 1997).

The preoperational stage occurs from ages three through seven and can be broken into two stages, the preconceptual stage (ages two to four) and the intuitive stage (ages four to seven) (Evans, 1973). During the preoperational stage, the child develops linguistic skills, engages in imaginative play, and symbolic function is present. Children in this stage are unable to acknowledge conservation and thought is generally geocentric and self-centered (Evans, 1973). The concrete operational stage occurs in children ages eight to eleven and is characterized by a shift of mental activities from overt actions to

intellectual operations. This stage also establishes foundations for logical thinking and the child can utilize relational terms (Evans, 1973).

Child neglect is not as prevalent for children in the preoperational and concrete operational stages. The likelihood of child neglect decreases as the child ages. It is possible that victims of child neglect experiences varying types of child neglect, dependent on his or her current developmental stage (Jones & McCurdy, 1992). Victims of child neglect in the older age categories may be more likely to experience accidents and injury due to hazardous materials or objects (i.e. a loaded gun kept in an unlocked drawer), untreated health conditions, and developmental delays (Slack et al., 2003). Piaget's final stage is the formal operational period that occurs between ages 12 and 15 and the adolescent has the understanding that reality is but one set of all possibilities and has a preoccupation with the mechanisms of thought (Evans, 1973). Although child neglect occurs for children in this stage, the prevalence is lower than for any other stage. A child in this stage may experience emotional neglect in the form of being exposed to criminal activity by a parent or caretaker (i.e. parent uses illegal drugs in the presence of the child). Situations that may have constituted neglectful situations for children in prior stages may not be considered neglect for children in the formal operational period (i.e. leaving small objects within the reach of a child in this stage would not be neglect, whereas this same situation may be considered for neglect for children in the sensorimotor stage).

Special Needs. The federal Maternal and Child Health Bureau's Division of Services for Children with Special Health Care Needs (DSCSHCN) established a special work group to establish a definition of the term "children with special health care needs"

in 1994 and 1995 (McPherson et al., 1998). The following definition is currently used by federal and state agencies to define children with special needs:

Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (McPherson et al., 1998).

Increased risks in this definition may include both biological (i.e. low birth weight) and environmental risks such as extreme poverty and child abuse and neglect (McPherson et al., 1998). McPherson and colleagues (1998) also provided examples of health and related services a child with special needs may require such as medical care, speech and occupational therapy, mental health services, family support services, and medical and assistive equipment supplies. The definition established by the DSCSHCN is broad and inclusive as it includes children who are at increased risk for developing a condition as well as including children who need services as opposed to those who are currently receiving services (McPherson et al., 1998).

The National Survey of Children with Special Health Care Needs examined the characteristics and size of the population of children with special needs at both the state and national level. This survey was sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration and carried out by the National Center for Health Statistics of the Centers for Disease Control and Prevention (U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2004). A total of 38,866 families of children with special health care needs were interviewed by telephone between 2000 and

2001. The authors note this sample is nationally representative; however, the survey itself is based on families' subjective experiences (U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2004).

The results of The National Survey of Children with Special Health Care Needs indicated that approximately 12.8 percent, or 9.4 million, children in the United States have special health care needs as defined by McPherson et al. (1998). The National Survey of Children with Special Health Care Needs also found that 12 percent of children with special health care needs were uninsured at some point during the year prior to the survey which may contribute to the child not receiving needed services (U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2004). Another result from the survey was the prevalence of special health care needs in children increased with child age. The higher prevalence of special health care needs among older children may be attributable to conditions that are not diagnosed or that do not develop until later in childhood (i.e. learning and behavioral disorders). The survey overall indicated that the majority of children with special needs are receiving adequate care however it noted that there is room for improvement for children with special needs who are the most vulnerable, such as those in low-income families as these children are twice as likely to be uninsured than children from families whose income is twice the poverty level or more (U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2004).

Children with special needs are at a greater risk to be victims of child maltreatment. Many theories have been proposed regarding the relationship between child maltreatment and children with disabilities. Historically, the dependency stress theory was dominant in which it was believed that that children with disabilities or special needs created excessive stress for his or her caregiver and the caregiver responded by abusing or neglecting the child (Friedrich & Boriskin, 1978). This theory, however, was not empirically supported (Benedict, Wulff, & White, 1992). A similar theory proposed by Sobsey and Calder (1999) adapts Bronfenbrenner's (1977) ecologic model of child development for children with disabilities and their risk for maltreatment. This theory proposes that children are vulnerable to abuse because they lack power and skills to escape, avoid or resist powerful abusers and disabilities increase this risk.

Another theoretical viewpoint regarding maltreatment and special needs views maltreatment as a causal factor for disability. Specifically, medical neglect has been found to contribute to disability. Flaherty and Weiss (1990) found children whose ear infections were left untreated often acquired permanent hearing impairments. Child maltreatment appears to be a causal factor in only a minority of cases of children with disabilities (Sobsey, 2002). Sobsey (2002) discussed another theory that posits the same causal factors that increase a child's risk for maltreatment also increase the risk for disability. For example, substance abuse during pregnancy and spousal abuse during pregnancy are both particularly associated with higher risks for disabilities and later child maltreatment (Sobsey, 2002).

A consensus regarding which theory of maltreatment and special needs is more accurate does not exist. Most research focuses on the prevalence of maltreatment among

children with special needs. Crosse, Kaye, and Ratnofsky (1993), using a nationally representative sample of confirmed reports of child maltreatment, found children with disabilities to be 1.67 times more likely to be maltreated as children without disabilities. This number, however, may be an underestimate because using confirmed cases of child maltreatment does not account for all children who are maltreated and the authors also noted the procedures used in their study suggested disabilities may be underdiagnosed in maltreated children. Another study examined over 50,000 children attending school in Nebraska to determine the relationship between the need for special education services and the likelihood of maltreatment (Sullivan & Knutson, 2000). The authors found that children identified as needing services were 3.4 times more likely to be maltreated, and specifically 3.76 times more likely to be neglected than children who did not require special education services. Sullivan and Knutson (2000) noted that as this study also only included confirmed cases of maltreatment the actual percentage of children with disabilities who are maltreated was likely higher than the reported numbers.

Lack of Attention to Severity

As many parents engage in some form of neglectful behavior on at least one occasion, the issue of severity is critical in the assessment of child neglect (Cowen, 1999). Current child neglect assessment measures often do not address severity of child neglect in general, or of specific incidents of child neglect. Some incidents alone may not constitute child neglect which makes severity an important component (National Clearinghouse on Child Abuse and Neglect Information, 2001). Severity should be based on the estimation of the degree of harm involved (Dubowitz et al., 1993). The presence of actual harm meets the definitions of child neglect in most states but the inclusion of

potential harm in an assessment measure could be seen as controversial as most states do not include the risk of harm in their definitions (Dubowitz et al., 1993). Potential harm, however, is important as many forms of child neglect do not have immediate or short-term consequences. The severity and frequency of child neglect is often overlooked by current child neglect assessment measures and future measures should address these limitations.

Social Desirability Bias

Self report instruments, and other assessment measures that rely on information that is partly obtained from parents, may be affected by social desirability bias. Social desirability responding is the tendency to give answers to make the respondent look good, and has been found to affect measurements of personality variables, attitudes, and self reported behaviors (Bardwell & Dimsdale, 2001; Fisher & Katz, 2000). When individuals are asked to report feelings, attitudes, or behaviors it is common to respond in socially desirable ways that do not accurately reflect their true experiences. These effects may attenuate, inflate or moderate variable relationships (Fisher & Katz, 2000). Paulhus (1992) suggests social desirability bias can be portioned into the factor of self-deceptive positivity which is an honest but overly favorable self presentation; and impression management, which is associated with the desire to present oneself in a socially conventional way. The degree of response bias will vary according to the degree that the value is strongly prescribed within the social system (Fisher & Katz, 2000). No one mode of measurement has been shown to demonstrate a large advantage for addressing this issue (Slack et al., 2003).

The impact of social desirability bias can be reduced through the use of various test construction techniques as well as the use of measures or scales designed to assess for social desirability bias. The MMPI-2 uses a validity scale called the Lie scale to detect blatant socially desirable responding and the K scale to identify more subtle forms. The Marlowe-Crowne Social Desirability Scales (MCSDS) were developed to identify subtle forms of social desirability and is one of the most frequently used tools to detect response bias (Crowne & Marlowe, 1960). The MCSDS reflects the inclination to seek approval or avoid disapproval and indicated that those who score high are likely to bias their responses as a way of blending in and escaping negative evaluations (Crowne & Marlowe, 1960).

Sensitive questions that a respondent may feel uncomfortable answering directly are especially susceptible to this bias and the nature of child neglect assessment makes this a problem inherent in all child abuse and child neglect assessment procedures. The accuracy of maltreating parents' self reports may be influenced by unrealistic expectations, misattributions, or the desire to give socially desirable responses (Hansen & MacMillan, 1990). The CAPI has a lie scale incorporated into it to reduce the number of false negative classifications that were being found with the abuse scale alone (Robertson & Milner, 1985). Robertson and Milner (1985) found the lie scale to successfully discriminate between subjects in the honest and faking good conditions of their study, however, the MCSDS was the only scale able to discriminate subjects faking bad. Questions and items of child neglect assessment measures often imply parental blame and attach a stigma to families found to neglect their children which makes social desirability response bias problematic for assessment procedures.

Inherent Blame and Stigma

Most states and CPS systems use narrow definitions to define child neglect and these definitions are focused on parental omissions in care (Dubowitz et al., 1993). Parental responsibility and blameworthiness are at least implicit in the definitions of child neglect and most often are found in child neglect assessment measures (Dubowitz et al.). Dubowitz and colleagues suggested there is a tendency to categorize families as either “good” or “bad” or “neglecting” or “nonneglecting” and these categories are arbitrary and simplistic. Due to the stigma and bias in many child neglect assessment tools, maltreating parents may be hypersensitive to negative evaluation and prone to make inaccurate interpretations of assessment procedures if they are not explained thoroughly (Hansen & MacMillan, 1990).

The ecological model of child neglect is supported by research and implies that the victim-perpetrator framework should be replaced by consideration of individual, family, community, and societal factors contributing to neglect (Dubowitz et al., 1993). Brassard and Hardy (1997) attempted to address the inherent stigma of verbal abuse by parents by asking parents to report the number of incidents that they had witnessed in their family during the last year as opposed to how many times they personally had verbally abused their child. Slack et al. (2003) also suggested setting parental responsibility temporarily aside as it is an issue for intervention, not assessment. Research suggested that moving from a focus on the neglect perpetrator as the target of measurement toward one that focused on the child in terms of risk exposure would be more useful (Dubowitz et al., 1993; Slack et al., 2003).

The use of blame reducing statements is one method to try to reduce the blame and stigma inherent in child neglect assessment measures and to reduce the potential for social desirability bias. The CTSPC uses one statement to precede its neglect supplementary questions. The statement describes some possible barriers to properly caring for a child (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). Although the CTSPC uses these types of statements, it still focuses on the parent, and the parent's responsibility, as the parent is asked how often in the past year particular behaviors have been done or not (Straus et al., 1998). Slack and colleagues (2003) developed a measure that is currently being used in The Illinois Families Study that relies heavily on self report items to identify risk for child neglect while attempting to use questions that are not threatening to respondents. The scale that Slack et al. developed avoids probes for poor parenting and has potential qualifiers for sensitive questions to reassure respondents there is no underlying assumption (e.g. Some children are much more active than others, which can make it difficult to 'keep an eye' on them much of the time. Overall, how active would you say your child is compared to other children his/her age?). Blame reduction or removal statements are one potential method to reduce social desirability bias.

Methods of Identifying Child Neglect Situations

As previously described in detail, there is not a universal definition of child neglect. Variations in definitions contribute to variation of item content in child neglect assessment measures. Child neglect assessment measures may identify neglect situations through searches of risk factors identified in the literature, as well as items from previous self-report assessment measures. However, this method has the limitation of using

definitions and situations based on research which may not correspond to “real-world” situations (Hamby & Finkelhor, 2000). This problem may be alleviated in part by identifying real world child neglect situations.

One method of identifying “real-world” child neglect situations is to obtain information from professionals who encounter child neglect (i.e. CPS caseworkers). This information may be obtained through interviews and focus group discussions.

Historically, focus groups date back to the 1920s and were most often used as a market research technique. Focus groups have since evolved into a data collection technique that is commonly used in the social sciences (Powell, Single, & Lloyd, 1996). The validity of existing questionnaires has been enhanced through the use of focus groups in addition to their use in devising new questionnaires (Mitra, 1994). Karoll and Poertner (2002) used focus groups to identify a list of preliminary indicators of safe reunification for children placed in foster homes because of parental substance abuse. The items identified in the groups, which were comprised of professionals, were then put into an instrument to be given to judges, caseworkers and substance abuse counselors to identify indicators.

Focus groups allow those affected by research aims to feel like an integral part of the developmental process (Nabors, Ramos, & Weist, 2001). In terms of optimal group size, Millward (1995) reported that recent focus group research in psychology had an average of nine participants per session with a range of six to twelve with the theory that group size is inversely related to the degree of participation fostered.

Study Aims

The proposed study had two primary objectives. The first was to develop a pool of items to be used at a future time to develop a child neglect assessment measure. The item pool was based upon child neglect situations identified in interviews with CPS employees. Interview participants were asked to depict scenarios they considered child neglect. A questionnaire containing potential scale items was distributed to additional professionals in the area of child neglect. This questionnaire assessed the likelihood the professional considered the item neglect for four age categories and a special needs category as well as the perceived harm level of each item for each age category. The second objective of this study was to examine the relevance of child age and special needs on CPS employees' questionnaire responses.

CHAPTER 3

METHODOLOGY

The study aims were addressed in two phases. The first phase involved the development of an item pool based on child neglect situations identified in interviews. Interviews were conducted with Child Protection Services (CPS) caseworkers and supervisors. Situations identified in interviews were used to create items for an item pool for an item questionnaire used in phase two.

The second phase of this study involved the administration of a questionnaire to additional CPS workers not included in the original sample. The purpose of this questionnaire was to determine the extent to which the situations generated in interviews represented child neglect situations that would be substantiated for child neglect. Additionally, the perceived level of harm and frequency for each situation was obtained. A second aim of this questionnaire was to examine the potential impact of child age and special needs on participant responses to questionnaire items.

Participants

Phase One

Participants in phase one were 11 volunteer caseworkers and supervisors in Clark County, Nevada who were employed by a division of the Clark County Department of

Child and Family Services. Participants were 11 Child Protective Services supervisors (n=5) and field investigators (n=6). Three participants were male and eight were female. The majority were European American (n=10), with one participant being African American. The mean age of participants was 44 years, with a standard deviation of 10 years. The majority of participants had a master's degree in social work or psychology and the other participants had a bachelor's degree in psychology, sociology, or criminal justice. All participants reported being very knowledgeable or extremely knowledgeable about child neglect assessment. One volunteer was not eligible to participate due to not having supervised or investigated a case of child neglect. The demographic characteristics of the participants in phase one were consistent with the demographic characteristics reported by the agency.

Phase Two

Participants for phase two were 128 volunteer CPS caseworkers (n= 104) and supervisors (n=24) in Minnesota (n=60) and Nevada (n=68). One individual did not consent to participate. The demographic makeup of the participants was 91.4% European American, 3.1% Hispanic, 2.3% other ethnic background, and 1.6% African American and .8% Native American. One participant did not indicate his or her ethnicity. Participants were 76.6% female and had a mean age of 41.37 years, with a standard deviation of 11 years. The majority of participants had either a bachelor's degree (n=90) or a master's degree (n=35). Two participants indicated other degrees and one participant indicated that high school was his or her highest level of education. The majority of participants had a degree in social work (n= 93). On average, participants rated themselves as somewhat knowledgeable of child neglect and somewhat experienced in

the area of child neglect. These demographic characteristics were consistent with the overall characteristics reported by the participating agencies.

Procedures

The measures and procedures were in accordance with UNLV policies regarding research with human subjects. The Office for the Protection of Research Subjects, Institutional Review Board (IRB), Social and Behavioral Sciences committee approved protocol #113S1003-353 on November 12, 2003.

Phase One

Establishment of interviews

Individual interviews are the most widely used method in qualitative research and allow researchers to focus on an individual and his or her perceptions (Ritchie & Lewis, 2003). Paired or triad interviews are in-depth interviews that are conducted with two or three people simultaneously. These provide an opportunity for individual in-depth focus but also allow participants to make comparisons to others, and this may be especially useful when the subject matter is complex (Ritchie & Lewis, 2003). Focus groups or group discussions generally involve 4-10 people and allow participants the opportunity to reflect and refine their opinions based on discussion with other group members (Ritchie & Lewis, 2003). Phase one of this study intended to utilize focus groups or triad interviews when possible for the generation of an item pool. However, due to subject time constraints, individual interviews were the only method utilized.

Participants were recruited from the Clark County Department of Family Services (CCDFS). In cooperation with CCDFS, caseworkers and supervisors were notified of the

opportunity to participate in interviews via email. A script was used for the recruitment process to ensure that all participants received the same invitation to participate. Previous researchers have indicated the usefulness of a telephone and e-mail recruitment script (Nabors et al., 2001). The script used for recruiting participants is included in Appendix I. Caseworkers and supervisors were eligible to participate, provided they had previously been assigned or supervised a neglect case. The term neglect referred to the definition in the Nevada Revised Statutes which defines negligent treatment or maltreatment as follows:

Negligent treatment or maltreatment of a child occurs if a child has been abandoned, is without proper care, control or supervision or lacks the subsistence, education, shelter, medical care or other care necessary for the well-being of the child because of the faults or habits of the person responsible for his welfare or his neglect or refusal to provide them when able to do so (N.R.S. 432B.140).

Eligible caseworkers and supervisors who agreed to participate were asked to provide a range of available dates and times. Volunteer schedules did not allow for participation in focus groups, so individual interviews were conducted. After a participant indicated an available time, an email was sent with the date, time, and location of the interview. Personalized letters are recommended to improve attendance and allow the participants to feel they are personally wanted at the focus group or interview (Krueger & Casey, 2000). The location was in an environment designed to facilitate communication and be convenient for participants. In all instances, the interview was held at the participant's CPS agency.

Interview procedures

Interview participants were asked to sign an informed consent form. The informed consent form is included in Appendix II. After informed consent was obtained from the participant, the purpose and rationale of the interview was discussed. The moderator of the interview stated: “The purpose of this interview is to discuss situations involving child neglect, as well as to identify possible reasons for the occurrence of these situations. These reasons may include reasons that the parent or caretaker has little or no control over, such as limited income to pay for child care. As a CPS employee, you are considered an expert in the field of child neglect and the information gathered today will be used to develop an assessment tool for child neglect. There may be instances in which it will be necessary for me to guide the discussion and ask questions about the situations that are discussed. Responses will also be recorded to use the information at a later time to develop the child neglect assessment tool items.”

The interviewer was primarily concerned with directing the discussion, keeping the conversation flowing, and taking a few notes to identify key ideas (Krueger & Casey, 2000). The interviewer ensured the discussion was productive and covered relevant issues in sufficient depth. Control over the content was minimal. An assistant was also present during several of the interviews and took comprehensive notes and was in charge of the audio recording. The issues to be focused on were determined in advance by the research team based on literature reviews.

After the rationale was provided to the participant, a background survey was given. The interviewer began the discussion by providing a broad definition of child neglect. Although a universal definition of neglect does not exist, the definition provided

to the participant incorporated elements that most definitions have (Cowen, 1999; Dubowitz et al., 1993; Slack et al., 2003). The interviewer, in defining child neglect, said the following: “While there is not a single agreed upon definition of child neglect, for purposes of this discussion we are defining child neglect as an act of omission in which the basic needs of a child are not met. We are interested in hearing your perceptions of what constitutes a neglectful situation. While we want to hear all the possible responses you might have, we would like to guide the discussion in a manner that addresses situations in terms of physical, emotional, and educational neglect. An example of a situation that is physical neglect may be a young child that is left home alone for eight hours a day.” The categories of physical, emotional, and educational neglect are based on the NIS-2 study that identified the three categories (DHHS, 1988). The use of these categories provided a guide for the interviewer to structure the discussion, but participant responses were not limited to these categories.

Throughout the course of the discussion, the interviewer used probes. Probes are questions used for clarification and to gain further information (Nabors, Ramos, & Weist, 2001). Probes included more detail, clarification, additional situations, and other categories. More detailed probes were used when the given situation lacked detail (e.g., What kind of medical care was the child not receiving?). Clarification probes were used when the situation or portions of a situation were unclear (e.g., The situation is a child in a car in excessive heat. Could you clarify what excessive heat is?). Additional situation probes were used when participants only had a few situations for a given category (e.g., These are great scenarios, can you think of more physical neglect situations?). Additional category probes were used when the moderator believed a new category or

new aspect of a category should have been addressed (e.g., We have talked about many situations involving home safety, can anyone think of scenarios for physical neglect that do not involve home safety?). The goal of the interview was to generate at least five situations for each of the three subtypes of neglect. The interviewer utilized the probes for additional categories when the number of items for one subtype of neglect had five situations or the interviewer believed time was going to expire before another subtype was addressed.

If necessary, the interviewer used prompts to guide the discussion away from areas that were covered in excess in the current or past interviews. New situations were not generated after the third interview, even with continued use of prompts to encourage the generation of new situation. When too much information was generated for one item, the interviewer prompted the individual to consider another situation.

The interviewer ensured that the interview did not exceed 45 minutes. At the conclusion of the discussion, the interviewer thanked the participant for his or her perceptions of child neglect. The participants had the opportunity to ask questions and were encouraged to call the researcher if questions arose at a later time. The interviewer completed a checklist to ensure that procedures were followed when conducting the interview. The interview checklist is included in Appendix IV.

Qualitative Analysis Procedures

Audio recordings of the interviews were transcribed verbatim by the researcher and checked for accuracy by a research assistant. Transcripts were coded using the N6 program, a qualitative analysis program. This software package allows the creation of categories of which data were coded. Codes were intended to generate categories (e.g.,

lack of parental supervision) to place various groups of responses into meaningful sequences or interrelated patterns to create potential item pool items. Similar and related scenarios were combined to avoid overlap and create distinct situations. Initially, a list of literature based child neglect situations was used as categories to orient the search for codes. Additional categories were created when the list was not adequate to categorize the child neglect situations identified in the interviews.

Two raters were used in the qualitative analysis process, the researcher and an assistant. Initial training involved further familiarizing the research assistant to the area of child neglect by providing basic information and statistics. The training also provided a list of literature based child neglect categories with detailed descriptions and examples to use for sample transcripts and subsequent interview transcripts. After the initial training, both raters coded a same sample transcript to examine inter-coder reliability.

Inter-coder reliability verification (ICRV) was calculated using the process outlined by Bourdon (2000). This process allows the agreement between two or more coders in qualitative analysis to be calculated by examining the degree of agreement, in which both coders have coded or omitted coding the same text unit, over the degree of disagreement, which occurs when one coder omits to code a unit or both disagree in the coding of a unit. The initial ICRV for the sample transcript was .68. This number was deemed too low and additional training was conducted to improve agreement, particularly in the area of omissions as the examination of the ICRV revealed this to be the area of greatest disagreement. Additional training involved discussing each text of a sample transcript and the rationale for coding it in a particular category. Each coder then independently coded the same randomly selected interview transcript and ICRV was

calculated. The ICRV for the first interview transcript was .922. This ICRV was deemed acceptable. Each rater coded interview transcripts independently and ICRV was calculated for 20 percent of the transcripts coded, in addition to the first interview transcript examined for training purposes. The interviews that were to be coded by both raters and ICRV calculated were selected randomly and the ICRV values were .933 and .956, indicating good inter-coder reliability.

Phase Two

Questionnaire Procedures

In phase two, neglect situations generated from individual interviews were assembled into questionnaire format. Categories established in qualitative analysis were examined and used to develop the questionnaire for phase two. The situations were based on interview data and qualitative analysis and the exact wording of the items was determined by the research team. Each category established in qualitative analysis was used to create one or more situations for the questionnaire, with the wording based on literature, prior assessment tools, and the examples coded in each category. For example, the category of “Lack of Supervision” resulted in three separate items based on literature review and the analysis of the interviews that differ on the time a child is left without supervision. The resulting questionnaire was administered to professionals who encountered child neglect throughout Minnesota and Nevada. The questionnaire also examined the perceived level of harm of each item for different age groups. Magura and Moses (1986) used a similar format for deriving of seriousness scores on the Child Well-Being Scales in which vignettes were given to professionals and they were asked to rate the seriousness of each.

Recruitment of participants was attempted by region. Two states were randomly selected in three regions of the country and asked to participate in phase two of this study. The three regions of the country randomly selected were the south, central and western regions of the United States. The two states randomly selected and invited to participate from the southern region were Arkansas and Kentucky. The study was approved by state IRB officials in both states but due to time constraints of CPS employees neither state could complete the study. The states invited to participate from the central region were Wisconsin and Minnesota. State officials from the state of Wisconsin declined to participate and individuals throughout Minnesota participated in phase two of the study. The two states selected in the western region were California and Nevada. The study was approved by the Los Angeles County Department of Health and Human and Services IRB board. However, due to time constraints and other obligations of the CPS employees, the study could not be completed by individuals in California. Agencies under the direction of the state of Nevada participated in the second phase of this study.

CPS caseworkers and supervisors throughout the states of Minnesota and Nevada were recruited for participation. Participants of phase one were not eligible to participate in phase two. Individuals who agreed to participate were either mailed a packet that included an informed consent form, instruction sheet, background survey, and a questionnaire or given a link to a secure server via email where the survey could also be completed. The secure internet site included all the information that was included in the paper version (i.e., informed consent, instruction sheet, background survey, item validity questionnaire.) The informed consent form is included in Appendix II. The instruction sheet asked the participant to complete the survey online or return it by mail in the

enclosed stamped envelope within one week. The participants' contact information was kept by the researcher to remind them to return the study materials. After two weeks, a reminder email was sent to participants to inquire if they were still interested in participating. If a participant indicated they had no interest or a three-week time period elapsed without the materials being returned, the participant was no longer included in the study.

Data analysis procedures

Responses of the total sample and the Minnesota and Nevada subsamples were factor analyzed separately via exploratory principal component analysis (PCA). The subsample analysis was conducted to determine if the factor structure of the two subsamples were appropriate to combine for factor analysis. The subsample factor comparison was conducted using the salient variable similarity index (s) (Cattell, Balcar, Horn, & Nesselroade, 1969) and the congruence coefficient (r_c) (Tucker, 1951). The salient variable similarity index, a nonparametric statistic, compares two factors with respect to agreement of positive and negative salient variables and hyperplane variables (Cattell, 1978). For the purposes of salient factor determination in this portion of the study, factor pattern coefficients of $\pm .50$ served as the criterion cutoff to indicate salient variables. This criterion was chosen based on the sample size of each state. The coefficient of congruence, a parametric statistic, examines the amount of shared variance between matched factors. The coefficient of congruence is affected by factor size and violations of the assumptions of equivalent variance-covariance matrices (Cattell, 1978). Research has shown comparable results from the s and r_c statistics and both may be used jointly in the comparison of factors (Cattell, 1978). In instances in which there are large

differences in some of the factor loadings between two factors being compared, the *s* statistic alone is more appropriate (Cattell, 1978).

Exploratory PCA (PCA) was conducted for the total sample within each age category for the likelihood to substantiate neglect, the frequency of occurrence of neglect, and the perceived level of harm to address both aims of this study. Research has identified exploratory factor analysis as an appropriate method for scale development, or in this instance item pool development, when there is little theoretical basis for specifying a priori the number of factors (Hayton, Allen, & Scarpello, 2004). The procedure of PCA implies that all the variance is common or shared (Joliffe, 2002). PCA allows for identifying groups of inter related variables as well as reducing the number of variables. Factors extracted with this method were rotated using an oblique procedure (Promax). Correlation coefficients were calculated for each set of factors across each age group for substantiation, frequency, and harm to determine if the appropriate rotational procedure was used.

The determination of the number of factors to retain was based primarily on the statistical procedure of parallel analysis; however, these results were compared to results from scree plots and the eigenvalues greater than 1.0 criterion. Further reduction in the number of factors was based on interpretability (Stevens, 2001). Interpretability for each factor was based on the number of variables with loadings $\geq |.47|$, based on Cliff and Hamburger's (1967) results which took sample size into account to determine adequate loading cutoff points. One of the most commonly used methods to determine the number of factors to retain is the eigenvalues greater than 1 criterion (Kaiser, 1970). This method involves retaining all factors with eigenvalues greater than 1.0, with the rationale that the

reliability of the factor will be nonnegative when the eigenvalue is greater than 1.0 (Kaiser, 1970). This method has been found to be more accurate when the number of variables is less than 30, the communalities are greater than .70 or there is a N greater than 250 (Stevens, 2001). The eigenvalues greater than 1 criterion has been found to overestimate the number of factors (Hayton, Allen, & Scarpello, 2004).

The scree test is a graphical representation of eigenvalues plotted on the vertical axis and ordinal numbers plotted on the horizontal axis (Cattell, 1966). The scree test involves retention of all eigenvalues in the descent before the first value where the line begins to level off. This method has been shown to be appropriate when the eigenvalues greater than 1.0 criterion is not appropriate and the N is greater than 200 (Stevens, 2001). Problems with the use of the scree test include ambiguity and subjectivity in the location of the descent of the line and agreement on the number of factors to retain (Hayton et al., 2004).

Parallel analysis has been identified as one of the most accurate methods for determining the number of factors to retain (Hayton et al., 2004; O'Connor, 2000; Zwick & Velicer, 1986). The procedure of parallel analysis involves comparing eigenvalues from the data of interest to parallel eigenvalues generated from random data. The number of factors that account for more variance than the parallel factors obtained from random numbers are retained (Hayton et al, 2004; O'Connor, 2000). Research has found parallel analysis to be more accurate than the eigenvalues greater than 1.0 criterion and has less of a tendency to overestimate the number of factors (Hayton et al., 2004). However, in some instances parallel analysis may underestimate the number of factors if the first eigenvalue is large (Turner, 1998).

In addition to exploratory PCA, 15 separate Multivariate Analysis of Variance (MANOVA) procedures were conducted to examine the main effects and possible interactions of state and gender on the factors across each age group for substantiation, frequency, and harm. Due to the number of analyses conducted, the alpha level was adjusted to account for Type I error to .003 (Stevens, 2001).

Instruments

Phase One

Background Survey

This instrument collected demographic information such as gender, age, and ethnicity. This instrument also collected information regarding a participant's perceived knowledge of child neglect assessment and reported experience with child neglect. This information allowed for a comparison of the sample with the overall population of CPS caseworkers and supervisors. The Background Survey is included in Appendix III.

Phase Two

The materials provided to the participants were intended to collect demographic information, perceived level of knowledge regarding child neglect, likelihood they would substantiate each item as neglect, likelihood of occurrence for each item, and ratings of perceived level of harm for each item. The instruments that were used for phase two are included in Appendixes III and IV.

Background Survey

This instrument collected demographic information such as gender, age, ethnicity, agency of employment, job title, and state and county of employment. This instrument

also collected information regarding the participant's perceived knowledge of child neglect assessment and reported experience with child neglect. This information allowed for a comparison of the current sample with the overall population of professionals in the area of child neglect. It was used to ensure a representative sample was obtained.

Item questionnaire

This instrument was intended to collect information regarding the subject's perceptions of child neglect situations. For each item, the participant was asked to rate the likelihood that the situation would be substantiated as child neglect, the frequency of occurrence, and the perceived level of harm of the situation for four age groups and a special needs category. The inclusion of the age ranges was to differentiate between situations that may be considered child neglect only for children in specific age ranges or with special needs. The age groups were birth to two years, three to seven years, eight to eleven years, and twelve to fifteen years. These age ranges were based upon Piaget's cognitive stages (Ginsberg & Oppen, 1969). The fifth group is a special needs group, which included medical conditions and developmental delays (McPherson et al., 1998).

The item questionnaire allowed comparisons of professional opinions on child neglect situations. A differentiation between situations pertaining to certain age categories was also made possible with this information. This questionnaire allowed variances in harm, frequency of occurrence, and likelihood of being substantiated as neglect due to child age to be examined for each item. The item questionnaire is included in Appendix V.

CHAPTER 4

RESULTS

Phase One

The first aim of this study was to develop a pool of items related to child neglect. This aim was partially addressed through the use of qualitative analysis. Qualitative analysis results yielded 26 categories (Table 1). The interview process examined physical, emotional, and educational neglect and gave participants the opportunity to add situations that were not within the aforementioned categories. All child neglect situations coded were classified into one of the three types of child neglect. Consistent with previous research, items that were coded into categories that were classified as child physical neglect (i.e., Toxins, Weapons, Lack of food, Unsanitary living conditions) were the most prevalent and discussed situations (Jones & McCurdy, 1992). All participants chose to begin the interview process by discussing physical neglect items and elaborated more on situations in that category. Analysis of items within the physical neglect category revealed more consistent views among participants regarding the examples given and their perceptions as to the need to address the given situation. For example, all participants gave examples of toxins, lack of food, unsanitary living conditions, and lack of supervision.

Emotional neglect items (i.e., Lack of communication, Preferential treatment of other children in the home) were discussed less frequently and in less detail than physical

neglect items. Participants also had opposing perceptions regarding emotional neglect items. For example, in the category “Lack of communication and/or contact with child,” one participant said “Emotional neglect can be a parent that won’t bond with their child . . . a lack of affect and a lack of interaction.” This can be contrasted to another participant’s statement, “Emotional neglect is really an attitude of a parent towards a child, but rarely is it something taken into account for purposes of a CPS intervention.” All participants, however, were consistent in describing emotional neglect of any type as the most difficult type of child neglect to substantiate.

Educational neglect items consisted of two categories identified in qualitative analysis, “Child does not attend school or does not receive approved home based education” and “Unresponsive to educational needs.” Participants were consistent in their perceptions of the items in this category and all participants gave the example of a child not attending school. Most participants indicated that, although they consider educational neglect a form of child maltreatment, it is difficult to substantiate in court.

Overall, the qualitative analysis results were consistent with previous research and literature with respect to situations of child physical neglect being the most identifiable and prevalent situations of child neglect and more variability being present in perceptions of emotional neglect (Jones & McCurdy, 1992). Child neglect literature, however, identifies more situations than those identified in the interview process. Numerous participants indicated that the literature and current assessment measures include situations that they may not substantiate in an investigation as child neglect (i.e., lack of developmentally appropriate books or toys in the home).

Phase Two

The primary aim of this study was to develop an item pool for a child neglect assessment scale, was addressed in part through exploratory principle component analysis. A secondary aim of this study, to examine the impact of child age and special needs on child protective services employees reported likelihood to substantiate questionnaire items as neglect, was addressed through factor analysis, MANOVA, and reliability analysis. These statistical procedures were also used to examine the impact of child age and special needs on participants' responses regarding frequency of occurrence of neglect and perception of harm regarding each questionnaire item.

Factor Analysis State Comparison for Substantiation

Exploratory principal component analysis (PCA) comparing the factor structures of the Minnesota and Nevada samples was conducted using the s and r_c statistical procedures. Factors were significantly correlated with each other; therefore, an oblique rotation (promax) was determined to be the most appropriate rotational procedure. The first analysis examined the factor structures between the states with respect to the likelihood to substantiate neglect for the 0-2 age group. The eigenvalues ≥ 1 criterion indicated that the Nevada sample had 11 factors and the Minnesota sample had 9 factors. Factors were further reduced based on interpretability, reducing the number of interpretable factors in both samples to 6. Factors were not considered interpretable if the factor contained less than three salient loadings. The interpretable factors were Lack of Attention, Basic Provisions of Care, Supplemental Care, Emotional, Education, and Neglect. The s and r_c statistical procedures comparing factor structures of Minnesota and

Nevada were performed on the six pairs of factors and the results are presented in Table 2. All pairs met the level of significance for s ($p \leq .05$) and r_c ($r_c \geq \pm .41$).

The analysis of the factor structures between the Minnesota and Nevada samples regarding the likelihood to substantiate neglect for age group 3-7 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained 9 factors and the Minnesota sample had 10 factors. Reduction of the factors based on interpretability revealed six factors. The interpretable factors were Basic Provisions of Care, Supplemental Care, Emotional, Lack of Attention, Neglect, and Education. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 3. All pairs met the level of significance for s ($p \leq .05$) and four of the six met significance for r_c ($r_c \geq \pm .41$).

Analysis of the factor structures between the state samples regarding substantiation for the age group 8-11 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained 10 factors and the Minnesota sample had 8 factors. Reduction of the factors based on interpretability revealed six factors. The interpretable factors were Lack of Attention, Basic Provisions of Care, Supplemental Care, Emotional, Education, and Supervision. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 4. All pairs met the level of significance for s ($p \leq .05$) and five of the six met significance for r_c ($r_c \geq \pm .41$).

Factor structure examination between the state samples for substantiation for the age group 12-18 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained nine factors and the Minnesota sample had eight factors. Reduction of the factors based on interpretability revealed six factors. Those factors were Basic Provisions

of Care, Lack of Attention, Emotional, Supervision, Hazards, and Neglect. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 5. All pairs met the level of significance for s ($p \leq .05$) and five of the six met significance for r_c ($r_c \geq \pm .41$). One of the pairs that did not meet significance for r_c approached significance ($r_c = .40$).

The last factor analysis comparison regarding substantiation between the Minnesota and Nevada samples was conducted for the special needs category. The eigenvalues ≥ 1 criterion indicated that the Nevada and Minnesota samples both contained 10 factors and further reduction of the factors based on interpretability revealed seven factors. The factors were Lack of Attention, Basic Provisions of Care, Emotional, Supervision, Supplemental Care, Physical Needs, and Neglect. The s and r_c statistical procedures were performed on the seven pairs of factors and the results are presented in Table 6. All pairs met the level of significance for s ($p \leq .05$) and six of the seven met significance for r_c ($r_c \geq \pm .41$). The one pair that did not meet significance for r_c approached significance ($r_c = .40$).

Factor Analysis State Comparison for Frequency

The analysis of the factor structures between the Minnesota and Nevada samples regarding the frequency of neglect for the 0-2 age group using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained seven factors and the Minnesota sample had nine factors. Reduction of the factors based on interpretability revealed six factors. The factors were Basic Needs, Lack of Attention, Supervision, Emotional, Supplemental Care, and Education. The s and r_c statistical procedures were performed on

the six pairs of factors and the results are presented in Table 7. All pairs met the level of significance for s ($p \leq .05$) and five of the six met significance for r_c ($r_c \geq .\pm 41$).

Analysis of the factor structures between the state samples for frequency for the age group 3-7 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained eight factors and the Minnesota sample had nine factors. Reduction of the factors based on interpretability revealed five factors. The factors were Basic Provisions of Care, Supplemental Care, Lack of Attention, Supervision, and Education. The s and r_c statistical procedures were performed on the five pairs of factors and the results are presented in Table 8. All pairs met the level of significance for s ($p \leq .05$) and r_c ($r_c \geq .\pm 41$).

Factor structure examination between the state samples for frequency for the age group 8-11 using the eigenvalues ≥ 1 criterion indicated that both state samples contained nine factors. Reduction of factors based on interpretability revealed five factors. The factors were Neglect, Basic Provisions of Care, Supplemental Care, Lack of Attention, and Physical Needs. The s and r_c statistical procedures were performed on the five pairs of factors and the results are presented in Table 9. All pairs met the level of significance for s ($p \leq .05$) and four of the five met significance for r_c ($r_c \geq .\pm 41$). The one pair that did not meet significance for r_c approached significance ($r_c = .37$).

Examination of the factor structures of the state samples for frequency for the age group 12-18 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained 10 factors and the Minnesota sample had 8 factors. Reduction of the factors based on interpretability revealed five factors. The factors were Basic Provisions of Care, Supplemental Care, Supervision, Education, and Lack of Attention. The s and r_c statistical

procedures were performed on the five pairs of factors and the results are presented in Table 10. All pairs met the level of significance for s ($p \leq .05$) and r_c ($r_c \geq .\pm 41$).

A factor analysis between Minnesota and Nevada samples regarding frequency was conducted for the special needs category. The eigenvalues ≥ 1 criterion indicated that the Nevada and Minnesota samples both contained eight factors and further reduction of the factors based on interpretability revealed six factors. The factors were Basic Provisions of Care, Lack of Attention, Neglect, Emotional, Supervision, and Supplemental Care. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 11. All pairs met the level of significance for s ($p \leq .05$) and three of the six met significance for r_c ($r_c \geq .\pm 41$). One of the pairs that did not meet significance for r_c approached significance ($r_c = .37$).

Factor Analysis State Comparison for Harm

Factor structures between the Minnesota and Nevada samples were compared regarding perceptions of harm for neglect situations in the 0-2 age group. The eigenvalues ≥ 1 criterion indicated that both states contained nine factors and a reduction of factors based on interpretability revealed six factors. The factors were Basic Provisions of Care, Emotional, Neglect, Supervision, Lack of Attention, and Hazards. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 12. All pairs met the level of significance for s ($p \leq .05$) and four of the six met significance for r_c ($r_c \geq .\pm 41$). The two pairs that did meet significance for r_c approached significance ($r_c = .40$; $r_c = .36$).

Examination of the factor structures of the state samples for perceived level of harm for the 3-7 age group using the eigenvalues ≥ 1 criterion indicated that the Nevada

sample contained 10 factors and the Minnesota sample had 9 factors. Using interpretability as a basis for reduction, the number of factors was reduced to six. The factors were Emotional and Educational Needs, Supervision, Physical Needs, Neglect, Basic Provisions of Care, and Lack of Attention. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 13. All pairs met the level of significance for s ($p \leq .05$) and four of the six met the level of significance for r_c ($r_c \geq \pm .41$). One of the pairs that did not meet the level of significance for r_c approached significance ($r_c = .32$).

Analysis of the factor structures between the state samples regarding harm for the age group 8-11 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample contained 10 factors and the Minnesota sample had 8 factors. Reduction of the factors based on interpretability revealed five factors. The factors were Supplemental Care, Lack of Attention, Hazards, Emotional, and Basic Provisions of Care. The s and r_c statistical procedures were performed on the five pairs of factors and the results are presented in Table 14. Four of the five pairs met the level of significance for s ($p \leq .05$) and r_c ($r_c \geq \pm .41$).

Examination of the factor structures of the state samples for perception of harm for the age group 12-18 using the eigenvalues ≥ 1 criterion indicated that the Nevada sample had 10 factors and the Minnesota sample contained 8 factors. The number of factors was reduced to five based on interpretability. The factors were Neglect, Emotional, Supervision, Basic Provisions of Care, and Physical Needs. The s and r_c statistical procedures were performed on the five pairs of factors and the results are presented in Table 15. Four of the five pair met the level of significance for s ($p \leq .05$)

and all pairs met the level of significance for r_c ($r_c \geq \pm .41$). The factor pair that did not meet significance for s showed a trend toward significance ($p = .06$).

The final factor analysis comparison regarding harm between the two samples conducted was for the special needs category. The eigenvalues ≥ 1 criterion indicated that both samples contained nine factors and further reduction of the factors revealed six interpretable factors. The factors were Basic Provisions of Care, Emotional and Educational, Supervision, Lack of Attention, Hazards, and Neglect. The s and r_c statistical procedures were performed on the six pairs of factors and the results are presented in Table 16. All pairs met the level of significance for s ($p \leq .05$) and four of the six pairs met significance for r_c ($r_c \geq \pm .41$).

State Comparison Results

Overall, the results of the factor comparisons across all age groups for substantiation using the coefficient of congruence and salient variable similarity index, with the s index being more indicative of similarity, suggest the factorial structures of the Nevada and Minnesota samples were similar. Based on these findings, it was determined it was appropriate to combine the samples to conduct an exploratory factor analysis on the entire sample for the likelihood to substantiate the four age groups and special needs. The same results were also found for frequency and substantiation across all age groups based on r_c and s statistics and the determination to combine samples for all factor analyses was made.

Factor Analysis for Combined Sample

Exploratory PCA with promax rotation was completed for the likelihood to substantiate neglect, frequency, and perceptions of harm for the 30 questionnaire items

for the four age groups and the special needs category. The procedure of parallel analysis was used to reduce the number of factors. In some instances interpretability further reduced the number of factors. Parallel analysis results were compared to results obtained from the eigenvalues greater than one rule and the scree test. A comparison of the number of factors each procedure indicated as ideal is listed in Table 17. The pattern and structure matrixes with respect to likelihood to substantiate neglect for each age group are located in Tables 18-22. The pattern and structure matrixes with respect to frequency of neglect for each age group are located in Tables 23-27. The pattern and structure matrixes with respect to perception of harm for each age group are located in Tables 28-32. A complete listing of items is located in Table 33.

Factor Analysis Combined Sample for Substantiation Ages 0-2

Parallel analysis yielded five factors for the 0-2 age category accounting for 48.68% of the variance. The first factor (19.74% of the variance, 5 items), Lack of Attention, contains situations in which there is a lack of attention and, as a result, the child has access to or is exposed to dangerous situations or conditions. Internal consistency for the factor, computed using Cronbach's alpha, was .82. The second factor (9.05% of the variance, 5 items), Basic Provisions of Care, contained situations in which basic aspects of child care are not being met, such as clothing or hygiene. Cronbach's coefficient alpha for Basic Provisions of Care was .76. The third factor (7.80% of the variance, 3 items) indicated by parallel analysis was Emotional neglect and contained situations that impact emotional well-being or are a result of emotional neglect. Cronbach's coefficient alpha for this factor was .77.

The fourth factor was Education (6.53% of the variance, 2 items) and referred to school attendance and parental involvement in educational needs. The two identified situations have been the primary situations identified as areas of concern for educational neglect, so the factor was considered interpretable with only two salient loadings. Cronbach's coefficient alpha for the Education factor was .78. The fifth factor was Neglect (5.83% of the variance, 3 items), and contained situations in general that were indicative of child neglect. Cronbach's coefficient alpha for this factor was .52. The lack of specificity in the nature of this factor may have contributed to the lower internal consistency.

Factor Analysis Combined Sample for Substantiation Ages 3-7

Parallel analysis reduced the number of factors for the 3-7 age category to three, accounting for 39.83% of the variance. The first factor (19.99% of the variance, 6 items), Basic Provisions of Care, had a Cronbach's coefficient alpha of .82. The second factor (11.11%, 4 items), Lack of Attention, had a Cronbach's coefficient alpha of .81. The third factor was Physical Needs (8.72% of the variance, 4 items) and contained situations that pertained to a child's immediate physical needs. Cronbach's coefficient alpha for the Physical needs factor for the 3-7 age category was .72.

Factor Analysis Combined Sample for Substantiation Ages 8-11

Parallel analysis yielded three factors for the 8-11 age category accounting for 42.56% of the variance. The first factor (22.48% of the variance, 7 items), Basic Provisions of Care, had a Cronbach's coefficient alpha of .84. The second factor (11.00% of the variance, 5 items), Lack of Attention, had a Cronbach's coefficient alpha of .70.

The third factor (9.08% of the variance, 4 items), Physical Needs, had a Cronbach's coefficient alpha of .62.

Factor Analysis Combined Sample for Substantiation Ages 12-18

Parallel analysis reduced the number of factors for the 12-18 age category to four, accounting for 49.12% of the variance. Factor one (25.34% of the variance, 5 items), Lack of Attention, had a Cronbach's coefficient alpha of .81. Factor two (10.72% of the variance, 6 items), Basic Provisions of Care, had a Cronbach's coefficient alpha of .78. Factor three (6.98% of the variance, 3 items), Neglect, had a Cronbach's coefficient alpha of .69. Factor four (6.08% of the variance, 3 items), Supervision, contained situations with inadequate or a lack of supervision. Cronbach's coefficient alpha for the Supervision factor for the 12-18 age category was .67.

Factor Analysis Combined Sample for Substantiation Special Needs

Parallel analysis yielded four factors for the special needs category, which accounted for 45.93% of the variance. The first factor (21.42% of the variance, 6 items), Lack of Attention, had a Cronbach's coefficient alpha of .84. The second factor (9.92% of the variance, 4 items), Supplemental Care, pertains to care that is not basic but still contributes to the child's overall well-being. Cronbach's coefficient alpha of the Supplemental Care factor for the special needs category was .76. The third factor (8.66% of the variance, 4 items), Basic Provisions of Care, had a Cronbach's coefficient alpha of .71. The fourth factor (5.94% of the variance, 3 items), Neglect, had a Cronbach's coefficient alpha of .69.

Examination of Factors Across Age Groups Combined Sample for Substantiation

Factor analysis results from the four age groups and the special needs category included a Lack of Attention factor for each category. According to Stevens (2001), a factor structure's reliability may be determined in addition to the internal consistency (Cronbach's alpha) by the factor loadings. If a factor contains four or more loadings $\geq \pm .6$ or three loadings $\geq \pm .8$ the factor may be considered reliable regardless of the sample size (Stevens, 2001). In regards to substantiation, the Lack of Attention factors for ages 0-2, 3-7, 12-18, and Special Needs were considered reliable based on factor loadings and all factors were considered adequate with respect to Cronbach's alpha. All Lack of Attention factors had items 2 and 7 in common. Lack of Attention Factors for age categories 0-2, 3-7, 12-18, and special needs had items 3 and 4 in common. The Lack of Attention factor for age group 8-11 showed the most variability, least consistency with the other age groups, and had the lowest Cronbach's alpha.

The factor structures of the four age groups and special needs category all included a Basic Provisions of Care factor. With respect to reliability, this factor would be considered reliable based on factor loadings for age groups 0-2, 3-7 and 8-11. The Basic Provisions of Care factors for all categories had adequate Cronbach's alpha. All categories had item 17 in common. Age group 0-2, 3-7, 8-11, and 12-18 had items 12, 19, and 20 in common and age groups 3-7, 8-11, and 12-18 had item 21 in common. The special needs category showed the most variability, least consistency with the other age groups, and the lowest Cronbach's alpha.

Neglect factors were present for age categories 0-2, 12-18, and the special needs category. None of these factors met criteria for reliability based on factor loadings.

Cronbach's alpha for the 0-2 age group was considered poor ($\alpha = .52$). Alpha levels for the remaining categories were improved but less than adequate, with an α of .69 for the 12-18 age group and .68 for the special needs category. The factor structures for age group 0-2 and the special needs category shared item 8 in common and the factors structures for age groups 0-2 and 12-18 share item 6 in common. The factor structure of Neglect appears to have little reliability or consistency across or within the age groups.

A Physical Needs factor was present for likelihood to substantiate neglect for age groups 3-7 and 8-11. Neither factor structure met standards of reliability based on factor loadings alone. However, the Cronbach's alpha for the factor structure for the ages 3-7 group was adequate. The Cronbach's alpha of the Physical Needs factor for the 8-11 age category was considered questionable ($\alpha = .62$), indicating this factor may not be reliable. Both factors shared items 12 and 14 in common.

Factor Analysis Combined Sample for Frequency Ages 0-2

Parallel analysis yielded four factors for the 0-2 age category for frequency of neglect accounting for 51.42% of the variance. The first factor (27.05% of the variance, 7 items), Lack of Attention, contains situations in which there is a lack of attention and, as a result, the child has access to or is exposed to dangerous situations or conditions.

Cronbach's alpha for this factor was .85. The second factor (9.60% of the variance, 5 items), Physical Needs, contained situations that pertain to a child's immediate physical needs. Cronbach's coefficient alpha for the Physical needs factor for the 0-2 age category was .81. The third factor (7.81% of the variance, 3 items) indicated by parallel analysis was Emotional neglect and contained situations that impacted emotional well-being or were a result of emotional neglect. The Cronbach's alpha of the Emotional factor was

.79. The fourth factor indicated by parallel analysis was Basic Provisions of Care (6.96% of the variance, 3 items) and contained basic aspects of child care that are not being met such as clothing or hygiene. The Cronbach's alpha for the Basic Provisions of Care factor for the 0-2 age group for frequency of neglect is .81.

Factor Analysis Combined Sample for Frequency ages 3-7

The procedure of parallel analysis was conducted to reduce the number of factors and four factors were determined to be present for ages 3-7 regarding frequency of neglect accounting for 50.77% of the variance. The first factor (26.72% of the variance, 6 items), Lack of Attention, had a Cronbach's alpha of .83. The second factor (9.47 % of the variance, 5 items), Emotional, had a Cronbach's alpha of .80. The third factor based on parallel analysis was Basic Provisions of Care (7.42% of the variance, 3 items). The Cronbach's alpha for this factor was .83. The fourth factor (7.17% of the variance, 3 items), Physical Needs, had a Cronbach's alpha of .73.

Factor Analysis Combined Sample for Frequency ages 8-11

Parallel analysis yielded five factors for ages 8-11 accounting for 54.23% of the variance. One of factors was considered non-interpretable due to only two salient irrelevant factor loadings. This reduced the variance accounted for by the remaining four factors to 48.17%. The first factor (25.84% of the variance, 5 items), Lack of Attention, had a Cronbach's alpha of .80. The second factor (9.52% of the variance, 5 items), Emotional, had a Cronbach's alpha of .79. The third factor yielded by parallel analysis was Basic Provisions of Care (7.29% of the variance, 3 items). This factor had a Cronbach's alpha of .84. The last interpretable factor indicated by parallel analysis for ages 8-11 for frequency of neglect was the Neglect factor (5.53% of the variance, 3

items). The Neglect factor had a Cronbach's alpha of .63, which is considered questionable.

Factor Analysis Combined Sample for Frequency Ages 12-18

Parallel analysis yielded four factors accounting for 47.22% of the variance. One factor was deemed non-interpretable due to less than three salient factor loadings, the remaining three factors accounted for 40.68% of the variance. The first factor (23.95% of the variance, 6 items), Lack of Attention, had a Cronbach's alpha of .82. The second factor (10.12% of the variance, 6 items), Emotional, had a Cronbach's alpha of .72. The last interpretable factor for ages 12-18 for frequency of neglect from parallel analysis was Physical needs (6.60% of the variance, 4 items), which had a Cronbach's alpha of .71.

Factor Analysis Combined Sample for Frequency Special Needs

For frequency of neglect, the special needs category had four factors as indicated by parallel analysis accounting for 52.72% of the variance. The first factor (29.91% of the variance, 5 items), Lack of Attention, had a Cronbach's alpha of .80. The second factor (9.53% of the variance, 3 items), Basic Provisions of Care, had a Cronbach's alpha of .78. The third factor identified by parallel analysis was Supplemental Care (6.82% of the variance, 6 items) which contained situations involving care that was not basic that still contributed to the child's overall well-being. The Cronbach's alpha for the Supplemental Care factor for the special needs category was .79. The fourth factor (6.46% of the variance, 4 items), Emotional, had a Cronbach's alpha of .76.

Examination of Factors Across Age Groups Combined Sample for Frequency

Examination of the factor analysis results from the four age groups and the special needs category indicates a Lack of Attention factor was present for each category. With

respect to frequency of neglect, the Lack of Attention factor for all categories were considered reliable based on factor loadings and all were considered adequate with respect to Cronbach's alpha. All Lack of Attention factors had items 1, 3, 4, and 7 in common. Lack of Attention Factors for age categories 0-2, 3-7, 8-11, and 12-18 had item 5 in common and age categories 3-7, 12-18, and special needs had item 2 in common. The Lack of Attention factors were reasonably consistent across age categories and showed adequate reliability.

The factor structures of the four age groups and special needs category all included an Emotional neglect factor for the frequency of child neglect. None of these categories met the criteria for reliability based on factor loadings but the Cronbach's alpha levels for all factors were considered adequate, exhibiting internal consistency within the factors. All Emotional factors had items 23, 25, and 27 in common. Age groups 8-11 and 12-18 had item 26 in common and age categories 3-7 and special needs had item 20 in common. The Emotional neglect factors showed some consistency across the age groups and adequate reliability as demonstrated by Cronbach's alpha.

Basic Provisions of Care factors were present for age categories 0-2, 3-7, 8-11, and the special needs category. None of the factors met criteria for reliability based on factor loadings. However, internal consistency was adequate based on Cronbach's alpha levels. All age categories had items 15, 16 and 17 in common. The factor structures of the Basic Provisions of Care factors across age groups for frequency of neglect exhibited a high degree of similarity and each factor had adequate internal consistency.

The age categories 0-2, 3-7, and 12-18 each contain a Physical Needs factor for the frequency of child neglect. All three factors exhibited adequate internal consistency,

as exhibited by Cronbach's alpha. However, none met the reliability standards based on factor loadings. All factors had items 11, 12, and 14 in common. The Physical Needs factor structures showed consistency across age categories and reliability based on Cronbach's alpha levels.

Factor Analysis Combined Sample for Harm Ages 0-2

Parallel analysis yielded four factors for the 0-2 age category for perception of harm of neglect accounting for 47.51% of the variance. The first factor (22.95% of the variance, 6 items), Basic Provisions of Care, contained basic aspects of child care that are not being met, such as clothing or hygiene. The Cronbach's alpha for the Basic Provisions of Care factor for the 0-2 age group for perception of harm is .78. The second factor (9.48% of the variance, 5 items), Lack of Attention, contained situations in which there was a lack of attention and as a result the child had access to or was exposed to dangerous situations or conditions. Cronbach's alpha for this factor was .77. The third factor (8.34% of the variance, 3 items), Supervision, contained situations with inadequate or a lack of supervision. Cronbach's coefficient alpha for the Supervision factor for the 0-2 age category was .74. The fourth factor (8.34% of the variance, 4 items) indicated by parallel analysis was Supplemental Care and contained situations involving care that was not basic but still contributed to the child's overall well-being. The Cronbach's alpha of the Supplemental Care factor for the 0-2 age group for harm was .68, which is considered questionable.

Factor Analysis Combined Sample for Harm Ages 3-7

Reduction of factors by parallel analysis yielded four factors for ages 3-7 for perception of harm that accounted for 46.99% of the variance. The first factor (24.07% of

the variance, 6 items), Basic Provisions of Care, had a Cronbach's alpha of .83. The second factor (9.119% of the variance, 4 items), Physical Needs, contained situations that pertained to a child's immediate physical needs, such as food and supervision. The Cronbach's alpha for Physical Needs was .62, which was considered questionable with respect to internal consistency. The third factor (7.76% of the variance, 3 items), Neglect, contained situations in general that were indicative of child neglect. The Cronbach's alpha of the Neglect factor for the 3-7 age category for harm was .74. The fourth factor indicated by parallel analysis was Lack of Attention (6.05% of the variance, 3 items), which had a Cronbach's alpha of .65. The Cronbach's alpha of the Lack of Attention factor for the 3-7 age category was considered questionable, indicating the factor may lack internal consistency.

Factor Analysis Combined Sample for Harm ages 8-11

Parallel analysis yielded three factors for ages 8-11 for perception of harm of neglect which accounted for 42.87% of the variance. The first factor (27.87% of the variance, 7 items), Basic Provisions of Care, had a Cronbach's alpha of .83. The second factor (8.32% of the variance, 4 items), Emotional, contained situations that impacted emotional well-being or were a result of emotional neglect. The Cronbach's alpha of the Emotional factor for the 8-11 age group for harm was .76. The third factor indicated by parallel analysis was Lack of Attention (6.67% of the variance, 3 items) with a Cronbach's alpha of .74.

Factor Analysis Combined Sample for Harm Ages 12-18

Four factors were present after parallel analysis for ages 12-18 for perception of harm accounting for 48.82% of the variance. The first factor (26.07% of the variance, 7

items), Basic Provisions of Care, had a Cronbach's alpha of .86. The second factor (9.27% of the variance, 6 items), Lack of Attention, had a Cronbach's alpha of .79. Neglect was the third factor identified by parallel analysis, accounting for 7.02% of the variance (4 items). The Cronbach's alpha for the Neglect factor for ages 12-18 was .76. The fourth factor (6.45% of variance, 4 items), Emotional, had a Cronbach's alpha of .76.

Factor Analysis Combined Sample for Harm Special Needs

Parallel analysis yielded three factors for the special needs category for harm accounting for 40.43% of the variance. The first factor (24.73% of the variance, 6 items), Basic Provisions of Care, had a Cronbach's alpha of .81. The second factor, (8.34% of the variance, 5 items), Emotional and Educational neglect, includes situations that impact emotional well-being or are a result of emotional neglect and those that involve school attendance and parental involvement in educational needs. Cronbach's alpha for the Emotional and Educational factor for the special needs factor was .77. Lack of Attention (7.37% of the variance, 4 items) was the third factor indicated by parallel analysis for the special needs category for perception of harm. The Lack of Attention factor had a Cronbach's alpha of .73.

Examination of Factors across Age Groups Combined Sample for Harm

Factor analysis results from all age categories for perception of harm include a Basic Provisions of Care factor for each category. With respect to perceptions of harm, all Basic Provisions of Care factors met standards of reliability based on factor loadings and internal consistency for all factors was adequate. All Basic Provisions of Care factors had items 16, 17, 19, 20, and 21 in common. Basic Provisions of Care factors for age categories 0-2, 3-7, and 8-11 had item 22 in common and factors for age categories 8-11,

12-18, and special needs had item 15 in common. The Basic Provisions of Care factors were fairly consistent across age categories and demonstrated reliability based on factor loadings and Cronbach's alpha levels.

A Lack of Attention factor was present for all age categories regarding perceptions of harm. The factor structures from age categories 0-2 and special needs were considered reliable based on factor loadings. The internal consistency of the factor structures for age categories 0-2, 8-11, 12-18, and special needs were considered adequate as demonstrated by Cronbach's alpha levels. The Cronbach's alpha level for the 3-7 age category was considered questionable, indicating the factor may not be reliable. All factors had item 3 in common. Factors for categories 8-11, 12-18, and special needs have item 4 in common. Factors 3-7, 12-18, and special needs have item 1 in common. The Lack of Attention factors for perception of harm are somewhat consistent across age groups, but demonstrate considerable variability in the items across the age groups. This variability may be indicative of the importance of child age on the harm of child neglect for items of this nature.

Factor analysis results yielded Emotional neglect factors in the 8-11 and 12-18 age categories. The Emotional and Educational factor for the special needs category demonstrates many similarities with the Emotional factors and is included here for comparison. The Emotional neglect factors and the Emotional and Educational factor demonstrated adequate internal consistency. However, none met the criteria for reliability based on factor loadings alone. All factors shared items 23 and 25 in common. The Emotional factors for age categories 8-11 and 12-18 shared item 26 in common and the Emotional factor for age category 8-11 and the Emotional and Educational factor for

special needs had item 27 in common. The Emotional factor appeared to be similar across the age groups in which it was found for perception of harm, though a key distinction was the presence of educational items for the special needs category.

Neglect factors were present in the 3-7 age category and the 12-18 age category for perception of harm of child neglect. The Cronbach's alpha levels for the two Neglect factors were considered adequate. Both factors shared items 28 and 29 in common. The Neglect factors for harm exhibited some consistency across the age groups in which they existed.

Multivariate Analysis of Variance (MANOVA)

Fifteen 2 X 2 multivariate analysis of variance (Gender of participants X State participant was located) procedures were conducted. The MANOVA procedures were conducted for each age category for substantiation, frequency, and harm with the interpretable factors identified in the previous sections serving as dependent variables. The purpose of these analyses was to determine if a significant effect was present for state, gender, or an interaction of the two across the factors for each age category for substantiation, frequency, and harm. To account for Type I error due the number of MANOVA procedures conducted, a Bonferroni correction was used which lowered the significance level to .003.

A significant state effect was found for all five MANOVA procedures conducted for substantiation of neglect, indicating the state effect was present in all five age categories. No significant gender, or state x gender interaction effects were shown in the substantiation MANOVA results. Results for substantiation of neglect for the 0-2 age category showed a significant multivariate effect for state, $F(5, 118) = 7.31, p < .001$.

Specifically, participants in Nevada had higher mean scores for the likelihood to substantiate items for the Lack of Attention ($M= 5.41$) and Emotional ($M= 5.38$) factors for ages 0-2 than participants in Minnesota ($M= 4.39$; $M= 4.63$). A significant multivariate effect for state was also shown for the 3-7 age category regarding substantiation of neglect situations, $F(3, 121) = 9.48, p < .001$. Further analysis revealed participants in Nevada ($M= 5.16$) had higher mean scores for reported likelihood to substantiate neglect for the Lack of Attention factor for ages 3-7 than participants in Minnesota ($M= 4.59$).

MANOVA results showed a significant multivariate state effect for the 8-11 age category for substantiation of neglect, $F(3, 121) = 5.56, p < .001$. Nevada participants ($M= 5.08$) had higher mean scores on the Lack of Attention factor than Minnesota participants ($M= 4.34$). Results also indicated a significant multivariate state effect for the 12-18 age category for substantiation of neglect, $F(4, 120) = 5.36, p < .001$. Further examination revealed that state differences were present for the Lack of Attention and Basic Provisions of Care factors for the 12-18 age category for substantiation of neglect. Participants in Nevada reported a greater likelihood to substantiate items in both factors as neglect (Lack of Attention $M= 3.28$; Basic Provisions of Care $M= 4.88$) than participants in Minnesota (Lack of Attention $M= 2.39$; Basic Provisions of Care $M= 4.04$). A state multivariate effect was shown for the special needs category for substantiation of neglect, $F(4, 120) = 8.20, p < .001$. Participants in Nevada (Lack of Attention $M= 5.01$; Supplemental Care $M= 5.58$) had higher mean scores on the Lack of Attention and Supplemental Care factors than participants in Minnesota (Lack of Attention $M= 3.78$; Supplemental Care $M= 4.56$).

Five MANOVA procedures were conducted regarding frequency of occurrence of neglect items, one for each of the five age categories. Gender and gender x state interaction effects were not significant for any of the MANOVA procedures conducted for frequency of neglect. A significant multivariate state effect was present for the 0-2 age category regarding frequency, $F(4, 119) = 4.90, p < .001$. Further analysis did not reveal significant mean differences on factor scores as a result of state. MANOVA results revealed a significant multivariate state effect for the 3-7 age category regarding frequency, $F(4, 119) = 6.13, p < .001$. Significant mean differences on factor scores as a result of state were not present for the 3-7 age category. MANOVA results for state effects for age categories 8-11, 12-18, and special needs were not significant.

Five MANOVA analyses, one for each age category, were conducted for the perception of harm using the factors identified in factor analysis as dependent variables. Gender and gender x state interaction effects were not significant for any of the five MANOVA analyses for harm. A significant multivariate state effect was shown for the 0-2 age category for harm, $F(4, 119) = 4.25, p < .003$. Further examination revealed that participants in Nevada ($M = 5.52$) had higher mean scores on the Lack of Attention factor than participants in Minnesota ($M = 4.80$). MANOVA results showed a significant state effect for the 8-11 age category for harm, $F(3, 120) = 8.04, p < .001$. Participants in Nevada had higher mean scores for the Basic Provisions of Care ($M = 5.26$) and Lack of Attention ($M = 3.77$) factors than participants in Minnesota ($M = 4.65$; $M = 2.76$). Results showed a multivariate state effect for the 12-18 age category for harm, $F(4, 119) = 5.53, p < .001$. Further examination indicated participants in Nevada had higher mean scores for the Basic Provisions of Care ($M = 5.26$) and Lack of Attention ($M = 4.03$) factors than

participants in Minnesota ($M = 4.49$; $M = 3.24$). MANOVA results for state effects for age categories 3-7 and special needs were not significant.

Kendall's Coefficient of Concordance (W)

Kendall's coefficient of concordance (W) was conducted to examine the agreement of participants across the 30 questionnaire items within each age category for substantiation, frequency, and harm. Kendall's W for the 0-2 age category for substantiation of neglect was .45, indicating there was moderate agreement among participants regarding substantiation scores for ages 0-2. The Kendall's W for the 3-7 age category (.40), which was indicative of less than moderate agreement among participants. The 8-11 age category had a Kendall's W of .44 for substantiation, a moderate level of agreement. Kendall's W for the 12-18 age category (.41) was a marginally moderate agreement. Results from the special needs category for substantiation demonstrated the lowest level of participant agreement for substantiation with a Kendall's W of .33.

Kendall's W for the 0-2 age category for frequency of neglect was .28, a relatively low level of agreement. The level of participant agreement for the 3-7 age category regarding frequency was .22. Kendall's W for the 8-11 age group was .25. Participant agreement for the 12-18 age category was .20 and Kendall's W for the special needs category was .16. Overall, participant agreement within the age groups for frequency of occurrence of neglect was low.

Kendall's W for the 0-2 age category for perception of harm for neglect was .42, a moderate level of participant agreement. The Kendall's W for the 3-7 age category was .35, a relatively low level of participant agreement. Participant agreement for the 8-11 age category for harm was .40. Kendall's W for the 12-18 age category was .39. The

participant agreement for the special needs category for harm was .27, a low level of agreement.

Correlational Analysis

Correlational analysis was conducted to examine the correlations between factors within each age group for substantiation, frequency, and harm. Bonferroni correction was conducted to correct for Type I error which reduced the significance level to .0008. Overall, the results indicated significant correlations between factors across age groups. These results supported the use of the oblique rotation in the factor analysis procedures. Results with respect to likelihood to substantiation neglect for ages 0-2 indicated significant correlations between the following factors: Lack of Attention and Emotional ($p \leq .0008$), Lack of Attention and Neglect ($p \leq .0008$), Emotional and Basic Provisions of Care ($p \leq .0008$), Emotional and Neglect ($p \leq .0008$), Basic Provisions of Care and Neglect ($p \leq .00081$),. The range of significant values was .23 - .37. The Educational factor was only significantly correlated with the Basic Provisions of Care factor. The Basic Provisions of Care factor was not significantly correlated with the Lack of Attention factor.

With respect to substantiation of neglect for ages three to seven, the Basic Provisions of Care factor and the Physical Needs factor were correlated ($p \leq .0008$). The Lack of Attention factor and the Basic Provisions of Care factor were not significantly correlated. Additionally, the Physical Needs factor was not significantly correlated to the Lack of Attention Category. Significant correlations were present with respect to substantiation of neglect for the 8-11 age category for Basic Provisions of Care factor and the Lack of Attention factor ($p \leq .0008$). The range of significant values was .22- .24. The

Basic Provisions of Care factor was not significantly correlated with the Physical Needs factor. Also, the Lack of Attention factor was not significantly correlated with the Physical Needs factor. Significant correlations were found among the following factors with respect to substantiation for children ages 12-18: Lack of Attention and Basic Provisions of Care ($p \leq .0008$), Lack of Attention and Neglect ($p \leq .00008$), Lack of Attention and Supervision ($p \leq .0008$), Basic Provisions of Care and Neglect ($p \leq .0008$), Basic Provisions of Care and Supervision ($p \leq .0008$), and Neglect and Supervision ($p \leq .0008$). The range of significant values was .27-.54. With respect to substantiation for children with special needs significant correlations were present among the following factors: Lack of Attention and Supplemental Care ($p \leq .0008$), Lack of Attention and Basic Provisions of Care ($p \leq .0008$), and Supplemental Care and Basic Provisions of Care ($p \leq .0008$). The range of significant values was .26-.55. The Neglect factor was not significantly correlated with the Lack of Attention, Basic Provisions of Care, or Supplemental Care factors.

Correlation analysis results revealed significant correlations among all factors with respect to the frequency of neglect for the 0-2 age category. The significant correlations were the following factor pairs: Lack of Attention and Physical Needs ($p \leq .0008$), Lack of Attention and Emotional ($p \leq .0008$), Lack of Attention and Basic Provisions of Care ($p \leq .0008$), Physical Needs and Emotional ($p \leq .0008$), Physical Needs and Basic Provisions of Care ($p \leq .0008$), and Emotional and Basic Provisions of Care ($p \leq .0008$). The range of significant was .25-.39. Significant correlations were present for the following pairs for frequency of neglect for the 3-7 age category: Lack of Attention and Neglect ($p \leq .0008$), Lack of Attention and Basic Provisions of Care ($p \leq .0008$), and Neglect and Basic Provisions of Care ($p \leq .0008$).

.0008), Neglect and Basic Provisions of Care ($p \leq .0008$), Neglect and Physical Needs ($p \leq .0008$), and Basic Provisions of Care and Physical Needs ($p \leq .0008$). The range of significant values was .29-43. The Lack of Attention factor was not significantly correlated with the Physical Needs factor.

With respect to frequency of neglect for age category 8-11, the following pairs of factors had significant correlations: Lack of Attention and Emotional ($p \leq .0008$), Lack of Attention and Basic Provisions of Care ($p \leq .0008$), Lack of Attention and Neglect ($p \leq .0008$), Emotional and Basic Provisions of Care ($p \leq .0008$), Emotional and Neglect ($p \leq .0008$), and Basic Provisions of Care and Neglect ($p \leq .0008$). The range of significant values was .20-40. Significant correlations were present for the following pairs of factors for frequency of neglect for the 12-18 age category: Lack of Attention and Emotional ($p \leq .0008$) and Emotional and Physical Needs ($p \leq .0008$). The range of significant values was .25-44. The Lack of Attention factor was not significantly correlated with the Physical Needs factor. With respect to frequency of neglect for the special needs category, the following factors were significantly correlated: Lack of Attention and Basic Provisions of Care ($p \leq .0008$), Lack of Attention and Supplemental Care ($p \leq .0008$), Lack of Attention and Emotional ($p \leq .0008$), Basic Provisions of Care and Supplemental Care ($p \leq .0008$), Basic Provisions of Care and Emotional ($p \leq .0008$), and Supplemental Care and Emotional ($p \leq .0008$). The range of significant values was .28-51.

Correlational analysis was conducted for all factors with respect to participants' perceptions of harm across all age categories. The following factors had significant correlations for the 0-2 age category for harm: Basic Provisions of Care and Lack of Attention ($p \leq .0008$), Basic Provisions of Care and Supplemental Care ($p \leq .0008$), and

Lack of Attention and Supplemental Care ($p \leq .0008$). The range of significant values was .30-.51. The Supervision factor was not significantly correlated with the Basic Provisions of Care, Lack of Attention, and Supplemental Care factors. Results with respect to perceived level of harm for ages 3-7 indicated significant correlations between the following factors: Basic Provisions of Care and Physical Needs ($p \leq .0008$), Basic Provisions of Care and Lack of Attention ($p \leq .0008$), and Physical Needs and Lack of Attention ($p \leq .0008$). The range of significant values was .27-.28. The Neglect factor was not significantly correlated with the Physical Needs, Lack of Attention, or Basic Provisions of Care factors.

The following factors had significant correlations for the 8-11 age category for harm: Basic Provisions of Care and Emotional ($p \leq .0008$), Basic Provisions of Care and Lack of Attention ($p \leq .0008$), and Emotional and Lack of Attention ($p \leq .0008$). The range of significant values was .30-.41. With respect to perceived level of harm for the 12-18 age category the following factors were significant: Basic Provisions of Care and Lack of Attention ($p \leq .0008$), Basic Provisions of Care and Neglect ($p \leq .0008$), Basic Provisions of Care and Emotional ($p \leq .0008$), Lack of Attention and Neglect ($p \leq .0008$), Lack of Attention and Emotional ($p \leq .0008$), and Neglect and Emotional ($p \leq .0008$). The range of significant values was .31-.49. With respect to perceived level of harm for the special needs category, the following factors were significantly correlated: Basic Provisions of Care and Neglect ($p \leq .0008$), Basic Provisions of Care and Lack of Attention ($p \leq .0008$), and Neglect and Lack of Attention ($p \leq .0008$). The range of significant values was .31-.43.

Reliability Analysis

Reliability analysis was conducted within age groups for substantiation, frequency, and harm for all 30 items. Reliability analysis within all age groups indicated good to excellent reliability for substantiation, frequency, and harm. The Cronbach's alpha for substantiation for age group 0-2 was .84, indicating that the 30 items prior to factor analysis demonstrated good reliability. The reliability for the 3-7 age group was also good, with a Cronbach's alpha of .85. Cronbach's alpha for substantiation for age group 8-11 was .87. The reliability for the 12-18 age category was .89 and Cronbach's alpha for the special needs category was .87. Regarding frequency of child neglect, the Cronbach's alpha for the 30 items within age category 0-2 was .90, .86 for age category 3-7, .893 for age category 8-11, .88 for age category 12-18, and .92 for special needs. Cronbach's alpha for perceived level of harm for age category 0-2 was .86, .88 for age category 3-7, .90 for age category 8-11, .89 for age category 12-18, and .88 for special needs.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Discussion of Results

This study examined the relevance of child age and special needs on child protective services (CPS) employees' likelihood to substantiate neglect for 30 questionnaire items. The impact of child age and special needs on CPS employees' ratings of harm and frequency for each item was also evaluated. The primary aim of this study was to generate an item pool for future development of a child neglect scale based on age and special needs. An item pool with respect to substantiation of neglect is presented in Table 34 containing items based on interpretable factors and Cronbach's $\alpha \geq .70$. The items are categorized by general, meaning the items are applicable to all age groups, and then delineated by items that are specific to age groups. Item pools with respect to frequency and harm are presented in Tables 35 and 36 based on the same criteria as the substantiation item pool.

Factor Analysis State Comparison Findings

A factor analysis comparing the Minnesota and Nevada samples was conducted to determine if the factor structures were similar in structure and could be combined to conduct additional factor analyses. Given the subject-to-item ratio, the factor structures were unstable. However, consistent factors emerged from both states across age groups.

In general, findings indicated that the factor structures for the Minnesota and Nevada samples were similar as illustrated by coefficient of congruence and salient variable similarity index results. With respect to likelihood to substantiate, the factors of Lack of Attention, Basic Provisions of Care, and Emotional were present in all age categories. Regarding frequency of neglect situations, Basic Provisions of Care, Lack of Attention, and Supervision factors were present across all age groups. The Basic Provisions of Care factor was present across all age groups for perceived level of harm.

The factors that were present across all age categories for Minnesota and Nevada samples, except for Emotional, could be categorized as physical neglect. Physical neglect, the most prevalent form of child neglect, is defined in the NIS-3 as harm or endangerment resulting from inadequate nutrition, clothing, hygiene, and supervision (Sedlack & Broadhurst, 1996). Additionally, health care neglect, abandonment, unsafe environments, and substandard housing have been cited as physical neglect (Cowen, 1999; Berry, et al., 2003). Researchers have found physical neglect to be often accompanied by emotional neglect (Glaser, 2002). The presence of physical and emotional factors in both states across all age groups supports previous research that physical neglect is the most prevalent form of neglect as perceived by CPS caseworkers and is accompanied by emotional neglect.

Factor Analysis Combined Sample Findings

Factor analysis findings subsequent to the combination of the Minnesota and Nevada samples revealed some similar factor structures across the age categories. With respect to CPS employees' likelihood to substantiate questionnaire items as neglect, Lack of Attention and Basic Provisions of Care factors were present across all age categories.

Both of these factor categories represent items that would be classified as physical neglect. As noted earlier, physical neglect is the most prevalent form of child neglect (Sedlack & Broadhurst, 1996). The presence of factors across the age categories that consist of physical neglect items was consistent with previous research findings that physical neglect is the most identifiable form of neglect by professionals (Cowen, 1999).

Although Lack of Attention and Basic Provisions of Care factors were present across all age categories, there were slight variations in the items that comprised the factors for all age categories. There were more items for the Lack of Attention factor for the special needs category. This indicated that children with special needs may require more attention, and that items not considered neglect for other age groups would be considered neglect for these children. With respect to the Basic Provisions of Care factor, most age groups showed consistency except the special needs category that had the fewest number of items.

Other factors revealed by factor analysis for likelihood to substantiate contained primarily physical neglect items, with the exception of the Emotional and Education factors for the 0-2 age category. As noted previously, physical neglect is often accompanied by emotional neglect (Glaser, 2002). Emotional neglect, as defined by the NIS-3, includes a failure to provide adequate affection and emotional support or permitting a child to be exposed to domestic violence (Sedlack & Broadhurst, 1996). The presence of the emotional factor only in the 0-2 age category may have been related to fact that children in this age category are more psychologically dependent on caregivers, and thus more vulnerable to emotional neglect (Belsky, 1993). The presence of the Education factor for the 0-2 age category may be explained by the clustering of the items

based on the ratings of participants being unlikely to substantiate a child in this age range not going to school or having educational needs as neglect. The lack of an education factor in the other age categories may be due to the opinion of many professionals that educational neglect is an issue that should be addressed by school systems and not social services (Berrick, 1997).

CPS employees' ratings with respect to the perceived frequency of neglect were examined and Lack of Attention and Emotional factors were present across all age categories. The Lack of Attention factor focused on physical neglect items. The items in the Lack of Attention factors were fairly consistent. However, the 0-2 age category contained several more items than other age categories. This finding was consistent with children under three experiencing the highest frequency of neglect, as measured by CPS substantiation reports (Sedlack & Broadhurst, 1996; Scannapieco & Connell-Carrick, 2002). The emotional neglect factors were also fairly consistent across age groups. The 12-18 age category contained the most items. Specifically, the item of a caretaker abandoning or rejecting a child was only present for the 12-18 age category.

Factor analysis findings with respect to participants' perceptions of harm for questionnaire items revealed Lack of Attention and Basic Provisions of Care factors across all age groups. The Lack of Attention and Basic Provisions of Care factors were comprised primarily of physical neglect items. However, there were items that would be classified as emotional neglect in both. The presence of physical and emotional neglect situations in the same factors is consistent with research that physical neglect is often accompanied by emotional neglect (Glaser, 2002).

The Lack of Attention factors across the age groups were fairly consistent. However, the 8-11 age category exhibited the most variability. This age category was the only one for harm that contained the item pertaining to abandonment. Unresponsiveness to educational needs was also found in the Lack of Attention factor for the 8-11 age category. With respect to the impact of educational neglect, children who are victims of educational neglect are at a significant risk for future educational failure and socio-emotional difficulties. These outcomes have also been associated with physical neglect (Berry et al, 2003). The only other age category for harm that had education items in a factor was the 0-2 age category (Education factor). In the 0-2 factor, these items most likely were together based on the perception of being harmless.

The items constituting the Basic Provisions of Care factors were moderately consistent across age groups, with the exception of the special needs category. The Basic Provisions of Care factor for the special needs category contained the fewest number of items. The special needs category did have a Supplemental Care factor that was not present in other age categories. This factor contained many of the items lacking from the Basic Provisions of Care factor for the special needs category but were present across other age categories. The presence of a separate factor for these items for the special needs factor indicates that participants' perceptions of harm were distinctly different for these items. Children with special needs, by definition, require care beyond that required by children generally (McPherson et al., 1998). This need for additional care may have impacted participants' perception of harm.

Overall, factor analysis findings indicated consistent patterns of certain factors across age groups for substantiation, frequency and harm. The items that comprised each

factor varied slightly in most cases based on the age category, indicating that child age and special needs were a relevant component. Factors that were present in only select age categories also indicated that age was a relevant factor. These findings are relevant for future directions in child neglect scale development.

Multivariate Analysis of Variance (MANOVA) Findings

MANOVA findings revealed significant state effects with respect to substantiation for all five age categories. Findings indicated these effects were based on a greater mean for Nevada participants with respect to items in various factors. Most of the significant effects were based on Nevada participants' higher mean ratings for substantiation for items in the Lack of Attention factors for all age categories. Findings revealed Nevada participants were more likely than Minnesota participants to substantiate certain categories of items as child neglect.

With respect to frequency of neglect, MANOVA findings revealed significant state effects for the 0-2 and 3-7 age categories. Nevada participants' had overall higher mean scores for frequency for the aforementioned age categories. Further analysis did not reveal significant state differences based on mean scores of factors. This finding indicated that Nevada participants perceived child neglect occurring more frequently for children ages 0-2 and ages 3-7 than participants in Minnesota.

MANOVA findings with respect to participants' perceptions of harm for items revealed significant state effects for age categories 0-2, 8-11, and 12-18. Findings revealed that Nevada participants perceived certain items as more harmful than Minnesota participants for the aforementioned age groups. Specifically, Nevada participants had higher mean scores for Lack of Attention factors for the 0-2, 8-11, and

12-18 age categories. Nevada participants also had higher mean scores on Basic Provisions of Care factors for the 8-11 and 12-18 age categories. These findings indicated that Nevada participants view specific groups of items for certain age groups as more harmful than Minnesota participants.

Overall, MANOVA findings indicated that Nevada participants were more likely to substantiate items as neglect and consider them more harmful than participants from Minnesota. This finding was particularly relevant for the Lack of Attention factor across the age categories. Although the factor structures were similar, as illustrated by factor comparison results, participants' mean scores varied by state for some factors. This state effect may be a result of varying training or neglect assessment procedures. Neglect assessment and investigative procedures vary among states and little consensus exists as to which standards or procedures are best to use (Lyons et al., 1996; Johnson, 2001). Minnesota participants reported they are required to use a standardized assessment during neglect investigations. However, additional requirements and standards may be imposed by county agencies. Nevada participants did not report a requirement to use a standardized assessment tool during assessment procedures and reported variability of investigative procedures based on location within the state. These differences may have contributed to the MANOVA findings.

Conclusions and Recommendations for Future Directions

The findings of this study should be interpreted with caution due to several limitations of the current study. The foremost limitations concerned the sample. The limitations centered on sample size and sample location. With respect to sample size,

factor structures may be unstable when sample-to-item ratios are inadequate. Various sample size to item ratios have been suggested by researchers, ranging from 2-20 subjects per item (Stevens, 2002). The current study had a four subjects-per-item ratio. Some factors, however, may be considered reliable based on factor loadings regardless of sample size. Although many factors were considered reliable based on these criteria, a larger sample size may have yielded more interpretable reliable factors.

An additional concern regarding the sample was differences based on location. The current study had participants from two different states in two different regions of the country. The original aim of the study was to recruit participants from more than two states in more than two regions of the country to increase sample size and make regional comparisons. Due to unforeseen issues, several agencies declined participation. Although the state samples had comparable factor structures, it would have been desirable to use a larger sample from one state to have a more homogenous sample. To have an adequate sample size from one state, a state with a large population of CPS employees would have been utilized which would have limited the use of more rural states such as Nevada. Another option would have been to increase the original recruitment efforts among the various regions of the country and make regional comparisons with adequate number of subjects from each region.

Additional concerns regarding this study concerned the administration of the questionnaire. Questionnaire items were administered in a manner in which each item was presented and the participant was to rate the likelihood of substantiation, frequency of occurrence, and perception of harm across all five age groups. Each item was presented in a matrix with the aforementioned elements present, indicating that the

participant had the ability to look at the ratings for the other age categories before progressing to the next item. This method of item presentation was used for efficiency, as participant completion time ranged from 20-45 minutes. Listing each item by age category, substantiation, frequency, and harm separately was not utilized as it was believed it would contribute to additional subject time. The method of presentation used, however, may have contributed to a carryover effect. The carryover effect may have been eliminated by presenting each item by age category separately. This most likely would have increased the administration time and subsequently led to a larger proportion of incomplete questionnaires. To accommodate this issue, a larger sample size would have been ideal and only complete questionnaires would have been used.

Despite these limitations, findings of this study suggest that child age and special needs are relevant issues to CPS employees' likelihood to substantiate neglect and their perceptions of the degree of harm. The primary aim of this study was to develop an item pool for future development of a child neglect assessment tool which was accomplished primarily through factor analysis. A secondary aim was to determine if child age and special needs was relevant to participants' responses. This study accomplished both of these aims and future directions include the development of a tool sensitive to age and special needs.

Researchers of future child neglect assessment tools should attempt to remove inherent blame and stigma that often lead maltreating caretakers to be hypersensitive to evaluation (Hansen & MacMillan, 1990). Several methods may be utilized to accomplish this in assessment procedures. One possible method is to develop blame reduction statements to precede sections of items or each item. Slack and colleagues (2003)

developed a measure that relied on blame reduction statements to avoid stigma. One potential problem with blame reduction statements is generating statements general enough in nature to apply to most families. Another approach in assessment development is to have questions that avoid specifically asking caretakers how many times they personally did or did not do something. Instead, the focus should be on how often he or she had witnessed the event in his or her family (Hardy, 1997). This approach focuses more on risk exposure of the child as opposed to identifying a perpetrator. Future research will attempt to utilize the item pool presented by this study as pilot data and create an age and special needs sensitive child neglect assessment measure that accounts for inherent blame and stigma.

Child age and special needs are relevant to child protective services employees' perceptions of harm and likelihood to substantiate child neglect. The findings of this study indicated that CPS employees perceived similar categories of neglect across age categories. However, the items that comprised the factors did vary as a function of child age. Because current child neglect assessment measures often fail to consider child age or special needs, this is an important next step. Additionally, inherent blame and stigma toward caretakers associated with current assessment measures should be addressed to facilitate more cooperation and child-focused assessment procedures.

APPENDIX I

INTERVIEW CORRESPONDENCE

Telephone Screening Questionnaire Script

Hello, my name is (your name) and I am assisting with research on child neglect at the University of Nevada, Las Vegas. I got your name from, _____ (Supervisor's name here) at the _____ (agency name). We are interested in the opinions of Child Protective Services caseworkers on the issue of child neglect. We are trying to recruit volunteers to participate in interviews to share their perceptions on neglectful situations and possible causes of these situations. This information potentially will be used in the development of a child neglect assessment tool. If you have previously been assigned to investigate or supervise child neglect cases, I would like to invite you participate. If you would like to participate we ask that you please provide us with a list of available dates and times.

If individual agrees to participate: Ask for available times or offer to call back or give an email address they can send them to. Ask if they are a caseworker or supervisor.

Thank them for agreeing to participate and let them know you will be sending a follow up letter with the date, time, and location of the interview.

If individual does not want to participate: Thank them for their time and give them a phone number they can call if they reconsider.

Email Participation Request Script

My name is _____ (your name) and I conducting research on child neglect at the University of Nevada, Las Vegas. I got your name from _____ (Supervisor's name here) and he/she indicated you may be interested in participating in this project. This project is examining the opinions of Child Protective Services caseworkers on the issue of child neglect. We are trying to recruit volunteers to participate in interviews to share their perceptions on neglectful situations and possible causes of these situations. This information potentially will be used in the development of a child neglect assessment tool. I would like to invite you participate. Participation would take approximately 60 minutes and would consist of filling out a very brief questionnaire and participating in a discussion about child neglect. If you would like to participate, we ask that you please provide us with a list of dates and times you are available after _____ (start date of project). You may e-mail this information to: _____ (email address) or call _____ and leave a message with the information and someone will let you know as soon as possible when the interview will take place. Most likely the interviews will take place on the UNLV campus or at CPS offices, the exact location will be determined after the number of participants is determined. Refreshments will be provided and this experience should be beneficial for all involved. Thank you for considering participating and if you know any other individuals employed at CPS that may also be interested, please feel free to give them this information as well.

Thank You,

(Your name and information)

Follow-Up Letter Template

Participant Name
Address

[Date]

Thank you for accepting our invitation to participate in an interview to discuss the issue of child neglect. We feel your expertise in the field will help facilitate a discussion of neglectful situations and their possible causes. The interview we would like you to participate in will be held:

Date

Time

Location

If for any reason you will not be able to participate, please call Stephanie Stowman at 567-1442. We are looking forward to meeting you and hearing your views on this issue. If you have any questions please call.

Sincerely,

Stephanie Stowman
University of Nevada, Las Vegas

APPENDIX II

INFORMED CONSENT FORMS

University of Nevada, Las Vegas

Department of Psychology

INFORMED CONSENT

Phase One

General Information:

Stephanie Stowman, a graduate student in the psychology department at the University of Nevada, Las Vegas, is the researcher on this project. You are invited to participate in a research study. The aim of this study is to develop a child neglect assessment tool based on information obtained in focus groups and feedback by professionals in the field of child neglect.

Procedure:

If you volunteer to participate in this study, you will be asked to participate in an individual interview or a group discussion to identify child neglect situations and the possible causes for these types of situations. An individual interview is expected to last 45 minutes and a group discussion is expected to last forty-five to sixty minutes. The information obtained in this discussion may be used in the development of a child neglect assessment instrument.

Risks and Benefits of Participation:

By participating you will have the opportunity to share your knowledge and expertise of child neglect and assist in the development of child neglect assessment tool that may later be used by your agency. You will also receive an increased understanding of the perceptions of child neglect held by other professionals in your field. There is, as in all studies, the potential risk of violating participants' confidentiality. Therefore, consistent with the ethical guidelines of the American Psychological Association, every effort will be made to protect individual's confidentiality (i.e., data will be recorded with id #s).

Contact Information:

If you have any questions about the study or you experience harmful effect as a result of participation in this study you may contact Stephanie Stowman at 567-1442 or Dr. Donohue at 895-0181.

For questions regarding the rights of research subject, you may contact the UNLV Office for the Protection of Research Subjects at 895-2794.

Voluntary Participation:

Your participation in this study is voluntary. You may refuse to participate in this study or any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality:

All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least 3 years after the completion of the study.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

Signature of Research Assistant

University of Nevada, Las Vegas
Department of Psychology

INFORMED CONSENT

Phase Two

General Information:

Stephanie Stowman, a graduate student in the psychology department at the University of Nevada, Las Vegas, is the researcher on this project. You are invited to participate in a research study. The aim of this study is to develop a child neglect assessment tool based on information obtained in focus groups and feedback by professionals in the field of child neglect.

Procedure:

If you volunteer to participate in this study, you will be asked to examine a list of child neglect scenarios and rate the degree to which you view the situation as child neglect for different age groups. You will also be asked to rate the severity of the item for different age groups. The expected completion time is twenty to thirty-five minutes.

Risks and Benefits of Participation:

By participating you will have the opportunity to share your knowledge and expertise of child neglect and assist in the development of child neglect assessment tool. There is, as in all studies, the potential risk of violating participants' confidentiality. Therefore, consistent with the ethical guidelines of the American Psychological Association, every effort will be made to protect individual's confidentiality (i.e., data will be recorded with id #s).

Contact Information:

If you have any questions about the study or you experience harmful effect as a result of participation in this study you may contact Stephanie Stowman at 567-1442 or Dr. Donohue at 895-0181.

For questions regarding the rights of research subject, you may contact the UNLV Office for the Protection of Research Subjects at 895-2794.

Voluntary Participation:

Your participation in this study is voluntary. You may refuse to participate in this study or any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality:

All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least 3 years after the completion of the study.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

Signature of Research Assistant

APPENDIX III

BACKGROUND SURVEYS

Background Survey: Phase 1

Please put an X next to the appropriate response.

1. Gender

_____ Male

_____ Female

2. Age

_____ Years

3. Ethnicity

_____ African American

_____ Caucasian

_____ Hispanic

_____ Other

4. Name of Agency Currently Employed at: _____

5. Position Title: _____

6. Highest Level of Education:

_____ Bachelors Degree

_____ Masters Degree

_____ PhD

Degree Field:

_____ Psychology

_____ Social Work

_____ Other: Please specify _____

Please circle the number of the response.

7. Rate your knowledge of child neglect assessment.

Extremely Unknowledgeable 1	Very Unknowledgeable 2	Somewhat Unknowledgeable 3	Neutral 4
Somewhat Knowledgeable 5	Very Knowledgeable 6	Extremely Knowledgeable 7	

8. How experienced are you in the assessment of child neglect?

Extremely Inexperienced 1	Very Inexperienced 2	Somewhat Inexperienced 3	Neutral 4
Somewhat Experienced 5	Very Experienced 6	Extremely Experienced 7	

Background Survey: Phase 2

Please put an X next to the appropriate response.

1. Gender

_____ Male

_____ Female

2. Age

_____ Years

3. Ethnicity

_____ African American

_____ Caucasian

_____ Hispanic

_____ Other

4. Name of Agency Currently Employed at: _____

5. Position Title: _____

6. Highest Level of Education:

_____ Bachelors Degree

_____ Masters Degree

_____ PhD

Degree Field:

_____ Psychology

_____ Social Work

_____ Other: Please specify _____

7. State and county of employment:

Please circle the number of the response.

8. Rate your knowledge of child neglect assessment.

Extremely Unknowledgeable 1	Very Unknowledgeable 2	Somewhat Unknowledgeable 3	Neutral 4
Somewhat Knowledgeable 5	Very Knowledgeable 6	Extremely Knowledgeable 7	

9. How experienced are you in the assessment of child neglect?

Extremely Inexperienced 1	Very Inexperienced 2	Somewhat Inexperienced 3	Neutral 4
Somewhat Experienced 5	Very Experienced 6	Extremely Experienced 7	

APPENDIX IV

PROCEDURES CHECKLIST

Interview Procedures Checklist

Moderator or Interviewer:

Date:

Participant Subject Number(s):

Place an X on the line before each item if you completed the procedure according to protocol.

_____ Introductions

_____ Informed Consent

_____ Interview: "The purpose of this interview is to discuss situations involving child neglect, as well as to identify possible reasons for the occurrence of these situations. As a CPS employee, you are considered an expert in the field of child neglect and the information gathered today will be used to develop an assessment tool for child neglect. There may be instances in which it will be necessary for me to guide the discussion and ask questions about the situations that are discussed. Responses will also be recorded in order to use the information at a later time to develop the child neglect assessment tool items."

_____ Background Survey

Defined Child Neglect

_____ "While there is not a single agreed upon definition of child neglect, for purposes of this discussion we are defining child neglect as an act of omission in which the basic needs of a child are not met. We are interested in hearing your perceptions of what constitutes a neglectful situation. While we want to hear all the possible responses you might have, we would like to guide the discussion in a manner that addresses situations in terms of physical, emotional, and educational neglect."

Generated Situations in at least the 3 subtypes of neglect: (At least 5 per subtype for group discussions and 3 per subtype for interviews)

_____ Physical

_____ Emotional

_____ Educational

APPENDIX V

ITEM QUESTIONNAIRE

Listed on the next page are situations that may or may not constitute child neglect. For each situation, you are asked to indicate how likely you would be to substantiate it as neglect, how frequently it occurs, and how harmful it is for EACH age category.

The situations listed are purposefully vague in an attempt to avoid biasing responses towards specific examples. The intent of this questionnaire is to get a broad idea of what areas should be focused upon during child neglect investigations.

This questionnaire is just one of many steps in the development process of a child neglect assessment tool. Responses from this questionnaire will allow the researchers to focus the actual assessment tool items on the areas identified. The items on this questionnaire are NOT the same items that will be used on the assessment tool.

Please answer all questions for all age groups.

Please use the scales below when answering all questions:

How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
1 Extremely Unlikely	1 Extremely Infrequent	1 Extremely Harmless
2 Very Unlikely	2 Very Infrequent	2 Very Harmless
3 Somewhat Unlikely	3 Somewhat Infrequent	3 Somewhat Harmless
4 Neutral	4 Neutral	4 Neutral
5 Somewhat Likely	5 Somewhat Frequent	5 Somewhat Harmful
6 Very Likely	6 Very Frequent	6 Very Harmful
7 Extremely Likely	7 Extremely Frequent	7 Extremely Harmful

It may be helpful to use this sheet when answering the questionnaire to know what each number represents.

*Children with special needs may include developmental disabilities, severe medical problems (i.e. require use of ventilator, G-tube), and hearing and visual impairments.

1. Child has access to toxins.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

2. Child has access to weapons.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

3. Child has access to sharp objects.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

4. Child has access to small objects.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

5. Child has access to electrical hazards.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

6. The home has inadequate heating or cooling for the current weather conditions.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

7. The home is ill equipped to prevent unauthorized entry or exit of people or animals8. Unsanitary living conditions are present in the home.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

8. Unsanitary living conditions are present in the home.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

9. A child is left unsupervised for several minutes.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

10. A child is left unsupervised for several hours.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

11. A child is left unsupervised overnight.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

12. A child is left unsupervised for several days.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

13. A child is left in the care of someone who is inappropriate or incompetent

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

14. The child is not provided with or does not have access to food.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

15. The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

16. A child has inadequate hygiene.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

17. A child does not have adequate clothing.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

18. A child has an illness, injury, or medical condition that is not being treated.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

19. A child has pre-existing medical condition requiring treatment and the caretaker allows necessary medical insurance coverage (i.e. Medicaid or private medical insurance) to lapse.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

20. A child needs mental health services or medication for a psychological problem and is not receiving these services.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

21. A child is exposed to criminal activity.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

22. A child is exposed to domestic violence.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

23. There is a lack of communication and or contact between the caretaker and child.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

24. A caretaker abandons or rejects the child.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

25. A caretaker shows preferential treatment for other children in the home.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

26. A child is exhibiting inadequate physical growth.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

27. A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

28. A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

29. A caretaker is unresponsive to a child's educational needs.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

30. A caretaker does not provide shelter for his or her child.

	How likely would you be to substantiate this as neglect?	How frequently does this occur?	How harmful is this?
CHILD AGE			
0-2	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
3-7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
8-11	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
12-18	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Special Needs	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

APPENDIX VI

TABLES

Table 1

Categories Yielded from Qualitative Analysis in Phase One.

<i>Categories</i>
1. Toxins
2. Weapons
3. Sharp objects
4. Small objects
5. Electrical hazards
6. Inadequate heating/cooling
7. Unsecured home
8. Unsanitary living conditions
9. Lack of supervision
10. Inappropriate/inadequate supervision
11. Lack of food
12. Inadequate/ inappropriate food
13. Inadequate hygiene
14. Inadequate clothing
15. Lack of treatment for a medical condition
16. Needs mental health services and is not receiving
17. Exposure to criminal activity
18. Exposure to domestic violence
19. Lack of communication and/or contact with child
20. Rejection of the child/abandonment
21. Preferential treatment of other children in the home
22. Child exhibiting failure to thrive
23. Failure to meet emotional needs of child
24. Child does not attend school or does not receive approved home based education
25. Unresponsive to educational needs
26. Failure to provide shelter

Table 2

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Likelihood to Substantiate Ages 0-2.

Factor	r_c	s	p
Lack of Attention	.66*	.89	<.0005
Basic Care	.52*	.67	<.0005
Supplemental Care	.62*	.33	<.011
Emotional	.63*	.80	<.0005
Education	.83*	1.00	<.0005
Neglect	.42*	.33	<.011

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 3

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Likelihood to Substantiate Ages 3-7.

Factor	r_c	s	p
Basic Care	.66*	.89	<.0005
Supplemental Care	.52*	.67	<.0005
Emotional	.62*	.33	<.011
Lack of Attention	.63*	.80	<.0005
Neglect	.83*	1.00	<.0005
Education	.42*	.33	<.011

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 4

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Likelihood to Substantiate Ages 8-11.

Factor	r_c	s	p
Lack of Attention	.42*	.44	<.005
Basic Care	.84*	.83	<.0005
Supplemental Care	.22	.33	<.011
Emotional	.62*	.80	<.0005
Education	.46*	.33	<.011
Supervision	.54*	.80	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 5

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota samples for Likelihood to Substantiate Ages 12-18.

Factor	r_c	s	p
Basic Care	.50*	.50	<.001
Lack of Attention	.31	.33	<.011
Emotional	.58*	1.00	<.0005
Supervision	.69*	.80	<.0005
Hazards	.40	.40	<.007
Neglect	.41	.44	<.006

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 6

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota samples for Likelihood to Substantiate Special Needs.

Factor	r_c	s	p
Lack of Attention	.64*	.36	<.016
Basic Care	.77*	.86	<.0005
Emotional	.40	.40	<.007
Supervision	.51*	.67	<.0005
Supplemental Care	.42*	.50	<.005
Physical Needs	.62*	.67	<.0005
Neglect	.54*	.67	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

*

Table 7

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Frequency Ages 0-2.

Factor	r_c	s	p
Basic Provisions of Care	.48*	.67	<.0005
Lack of Attention	.47*	.50	<.001
Supervision	.77*	.80	<.0005
Emotional	.68*	.75	<.0005
Supplemental Care	.37	.33	<.011
Education	.63*	.80	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 8

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Frequency Ages 3-7.

Factor	r_c	s	p
Basic Provisions of Care	.50*	.36	<.016
Supplemental Care	.65*	.67	<.0005
Lack of Attention	.76*	.80	<.0005
Supervision	.68*	.67	<.0005
Education	.49*	.50	<.004

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 9

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Frequency Ages 8-11.

Factor	r_c	s	p
Neglect	.51*	.50	<.001
Basic Provisions of Care	.59*	.50	<.001
Supplemental Care	.61*	.50	<.001
Lack of Attention	.61*	.67	<.0005
Physical Needs	.37	.40	<.009

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 10

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Frequency Ages 12-18.

Factor	r_c	s	p
Basic Provisions of Care	.52*	.57	<.004
Supplemental Care	.64*	.86	<.0005
Supervision	.77*	.75	<.0005
Education	.46*	.25	<.047
Lack of Attention	.51*	.80	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 11

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Frequency Special Needs.

Factor	r_c	s	p
Basic Provisions of Care	.28	.25	<.047
Lack of Attention	.37	.44	<.006
Neglect	.61*	.67	<.0005
Emotional	.54*	.50	<.001
Supervision	.46*	.33	<.011
Supplemental Care	.18	.25	<.047

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 12

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Harm Ages 0-2.

Factor	r_c	s	p
Basic Provisions of Care	.55*	.55	<.001
Emotional	.40	.33	<.011
Neglect	.73*	.67	<.0005
Supervision	.73*	.60	<.0005
Lack of Attention	.53*	.33	<.011
Hazards	.36	.33	<.011

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 13

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Harm Ages 3-7.

Factor	r_c	s	p
Emotional and Educational	.57*	.67	<.0005
Supervision	.48*	.40	<.007
Physical	.32	.40	<.007
Neglect	.53*	.40	<.027
Basic Provisions of Care	.15	.33	<.011
Lack of Attention	.47*	.80	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 14

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Harm Ages 8-11.

Factor	r_c	s	p
Supplemental Care	.51*	.44	<.006
Lack of Attention	.28	.18	<.10
Hazards	.59*	.67	<.0005
Emotional	.68*	.57	<.001
Basic Provisions of Care	.61*	.80	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 15

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Harm Ages 12-18.

Factor	r_c	s	p
Neglect	.59*	.50	<.001
Emotional	.61*	.75	<.0005
Supervision	.57*	.80	<.0005
Basic Provisions of Care	.51*	.22	<.064
Physical Needs	.66*	.67	<.0005

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 16

Coefficients of Congruence (r_c) and Salient Variable Similarity Indexes (s) for Factor Structure Comparison of Nevada and Minnesota Samples for Harm Special Needs.

Factor	r_c	s	p
Basic Provisions of Care	.83*	.80	<.0005
Emotional and Educational	.45*	.67	<.0005
Supervision	.63*	.50	<.004
Lack of Attention	.59*	.57	<.001
Hazards	.13	.29	<.007
Neglect	.03	.33	<.011

Note. * Indicates a significant r_c value $\geq \pm .41$.

Table 17

Comparison of Eigenvalues ≥ 1 , Scree Plot, and Parallel Analysis Results for Number of Factors Indicated for Substantiation, Frequency and Harm of Neglect.

Factor Number Criterion	# Factors	# Factors	# Factors	# Factors	# Factors
<i>Substantiation</i>	<i>Ages 0-2</i>	<i>Ages 3-7</i>	<i>Ages 8-11</i>	<i>Ages 12-18</i>	<i>Special Needs</i>
Eigenvalues ≥ 1	10	9	8	9	9
Scree Plot	5	4	4	4	4
Parallel Analysis	5	3	3	4	4
<i>Frequency</i>	<i>Ages 0-2</i>	<i>Ages 3-7</i>	<i>Ages 8-11</i>	<i>Ages 12-18</i>	<i>Special Needs</i>
Eigenvalues ≥ 1	8	8	8	9	8
Scree Plot	4	4	6	4	4
Parallel Analysis	4	4	5	4	4
<i>Harm</i>	<i>Ages 0-2</i>	<i>Ages 3-7</i>	<i>Ages 8-11</i>	<i>Ages 12-18</i>	<i>Special Needs</i>
Eigenvalues ≥ 1	8	9	7	9	8
Scree Plot	4	6	5	4	3
Parallel Analysis	4	4	3	4	4

Table 18

Pattern and Structure Matrixes for Interpretable Factors With Respect to Likelihood to Substantiate, Ages 0-2.

Item #	Pattern Matrix					Structure Matrix					
	1	2	3	4	5	Item #	1	2	3	4	5
3	0.91	0.02	0.08	0.04	-0.13	3	0.86	0.18	0.36	0.14	0.01
4	0.85	-0.1	0.11	-0.13	-0.05	4	0.85	0.12	0.39	-0.03	0.18
2	0.78	-0.03	-0.22	0.17	-0.26	7	0.79	0.22	0.31	0.10	0.37
7	0.78	0.03	-0.06	0.01	0.28	2	0.64	0.03	0.00	0.25	-0.23
5	0.57	0.18	0.1	-0.23	0.15	5	0.64	0.33	0.39	-0.11	0.32
9	0.26	0.03	0.2	0.25	0.01	27	0.51	0.12	0.42	0.50	0.31
20	-0.01	0.81	0.1	0.18	-0.09	19	0.24	0.75	0.39	0.12	0.14
15	0.08	0.75	-0.19	0.01	0.1	20	0.12	0.74	0.33	0.23	0.02
19	0.05	0.72	0.11	0.02	-0.03	17	0.04	0.74	0.24	0.16	0.30
17	-0.22	0.68	-0.1	0.05	0.25	15	0.12	0.64	0.09	0.05	0.09
16	0.11	0.59	-0.22	-0.16	0.12	16	0.25	0.60	0.18	-0.09	0.36
18	-0.24	0.44	0.41	0.05	-0.05	18	0.04	0.55	0.52	0.16	0.15
21	-0.09	0.38	0.07	0.1	-0.01	25	0.34	0.21	0.83	0.09	0.32
15	0.02	-0.16	0.88	-0.03	0.13	23	0.37	0.37	0.81	0.13	0.09
23	0.09	0.07	0.85	-0.01	-0.09	28	0.03	0.17	0.10	0.85	-0.03
29	-0.01	0.05	-0.05	0.92	0.09	29	0.07	0.11	0.12	0.85	0.13
28	-0.05	0.13	-0.02	0.86	0	8	0.06	0.17	0.19	0.12	0.72
27	0.31	-0.21	0.18	0.41	0.23	26	0.16	0.17	0.57	-0.10	0.67
8	-0.12	0.02	0.01	0.06	0.91	6	0.32	0.30	0.23	0.15	0.59
6	0.2	0.19	-0.08	0.11	0.53	14	-0.03	-0.02	-0.06	0.09	0.01
26	-0.05	0	0.47	-0.08	0.51	13	0.31	0.26	0.20	0.21	0.39
14	-0.06	0	-0.11	-0.02	-0.11	11	-0.05	0.00	-0.01	-0.04	0.00
13	0.17	0.14	-0.12	0.05	0.23	30	0.05	0.02	-0.04	0.03	0.16
11	-0.04	0.07	0.03	0.04	-0.17	22	0.43	0.49	0.39	0.04	-0.11
30	-0.17	-0.21	-0.13	-0.19	0.11	10	0.15	0.06	0.25	0.33	0.19
22	0.2	0.24	0.19	-0.19	-0.35	9	0.49	0.31	0.46	0.40	0.23
10	-0.09	-0.18	0.15	0.18	-0.06	1	0.31	0.10	0.15	-0.08	0.10
1	0.28	0.06	-0.04	-0.11	-0.09	12	-0.07	-0.17	-0.07	0.14	0.11
12	-0.07	-0.14	-0.1	0.23	-0.05	24	0.22	0.04	0.16	-0.02	0.22
24	0.17	-0.08	0.18	-0.13	0.36	21	0.05	0.45	0.11	0.23	-0.12
1= Lack of Attention							3= Emotional	4= Education	5= Neglect		

Note. See Table 33 for a complete listing of items.

Table 19

Pattern and Structure Matrixes for Interpretable Factors With Respect to Likelihood to Substantiate, Ages 3-7.

Item #	Pattern Matrix			Item #	Structure Matrix		
	1	2	3		1	2	3
20	0.87	0.03	-0.16	20	0.80	0.21	-0.04
19	0.85	-0.06	-0.14	19	0.76	0.18	-0.06
21	0.81	-0.11	-0.06	21	0.71	0.06	0.02
15	0.72	-0.08	0.19	16	0.69	0.19	0.32
16	0.61	-0.01	0.15	15	0.69	0.08	0.29
17	0.52	-0.07	0.00	17	0.67	0.16	0.25
3	-0.08	0.94	-0.06	3	0.13	0.88	-0.05
2	-0.11	0.93	0.03	2	0.00	0.77	-0.03
4	-0.13	0.61	-0.04	4	0.11	0.70	-0.07
7	0.10	0.60	-0.07	7	0.27	0.65	-0.04
22	0.23	0.44	-0.08	22	0.43	0.59	0.06
12	-0.09	0.00	0.92	27	0.18	0.53	-0.02
11	-0.06	-0.15	0.87	12	0.03	-0.02	0.87
14	0.11	-0.03	0.75	11	0.07	-0.06	0.81
18	0.20	0.14	0.49	14	0.12	-0.06	0.70
25	-0.05	-0.10	-0.07	18	0.46	0.30	0.61
23	0.15	0.12	-0.01	25	0.20	0.29	-0.09
26	-0.13	-0.26	0.00	23	0.37	0.43	-0.01
1	-0.06	0.20	0.09	26	0.14	0.05	0.04
5	0.12	0.43	-0.02	1	0.09	0.28	0.08
6	0.28	-0.07	0.09	5	0.27	0.51	0.00
10	-0.07	-0.13	0.30	6	0.39	0.17	0.11
9	0.10	0.16	-0.18	10	0.07	0.11	0.32
28	-0.04	-0.08	-0.14	9	0.30	0.42	-0.05
30	-0.08	0.07	0.27	28	0.14	-0.03	0.03
8	-0.06	-0.25	-0.23	30	0.13	0.16	0.38
29	0.00	0.07	0.06	8	0.15	-0.02	-0.04
27	-0.14	0.29	-0.11	29	0.20	0.24	0.08
24	0.03	0.15	0.21	24	0.09	0.19	0.11
13	0.09	0.12	0.37	13	0.29	0.24	0.47
	1= Basic Provisions of Care			2= Lack of Attention			3= Physical Needs

Note. See Table 33 for a complete listing of items.

Table 20

Pattern and Structure Matrixes for Interpretable Factors With Respect to Likelihood to Substantiate, Ages 8-11.

Item #	Pattern Matrix			Item #	Structure Matrix		
	1	2	3		1	2	3
17	0.86	-0.17	-0.10	17	0.82	0.07	0.24
20	0.86	0.14	-0.11	20	0.80	0.27	0.10
21	0.78	0.25	-0.17	16	0.70	0.08	0.22
19	0.69	0.07	0.07	19	0.70	0.26	0.17
16	0.67	-0.12	-0.01	15	0.70	0.07	0.48
15	0.64	-0.10	0.36	21	0.69	0.21	0.04
18	0.48	-0.16	0.08	18	0.62	0.05	0.40
22	0.32	0.20	-0.06	22	0.42	0.33	0.13
24	-0.03	0.81	0.14	7	0.18	0.69	0.12
29	0.00	0.67	0.13	5	0.31	0.69	0.06
5	0.09	0.55	-0.09	29	0.24	0.65	0.17
2	-0.07	0.54	-0.27	2	0.00	0.62	-0.14
7	-0.04	0.48	0.06	24	0.08	0.62	0.19
13	0.06	0.40	0.34	13	0.32	0.53	0.41
14	-0.04	0.11	0.86	14	0.14	0.05	0.76
8	-0.12	-0.11	0.70	8	0.19	0.00	0.69
12	-0.05	0.19	0.58	30	0.21	0.22	0.60
30	0.05	0.17	0.49	12	0.04	0.06	0.60
6	0.07	-0.09	0.36	6	0.33	0.08	0.52
1	0.02	-0.28	0.05	3	0.24	0.65	0.04
4	0.01	-0.01	-0.07	4	0.15	0.38	0.00
3	0.03	0.32	-0.06	1	0.10	0.07	0.16
25	-0.08	0.02	-0.06	25	0.31	0.31	0.09
23	0.01	0.02	-0.17	23	0.35	0.25	0.03
27	-0.12	0.20	0.09	27	0.22	0.46	0.24
10	0.04	-0.13	0.08	9	0.33	0.40	0.06
9	0.03	0.20	-0.04	10	0.22	-0.08	0.16
11	-0.07	0.16	0.09	11	0.12	0.10	0.31
26	0.05	-0.02	0.08	28	0.12	0.12	0.42
28	0.04	0.11	0.35	26	0.29	0.14	0.14
	1= Basic Provisions of Care			2= Lack of Attention		3= Physical Needs	

Note. See Table 33 for a complete listing of items.

Table 21

Pattern and Structure Matrixes for Interpretable Factors With Respect to Likelihood to Substantiate, Ages 12-18.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
4	0.96	0.06	-0.40	-0.12	3	0.87	0.23	0.48	0.16
3	0.89	0.01	0.02	-0.07	1	0.80	0.14	0.40	0.19
1	0.88	-0.05	-0.03	0.02	4	0.74	0.12	0.09	0.01
7	0.52	0.09	0.16	0.13	7	0.69	0.24	0.44	0.23
2	0.48	-0.17	0.23	0.03	2	0.62	0.13	0.59	0.19
20	0.09	0.84	-0.03	-0.17	19	0.23	0.76	0.17	0.13
19	0.07	0.82	-0.19	-0.16	20	0.28	0.75	0.22	0.14
21	-0.32	0.73	-0.19	0.10	17	0.13	0.73	0.49	0.48
15	0.01	0.58	-0.03	0.33	15	0.14	0.70	0.25	0.58
17	-0.08	0.56	0.24	0.19	21	-0.06	0.68	0.10	0.23
22	0.15	0.52	0.41	-0.32	16	0.16	0.61	0.40	0.48
16	-0.02	0.41	0.19	0.19	18	0.22	0.55	0.37	0.44
18	0.16	0.39	0.14	0.16	6	0.18	0.20	0.76	0.19
6	-0.28	-0.06	0.97	-0.06	27	0.50	0.25	0.71	0.28
27	0.02	-0.06	0.75	0.12	5	0.58	0.16	0.68	0.25
5	0.16	-0.16	0.57	0.10	22	0.33	0.49	0.52	-0.08
11	-0.14	0.02	0.03	0.87	11	0.14	0.31	0.25	0.82
12	-0.01	-0.13	-0.03	0.79	12	0.05	0.16	0.19	0.76
13	0.32	0.04	-0.11	0.53	13	0.45	0.25	0.24	0.59
26	-0.19	-0.02	-0.11	-0.15	26	0.12	0.26	0.14	0.04
25	0.12	0.02	0.13	0.04	25	0.50	0.34	0.40	0.20
23	0.27	0.05	0.16	-0.04	23	0.63	0.37	0.50	0.18
14	0.08	0.10	-0.12	0.06	14	0.02	0.25	0.12	0.31
30	0.09	0.04	0.35	-0.06	30	0.23	0.23	0.49	0.19
10	0.02	0.12	-0.13	0.13	9	0.52	0.25	0.35	0.14
9	0.19	0.08	0.01	0.03	10	0.26	0.25	0.12	0.23
8	0.01	-0.06	0.33	-0.13	8	0.23	0.15	0.47	0.13
28	-0.03	0.02	0.27	0.05	28	0.34	0.13	0.35	0.14
29	-0.06	0.15	0.22	-0.06	29	0.39	0.30	0.35	0.11
24	0.02	-0.01	-0.21	0.16	24	0.14	0.15	0.20	0.15
	1= Lack of Attention				2= Basic Provisions of Care				3= Neglect
									4= Supervision

Note. See Table 33 for a complete listing of items.

Table 22

Pattern and Structure Matrixes for Interpretable Factors With Respect to Likelihood to Substantiate, Special Needs.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
3	0.86	-0.13	0.12	-0.05	3	0.83	0.13	0.14	-0.09
4	0.83	-0.18	0.10	-0.08	4	0.81	0.09	0.18	-0.08
2	0.73	-0.02	-0.19	-0.03	7	0.75	0.31	0.16	0.05
7	0.73	0.10	0.00	-0.02	2	0.70	0.06	-0.16	-0.14
27	0.70	-0.05	0.01	0.12	27	0.70	0.25	0.15	0.21
9	0.62	0.05	0.09	0.30	9	0.61	0.34	0.19	0.37
21	-0.21	0.97	-0.05	0.04	5	0.53	0.25	-0.13	0.12
19	0.04	0.76	0.14	-0.14	19	0.30	0.82	0.42	0.09
20	0.08	0.73	0.16	-0.21	20	0.37	0.80	0.41	0.01
15	-0.11	0.51	0.13	0.17	21	0.03	0.77	0.14	0.11
18	0.04	0.00	0.81	-0.02	15	0.09	0.58	0.28	0.30
16	0.01	0.15	0.64	0.19	18	0.21	0.27	0.77	0.05
17	-0.12	0.32	0.55	0.19	16	0.20	0.44	0.75	0.33
22	0.31	0.13	0.48	-0.21	17	0.07	0.52	0.65	0.35
30	-0.02	-0.16	0.37	-0.20	22	0.43	0.29	0.52	-0.17
10	0.07	-0.03	0.05	0.85	10	0.14	0.18	0.14	0.80
11	-0.07	-0.07	0.07	0.77	11	-0.01	0.00	0.07	0.64
8	-0.10	0.02	-0.06	0.59	8	0.02	0.14	0.10	0.63
14	-0.07	-0.01	0.04	-0.01	14	0.01	0.05	0.10	0.06
28	-0.27	0.02	0.00	-0.03	28	0.04	0.14	0.06	0.03
13	0.24	-0.06	0.23	0.33	13	0.32	0.20	0.36	0.39
29	0.33	0.11	-0.08	-0.17	12	0.12	0.01	-0.03	0.26
12	0.05	0.01	-0.01	0.36	24	0.34	0.17	0.12	0.06
24	0.25	0.14	0.08	0.09	6	0.31	0.23	0.05	0.11
6	0.12	0.09	-0.22	-0.06	26	0.11	0.09	0.26	0.18
26	-0.16	-0.21	0.13	-0.02	23	0.40	0.30	0.33	0.01
23	0.13	0.02	0.28	-0.04	25	0.44	0.30	0.16	0.20
25	0.11	0.01	-0.02	0.13	29	0.50	0.35	0.05	0.01
1	-0.08	0.04	0.05	0.21	1	0.15	0.13	0.18	0.14
5	0.34	0.15	-0.36	0.12	30	0.10	-0.10	0.37	-0.23
	1= Lack of Attention				2= Supplemental Care				
					3= Basic Provisions of Care				
					4= Neglect				

Note. See Table 33 for a complete listing of items.

Table 23

Pattern and Structure Matrixes for Interpretable Factors With Respect to Frequency, Ages 0-2.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
4	0.91	-0.20	-0.03	0.25	3	0.85	0.26	0.09	0.23
3	0.88	0.07	-0.04	0.09	4	0.83	0.06	0.08	0.34
7	0.70	0.13	0.06	0.12	5	0.76	0.38	0.15	0.24
5	0.64	0.12	0.03	0.03	7	0.70	0.31	0.18	0.30
1	0.62	0.00	-0.03	-0.46	1	0.66	0.21	0.06	-0.14
6	0.53	-0.14	-0.07	0.30	6	0.65	0.17	0.02	0.38
11	0.05	0.95	0.02	-0.09	9	0.58	0.27	0.23	0.07
12	0.02	0.90	0.03	0.13	11	0.26	0.89	0.19	0.19
10	-0.03	0.71	0.17	-0.29	12	0.20	0.80	0.22	0.29
14	-0.05	0.59	-0.19	0.23	14	0.24	0.70	-0.01	0.41
13	0.01	0.52	0.00	0.11	10	0.20	0.69	0.17	-0.05
27	-0.04	-0.01	0.79	-0.14	13	0.20	0.61	0.11	0.35
23	-0.03	-0.04	0.78	0.13	23	0.15	0.20	0.80	0.32
25	0.10	0.03	0.72	-0.05	25	0.31	0.31	0.78	0.26
20	-0.11	0.22	0.43	0.09	27	0.11	0.19	0.77	0.13
17	0.14	0.01	-0.02	0.87	20	0.04	0.33	0.59	0.30
16	0.08	-0.08	-0.01	0.81	17	0.31	0.27	0.19	0.84
15	0.12	0.13	0.11	0.52	16	0.31	0.27	0.23	0.84
18	-0.12	0.11	-0.16	0.44	15	0.33	0.39	0.32	0.68
24	-0.23	-0.03	0.31	0.10	18	0.25	0.44	0.11	0.59
26	0.04	-0.22	0.38	-0.05	19	0.30	0.36	0.53	0.56
30	-0.08	0.17	-0.14	0.08	24	0.18	0.35	0.48	0.38
2	0.36	0.14	-0.29	-0.15	26	0.33	0.15	0.46	0.20
22	-0.07	-0.15	-0.05	-0.04	30	0.32	0.49	0.02	0.30
21	0.03	-0.08	0.15	0.15	2	0.56	0.38	-0.07	0.09
28	0.06	0.01	0.08	0.06	22	0.13	0.14	0.03	0.17
29	0.03	-0.03	0.09	-0.01	21	0.21	0.23	0.30	0.40
8	-0.05	0.04	0.08	0.19	28	0.23	0.19	0.32	0.17
9	0.49	0.06	0.29	-0.11	29	0.26	0.21	0.33	0.16
19	0.10	0.07	0.30	0.27	8	0.21	0.25	0.03	0.21
1 = Lack of Attention						2 = Physical Needs			
						3 = Emotional			
						4 = Basic Provisions of Care			

Note. See Table 33 for a complete listing of items.

Table 24

Pattern and Structure Matrixes for Interpretable Factors With Respect to Frequency, Ages 3-7.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
3	0.85	0.02	0.11	0.17	3	0.82	0.14	0.22	0.25
4	0.83	-0.10	0.30	-0.16	4	0.79	0.04	0.34	0.05
1	0.73	0.09	-0.35	-0.08	5	0.71	0.26	0.24	0.33
7	0.65	-0.03	0.18	-0.03	1	0.71	0.20	-0.06	0.06
5	0.54	0.09	-0.10	0.10	7	0.70	0.12	0.35	0.21
23	-0.09	0.79	0.00	0.06	23	0.15	0.80	0.25	0.23
25	0.09	0.74	-0.04	0.02	25	0.32	0.79	0.23	0.23
27	-0.02	0.73	0.12	-0.14	27	0.08	0.75	0.21	0.06
20	-0.04	0.57	0.05	0.21	19	0.30	0.63	0.46	0.39
19	0.16	0.47	0.18	0.14	20	0.09	0.60	0.36	0.36
16	0.01	0.04	0.96	-0.17	16	0.21	0.26	0.87	0.25
17	0.03	0.07	0.89	-0.14	17	0.21	0.26	0.85	0.25
15	0.15	0.07	0.66	0.24	15	0.36	0.27	0.76	0.52
12	0.00	0.09	-0.13	0.92	11	0.15	0.17	0.22	0.85
11	-0.02	0.05	-0.16	0.92	12	0.13	0.20	0.18	0.80
14	-0.03	-0.25	0.29	0.49	14	0.20	-0.02	0.52	0.67
13	0.00	-0.07	0.21	0.38	13	0.20	0.08	0.51	0.59
29	0.03	0.02	-0.01	-0.06	18	0.24	0.17	0.52	0.59
28	0.07	0.08	-0.14	0.04	29	0.35	0.16	0.20	0.18
18	-0.07	-0.05	0.16	0.34	28	0.37	0.18	0.14	0.24
6	0.27	-0.07	0.19	-0.15	6	0.51	0.12	0.40	0.20
22	-0.04	-0.08	-0.18	-0.18	22	0.16	0.06	0.24	0.15
21	0.01	0.17	0.09	-0.13	21	0.20	0.33	0.43	0.23
8	-0.12	-0.03	0.12	-0.02	10	0.19	0.27	0.22	0.48
10	-0.04	0.18	-0.05	0.35	8	0.13	0.06	0.27	0.22
9	0.40	0.11	-0.04	-0.16	9	0.55	0.18	0.18	0.10
24	-0.21	0.24	0.18	-0.03	24	0.10	0.46	0.34	0.29
30	-0.05	-0.24	0.05	0.19	26	0.22	0.49	0.16	0.14
2	0.55	-0.12	-0.16	0.20	30	0.23	0.03	0.32	0.46
26	-0.05	0.33	0.01	-0.10	2	0.59	0.10	0.08	0.32
	1= Lack of Attention					3= Basic Provisions of Care			
						2= Emotional			
						4= Physical Needs			

Note. See Table 33 for a complete listing of items.

Table 25

Pattern and Structure Matrixes for Interpretable Factors With Respect to Frequency, Ages 8-11.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
3	0.83	-0.01	0.18	-0.08	3	0.84	0.18	0.32	0.14
1	0.76	0.05	-0.27	-0.18	1	0.73	0.13	-0.06	-0.03
4	0.75	0.00	0.20	-0.11	5	0.72	0.30	0.25	0.51
7	0.68	0.05	0.07	0.10	7	0.72	0.21	0.29	0.25
5	0.62	0.08	-0.06	0.32	4	0.67	0.07	0.19	0.00
27	-0.09	0.81	0.15	0.08	27	0.05	0.76	0.24	0.14
25	0.20	0.70	0.05	-0.02	25	0.37	0.75	0.27	0.16
23	0.07	0.63	-0.08	0.11	23	0.20	0.66	0.21	0.19
26	0.11	0.58	-0.19	0.11	26	0.29	0.66	0.05	0.30
19	0.01	0.47	0.28	-0.31	19	0.15	0.59	0.48	-0.10
16	0.05	0.02	1.01	0.00	16	0.24	0.19	0.86	0.23
17	-0.01	0.08	0.95	0.04	17	0.17	0.24	0.85	0.23
15	0.21	0.07	0.69	0.07	15	0.39	0.28	0.79	0.27
14	-0.07	-0.17	0.40	0.14	13	0.18	0.09	0.65	0.15
11	0.01	0.02	-0.21	0.02	14	0.18	0.12	0.61	0.39
12	-0.11	-0.01	-0.12	-0.02	20	0.13	0.23	0.49	-0.05
18	0.11	-0.15	0.16	0.16	11	0.19	0.26	0.28	0.18
13	-0.04	-0.17	0.31	-0.04	12	0.04	0.20	0.28	0.11
20	0.06	0.12	0.23	-0.09	18	0.27	0.12	0.51	0.33
28	-0.16	0.07	-0.04	0.89	28	-0.03	0.14	0.19	0.77
29	-0.01	0.48	-0.04	0.54	8	0.19	0.01	0.39	0.67
8	-0.07	-0.15	0.27	0.54	29	0.21	0.53	0.19	0.60
6	0.22	0.04	0.19	0.44	6	0.43	0.23	0.42	0.60
22	0.05	-0.02	-0.25	0.27	21	0.06	0.27	0.39	0.01
21	-0.08	0.11	0.01	-0.11	22	0.10	0.09	0.18	0.24
30	-0.14	-0.03	0.05	0.09	30	0.21	0.24	0.37	0.42
2	0.28	-0.06	-0.12	-0.29	2	0.47	0.16	0.14	0.06
24	-0.30	0.48	0.14	-0.13	24	0.03	0.63	0.34	0.17
10	-0.09	0.23	-0.11	0.20	10	0.15	0.31	0.19	0.29
9	0.44	-0.04	-0.08	-0.10	9	0.58	0.08	0.11	0.11
	1= Lack of Attention				2= Emotional				
					3= Basic Provisions of Care				
					4= Neglect				

Note. See Table 33 for a complete listing of items.

Table 26

Pattern and Structure Matrixes for Interpretable Factors With Respect to Frequency, Ages 12-18.

Item #	Pattern Matrix			Item #	Structure Matrix		
	1	2	3		1	2	3
3	0.85	-0.08	0.10	3	0.84	0.11	0.20
1	0.74	0.04	-0.27	1	0.75	0.17	-0.19
7	0.71	0.01	0.08	5	0.74	0.07	0.30
4	0.71	0.01	0.00	7	0.71	0.08	0.17
5	0.69	-0.01	0.23	4	0.67	0.10	0.05
2	0.48	0.08	-0.29	2	0.64	0.26	-0.05
27	-0.07	0.77	-0.13	27	0.08	0.74	0.09
25	0.09	0.70	0.07	25	0.33	0.70	0.19
26	0.12	0.60	0.08	19	0.17	0.61	0.40
19	0.05	0.48	0.14	24	0.09	0.60	0.19
12	-0.02	0.02	0.88	26	0.31	0.57	0.12
15	0.12	0.01	0.55	12	0.06	0.13	0.79
14	0.01	-0.02	0.54	15	0.30	0.15	0.71
16	0.03	0.13	-0.06	14	0.19	0.08	0.66
17	0.08	0.09	0.00	16	0.21	0.18	0.29
8	-0.17	-0.17	-0.22	17	0.22	0.17	0.36
22	-0.02	0.01	-0.23	21	0.04	0.08	0.42
21	-0.04	-0.10	0.17	20	0.15	0.11	0.33
20	0.11	-0.08	0.03	22	0.04	0.12	0.03
10	-0.01	0.11	0.03	10	0.24	0.21	0.08
9	0.27	-0.02	0.01	9	0.45	0.08	0.03
11	-0.09	0.09	0.50	11	0.09	0.24	0.56
13	-0.02	-0.22	0.36	13	0.19	-0.04	0.50
30	-0.03	0.11	0.05	30	0.29	0.23	0.27
24	-0.22	0.54	-0.01	18	0.16	0.03	0.43
18	-0.04	-0.09	0.27	8	0.10	-0.16	0.01
29	0.05	0.18	-0.07	28	-0.06	-0.02	0.22
28	-0.19	0.00	-0.01	29	0.14	0.21	0.20
23	-0.08	0.48	0.09	6	0.34	0.00	0.18
6	0.16	-0.04	-0.07	23	0.11	0.44	0.19
1= Lack of Attention			2= Emotional		3= Physical Needs		

Note. See Table 33 for a complete listing of items.

Table 27

Pattern and Structure Matrixes for Interpretable Factors With Respect to Frequency, Special Needs.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
4	0.77	0.14	0.20	0.11	4	0.82	0.27	0.39	0.31
3	0.77	-0.01	0.06	-0.10	3	0.81	0.17	0.31	0.10
1	0.73	-0.03	-0.02	0.02	1	0.74	0.13	0.20	0.19
2	0.61	0.17	-0.28	-0.41	7	0.62	0.28	0.49	0.12
7	0.52	0.10	0.35	-0.08	2	0.55	0.34	-0.06	-0.20
17	0.08	0.95	0.03	0.04	17	0.26	0.91	0.29	0.21
16	0.12	0.90	-0.10	0.15	16	0.30	0.86	0.22	0.31
15	-0.17	0.45	0.02	0.30	15	0.05	0.57	0.27	0.40
28	0.01	-0.14	0.69	0.03	28	0.22	0.10	0.75	0.20
14	-0.12	0.24	0.66	-0.04	6	0.42	0.19	0.70	0.20
13	0.10	0.16	0.63	0.14	13	0.31	0.48	0.68	0.35
6	0.22	-0.03	0.57	0.04	14	0.07	0.50	0.64	0.17
29	0.17	-0.13	0.51	0.44	5	0.59	0.15	0.64	0.09
5	0.45	-0.11	0.48	-0.12	29	0.37	0.13	0.63	0.58
27	-0.13	0.28	-0.16	0.73	27	0.13	0.38	0.19	0.75
23	-0.07	-0.06	0.25	0.61	23	0.18	0.21	0.45	0.69
25	0.01	0.03	0.19	0.53	25	0.26	0.24	0.47	0.65
20	0.02	0.05	-0.06	0.49	20	0.17	0.37	0.11	0.58
22	-0.07	-0.22	-0.01	0.05	21	0.29	0.49	0.37	0.34
21	0.05	0.08	0.07	0.14	22	0.13	0.21	0.26	0.20
19	0.17	0.18	-0.19	0.39	19	0.36	0.51	0.16	0.53
18	-0.32	0.36	0.08	-0.21	18	-0.07	0.58	0.35	-0.05
12	-0.07	-0.10	0.25	-0.10	12	0.05	0.26	0.30	0.05
11	0.13	-0.06	-0.11	0.17	11	0.28	0.23	0.16	0.26
26	0.09	-0.21	-0.07	0.21	26	0.25	0.07	0.26	0.35
24	0.05	0.27	0.08	0.19	24	0.22	0.41	0.36	0.39
30	0.06	-0.04	0.31	-0.11	30	0.30	0.30	0.60	0.13
9	0.18	-0.02	-0.10	0.19	9	0.40	0.08	0.29	0.20
8	0.00	0.38	0.19	-0.10	8	0.23	0.36	0.48	-0.02
10	-0.08	-0.18	0.20	0.13	10	0.16	0.11	0.44	0.18
	1= Lack of Attention					2= Basic Provisions of Care			
						3= Supplemental Care			
						4= Emotional			

Note. See Table 33 for a complete listing of items.

Table 28

Pattern and Structure Matrixes for Interpretable Factors With Respect to Perception of Harm, Ages 0-2.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
20	0.79	0.01	-0.13	-0.14	19	0.76	0.40	0.20	0.50
16	0.72	-0.23	-0.08	0.18	16	0.69	0.09	0.16	0.31
22	0.72	0.15	-0.36	0.08	20	0.67	0.16	0.02	0.12
19	0.71	0.07	-0.05	0.26	17	0.67	0.16	0.23	0.17
17	0.68	-0.09	-0.01	-0.13	22	0.67	0.33	-0.09	0.33
21	0.62	-0.02	0.17	-0.13	18	0.57	0.43	0.40	0.28
15	0.40	0.05	0.26	-0.07	15	0.44	0.22	0.38	0.13
2	-0.16	0.86	0.10	-0.17	27	0.18	0.74	0.08	0.35
27	-0.05	0.80	-0.17	0.02	2	0.04	0.74	0.20	0.21
25	0.09	0.70	-0.12	0.02	25	0.31	0.69	0.13	0.36
23	0.12	0.64	0.00	-0.09	23	0.40	0.67	0.26	0.32
3	-0.12	0.47	-0.10	0.35	3	0.16	0.65	0.15	0.61
11	-0.17	0.02	0.87	-0.08	11	0.06	0.22	0.80	0.14
10	-0.01	-0.14	0.82	0.09	10	0.23	0.18	0.76	0.28
12	-0.22	-0.13	0.74	0.05	12	-0.01	0.09	0.68	0.16
24	0.01	0.27	0.35	0.09	24	0.36	0.47	0.57	0.36
6	-0.02	-0.11	0.04	0.87	30	0.40	0.41	0.56	0.21
4	0.10	-0.13	-0.02	0.74	6	0.24	0.32	0.20	0.82
7	0.01	0.37	-0.03	0.58	4	0.39	0.31	0.28	0.76
8	0.10	0.04	0.03	0.51	8	0.34	0.41	0.28	0.67
29	-0.02	0.13	0.02	0.10	7	0.18	0.53	0.08	0.61
28	0.19	0.17	0.18	-0.17	29	0.03	0.21	-0.03	0.23
9	0.06	0.02	0.31	0.40	28	0.14	0.18	0.06	0.03
14	0.10	-0.15	0.23	-0.02	9	0.23	0.28	0.29	0.47
13	0.27	-0.07	0.12	0.10	14	0.15	0.05	0.33	0.13
18	0.42	0.21	0.08	-0.12	13	0.41	0.24	0.35	0.36
1	-0.18	0.36	0.10	0.00	1	-0.02	0.42	0.25	0.23
26	-0.14	0.06	-0.07	-0.05	26	0.11	0.13	0.12	0.13
5	0.09	-0.02	0.06	0.26	5	0.31	0.30	0.30	0.46
30	0.16	0.29	0.34	-0.05	21	0.51	0.17	0.22	0.11
1= Basic Provisions of Care						2= Lack of Attention		3= Supervision	
								4= Supplemental Care	

Note. See Table 33 for a complete listing of items.

Table 29

Pattern and Structure Matrixes for Interpretable Factors With Respect to Perception of Harm, Ages 3-7.

Pattern Matrix					Structure Matrix				
Item #	1	2	3	4	Item #	1	2	3	4
20	0.86	-0.03	0.17	-0.13	20	0.81	0.22	0.29	0.16
21	0.78	-0.04	-0.13	0.17	19	0.75	0.27	0.26	0.28
19	0.73	-0.06	0.07	-0.02	21	0.74	0.18	0.00	0.44
16	0.71	0.04	-0.13	-0.17	22	0.72	0.13	0.21	0.21
22	0.69	-0.18	0.03	0.00	16	0.67	0.26	0.10	0.13
17	0.55	0.10	0.17	-0.01	17	0.63	0.35	0.34	0.18
11	-0.19	0.86	-0.19	-0.04	10	0.36	0.74	0.23	0.34
10	0.12	0.75	-0.01	0.10	11	0.01	0.72	0.11	0.19
14	-0.12	0.64	0.00	-0.25	8	0.24	0.67	0.48	0.29
13	0.18	0.54	-0.16	0.37	14	-0.01	0.62	0.22	-0.04
9	0.15	0.47	0.05	-0.08	9	0.40	0.56	0.36	0.16
8	-0.04	0.44	0.23	0.11	30	0.26	0.55	0.32	0.43
30	-0.02	0.39	0.07	0.21	13	0.33	0.53	-0.02	0.44
29	0.02	-0.05	1.02	0.06	29	0.11	0.22	0.85	0.06
28	0.04	-0.09	0.91	0.01	28	0.14	0.17	0.83	0.06
26	0.07	-0.14	0.55	-0.07	26	0.19	0.10	0.55	0.05
3	-0.13	-0.12	0.04	0.80	3	0.20	0.19	0.18	0.80
1	-0.05	0.07	0.03	0.70	1	0.28	0.30	0.15	0.71
7	0.14	0.02	-0.13	-0.11	7	0.29	0.24	0.21	0.15
2	-0.02	-0.02	0.05	0.30	2	0.08	0.09	0.16	0.41
6	-0.06	0.13	0.23	0.24	6	0.21	0.43	0.45	0.36
25	-0.08	-0.03	-0.27	0.04	25	0.25	0.17	0.15	0.26
23	0.02	-0.01	0.11	0.28	23	0.35	0.25	0.37	0.47
27	-0.04	-0.07	0.31	-0.13	27	0.16	0.20	0.56	0.09
24	0.12	0.01	0.06	0.09	24	0.18	0.20	0.18	0.36
12	-0.01	0.42	0.08	-0.26	12	-0.08	0.35	0.18	0.01
4	0.09	0.01	-0.24	0.03	4	0.37	0.30	0.12	0.26
5	0.01	-0.08	-0.09	0.44	5	0.20	0.22	0.06	0.56
15	0.40	-0.08	-0.16	0.03	15	0.40	0.12	0.04	0.19
18	0.04	0.26	0.12	0.13	18	0.32	0.51	0.41	0.31
1= Basic Provisions of Care					2= Physical Needs				
					3= Neglect				
					4= Lack of Attention				

Note. See Table 33 for a complete listing of items.

Table 30

Pattern and Structure Matrixes for Interpretable Factors With Respect to Perception of Harm, Ages 8-11.

Item #	Pattern Matrix			Item #	Structure Matrix		
	1	2	3		1	2	3
20	0.81	0.19	0.09	20	0.78	0.39	0.28
21	0.80	-0.18	-0.24	16	0.74	0.30	0.39
15	0.77	-0.22	0.01	15	0.73	0.14	0.22
22	0.68	0.28	-0.22	21	0.71	0.18	0.05
16	0.64	-0.06	0.19	19	0.70	0.34	0.37
17	0.63	0.03	0.00	17	0.70	0.35	0.24
19	0.63	0.03	0.16	22	0.66	0.46	0.06
26	-0.14	0.88	0.04	27	0.27	0.77	0.26
27	-0.08	0.81	0.08	23	0.42	0.71	0.19
23	0.13	0.59	-0.08	26	0.15	0.70	0.13
25	0.11	0.53	0.36	25	0.43	0.68	0.56
28	0.01	0.46	-0.28	29	0.43	0.59	0.22
29	0.08	0.39	-0.05	28	0.33	0.58	-0.01
4	0.04	-0.03	0.88	4	0.23	0.14	0.81
3	-0.11	0.09	0.73	3	0.28	0.37	0.81
6	0.02	-0.16	-0.20	5	0.38	0.40	0.43
2	-0.12	-0.04	0.05	6	0.25	0.22	0.10
5	0.08	0.03	0.15	2	0.21	0.29	0.29
7	0.04	-0.03	0.46	7	0.33	0.32	0.64
1	-0.03	-0.06	0.40	1	0.28	0.26	0.55
14	0.01	0.06	-0.09	14	0.27	0.23	0.03
8	0.02	0.07	0.29	8	0.32	0.32	0.41
30	-0.06	0.24	-0.08	30	0.31	0.44	0.12
18	0.42	-0.03	0.02	18	0.58	0.27	0.21
10	0.01	-0.03	-0.01	10	0.12	0.08	0.05
9	-0.08	0.10	0.48	11	0.17	0.22	-0.03
11	-0.10	0.04	-0.18	9	0.23	0.35	0.60
12	-0.01	-0.19	0.13	12	0.23	0.03	0.19
24	0.04	0.36	0.06	24	0.32	0.47	0.24
13	0.25	-0.09	0.30	13	0.50	0.24	0.44
1= Basic Provisions of Care				2= Emotional		3= Lack of Attention	

Note. See Table 33 for a complete listing of items.

Table 31

Pattern and Structure Matrixes for Interpretable Factors With Respect to Perception of Harm, Ages 12-18.

Item #	Pattern Matrix				Item #	Structure Matrix			
	1	2	3	4		1	2	3	4
20	0.89	-0.02	0.12	-0.02	20	0.81	0.14	0.37	0.26
21	0.81	0.02	0.01	-0.02	16	0.75	0.16	0.30	0.30
19	0.76	0.26	-0.01	-0.04	19	0.74	0.31	0.27	0.19
17	0.65	0.01	-0.27	0.21	17	0.74	0.21	0.17	0.41
16	0.62	-0.07	0.01	0.05	18	0.71	0.13	0.39	0.30
18	0.62	0.02	0.12	0.06	21	0.70	0.09	0.25	0.18
15	0.57	-0.10	-0.07	-0.16	15	0.70	0.15	0.23	0.19
7	0.19	0.83	0.05	-0.20	1	0.13	0.75	0.26	0.18
1	-0.03	0.80	0.05	-0.02	3	0.12	0.74	0.29	0.40
3	-0.12	0.60	0.05	0.18	7	0.24	0.73	0.22	0.03
2	0.02	0.58	0.14	0.17	5	0.19	0.70	0.32	0.29
5	-0.06	0.56	0.06	-0.02	4	0.13	0.60	0.01	0.13
4	0.10	0.56	-0.15	-0.03	2	0.19	0.54	0.32	0.28
28	0.02	0.13	0.87	-0.10	28	0.29	0.32	0.85	0.31
30	0.03	0.06	0.63	-0.15	27	0.17	0.30	0.69	0.46
27	-0.16	0.02	0.62	0.13	29	0.47	0.14	0.69	0.41
29	0.19	-0.09	0.59	0.14	30	0.36	0.32	0.68	0.26
26	0.00	-0.13	-0.13	0.90	26	0.25	0.09	0.26	0.82
23	0.05	-0.02	-0.03	0.80	25	0.33	0.50	0.47	0.77
25	0.06	0.29	0.05	0.61	23	0.29	0.20	0.32	0.76
24	-0.04	-0.06	0.35	0.53	24	0.16	0.14	0.52	0.63
12	-0.09	0.18	-0.08	0.01	12	0.11	0.19	0.11	0.17
11	0.04	-0.02	0.07	-0.04	11	0.20	0.04	0.16	0.12
10	-0.05	-0.21	-0.01	0.07	10	0.05	-0.05	-0.04	0.06
9	0.02	0.47	-0.14	-0.01	9	0.11	0.55	0.00	0.11
14	0.09	-0.19	0.13	-0.01	14	0.38	0.13	0.33	0.31
13	0.04	0.11	0.25	-0.01	13	0.31	0.36	0.41	0.32
6	0.00	0.13	-0.05	0.14	6	0.24	0.23	0.18	0.21
8	-0.14	0.14	0.11	-0.08	8	0.18	0.37	0.24	0.14
22	0.38	-0.15	0.09	0.08	22	0.49	0.15	0.32	0.34
1= Basic Provisions of Care						2= Lack of Attention		3= Neglect	
								4= Emotional	

Note. See Table 33 for a complete listing of items.

Table 32

Pattern and Structure Matrixes for Interpretable Factors With Respect to Perception of Harm, Special Needs.

Item #	Pattern Matrix			Item #	Structure Matrix		
	1	2	3		1	2	3
20	0.88	0.01	-0.07	20	0.82	0.44	0.27
19	0.84	-0.12	-0.07	19	0.75	0.33	0.23
16	0.74	-0.03	-0.09	16	0.74	0.36	0.23
21	0.70	-0.16	0.09	17	0.73	0.42	0.31
15	0.70	-0.14	-0.08	15	0.62	0.19	0.20
17	0.64	0.17	0.00	21	0.60	0.20	0.31
22	0.45	0.11	0.07	18	0.60	0.57	0.54
18	0.30	0.30	0.26	22	0.51	0.36	0.24
28	0.01	0.83	-0.32	28	0.38	0.75	0.12
29	-0.07	0.74	0.01	29	0.31	0.72	0.34
27	-0.12	0.69	-0.17	27	0.20	0.68	0.14
23	0.05	0.60	0.13	25	0.27	0.66	0.52
25	-0.07	0.59	0.32	23	0.34	0.62	0.36
30	0.18	0.39	0.06	30	0.45	0.53	0.34
4	-0.04	-0.14	0.83	5	0.36	0.46	0.77
1	-0.11	-0.08	0.77	4	0.27	0.32	0.77
3	-0.05	-0.08	0.71	1	0.16	0.11	0.69
5	0.01	0.10	0.71	3	0.20	0.26	0.66
11	-0.10	0.05	-0.07	11	0.13	0.13	0.18
14	-0.05	0.06	-0.05	14	0.19	0.18	0.18
12	-0.03	-0.20	0.03	13	0.56	0.38	0.45
13	0.30	0.06	0.14	12	0.02	-0.07	0.15
9	0.07	0.12	0.04	7	0.23	0.34	0.21
7	0.16	0.23	-0.08	9	0.19	0.24	0.23
2	-0.09	0.43	0.19	2	0.13	0.45	0.37
6	-0.05	0.06	0.11	6	0.18	0.33	0.27
8	0.08	-0.04	0.27	8	0.37	0.32	0.42
10	0.03	-0.10	0.05	10	0.18	-0.02	0.12
26	-0.09	0.19	0.02	26	0.16	0.26	0.08
24	0.15	0.06	0.14	24	0.28	0.38	0.28
1 = Basic Provisions of Care				2 = Emotional and Educational		3 = Lack of Attention	

Note. See Table 33 for a complete listing of items.

Table 33

Complete Listing of Factor Analysis Items.

Item #	Item
1	Child has access to toxins.
2	Child has access to weapons.
3	Child has access to sharp objects.
4	Child has access to small objects.
5	Child has access to electrical hazards.
6	The home has inadequate heating or cooling for the current weather conditions.
7	The home is ill equipped to prevent unauthorized entry or exit of people or animals
8	Unsanitary living conditions are present in the home.
9	A child is left unsupervised for several minutes.
10	A child is left unsupervised for several hours.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
13	A child is left in the care of someone who is inappropriate or incompetent.
14	The child is not provided with or does not have access to food.
15	The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
16	A child has inadequate hygiene.
17	A child does not have adequate clothing.
18	A child has an illness, injury, or medical condition that is not being treated.
19	A child has pre-existing medical condition requiring treatment and the caretaker allows necessary medical insurance coverage (i.e. Medicaid or private medical insurance) to lapse.
20	A child needs mental health services or medication for a psychological problem and is not receiving these services.
21	A child is exposed to criminal activity.
22	A child is exposed to domestic violence.
23	There is a lack of communication and or contact between the caretaker and child.
24	A caretaker abandons or rejects the child.
25	A caretaker shows preferential treatment for other children in the home.
26	A child is exhibiting inadequate physical growth.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
28	A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
29	A caretaker is unresponsive to a child's educational needs.
30	A caretaker does not provide shelter for his or her child.

Table 34

Item Pool With Respect to Substantiation .

Item #	General
2	Child has access to weapons.
7	The home is ill equipped to prevent unauthorized entry or exit of people or animals.
17	A child does not have adequate clothing
19	A child has pre-existing medical condition requiring treatment and the caretaker allows necessary medical insurance coverage (i.e. Medicaid or private medical insurance) to lapse.
20	A child needs mental health services or medication for a psychological problem and is not receiving these services.
<i>Ages 0-2</i>	
3	Child has access to sharp objects.
4	Child has access to small objects.
5	Child has access to electrical hazards.
14	The child is not provided with or does not have access to food.
16	A child has inadequate hygiene.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
26	A child is exhibiting inadequate physical growth.
28	A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
29	A caretaker is unresponsive to a child's educational needs.
<i>Ages 3-7</i>	
3	Child has access to sharp objects.
4	Child has access to small objects.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
14	The child is not provided with or does not have access to food.
15	The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
16	A child has inadequate hygiene.
18	A child has an illness, injury, or medical condition that is not being treated.
21	A child is exposed to criminal activity.
<i>Ages 8-11</i>	
5	Child has access to electrical hazards.
15	The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
16	A child has inadequate hygiene.
18	A child has an illness, injury, or medical condition that is not being treated.
21	A child is exposed to criminal activity.
24	A caretaker abandons or rejects the child
29	A caretaker is unresponsive to a child's educational needs.

Ages 12-18

- 3 Child has access to sharp objects.
- 4 Child has access to small objects.
- 15 The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
- 21 A child is exposed to criminal activity.
- 22 A child is exposed to domestic violence.

Special Needs

- 3 Child has access to sharp objects.
 - 4 Child has access to small objects.
 - 9 A child is left unsupervised for several minutes.
 - 15 The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
 - 16 A child has inadequate hygiene.
 - 18 A child has an illness, injury, or medical condition that is not being treated.
 - 21 A child is exposed to criminal activity.
 - 22 A child is exposed to domestic violence.
 - 27 A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
-

Table 35

Item Pool With Respect to Frequency.

Item #	General
1	Child has access to toxins.
3	Child has access to sharp objects.
4	Child has access to small objects.
5	Child has access to electrical hazards.
7	The home is ill equipped to prevent unauthorized entry or exit of people or animals.
15	The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
<i>Ages 0-2</i>	
6	The home has inadequate heating or cooling for the current weather conditions.
9	A child is left unsupervised for several minutes.
10	A child is left unsupervised several hours.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
13	A child is left in the care of someone who is inappropriate or incompetent.
14	The child is not provided with or does not have access to food.
16	A child has inadequate hygiene.
17	A child does not have adequate clothing.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
<i>Ages 3-7</i>	
2	Child has access to weapons.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
14	The child is not provided with or does not have access to food.
16	A child has inadequate hygiene.
17	There is a lack of communication and or contact between the caretaker and child.
<i>Ages 8-11</i>	
16	A child has inadequate hygiene.
17	A child does not have adequate clothing.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
26	A child is exhibiting inadequate physical growth.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.

Item #	<i>Ages 12-18</i>
2	Child has access to weapons.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
14	The child is not provided with or does not have access to food.
19	A child has pre-existing medical condition requiring treatment and the caretaker allows necessary medical insurance coverage (i.e. Medicaid or private medical insurance) to lapse.
23	There is a lack of communication and or contact between the caretaker and child.
24	A caretaker abandons or rejects the child
25	A caretaker shows preferential treatment for other children in the home.
26	A child is exhibiting inadequate physical growth.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.

	<i>Special Needs</i>
2	Child has access to weapons.
6	The home has inadequate heating or cooling for the current weather conditions.
13	A child is left in the care of someone who is inappropriate or incompetent.
14	The child is not provided with or does not have access to food.
16	A child has inadequate hygiene.
17	A child does not have adequate clothing.
20	A child needs mental health services or medication for a psychological problem and is not receiving these services.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
28	A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
29	A caretaker is unresponsive to a child's educational needs.

Table 36

Item Pool With Respect to Harm.

Item #	General
17	A child does not have adequate clothing.
19	A child has pre-existing medical condition requiring treatment and the caretaker allows necessary medical insurance coverage (i.e. Medicaid or private medical insurance) to lapse.
20	A child needs mental health services or medication for a psychological problem and is not receiving these services.
21	A child is exposed to criminal activity.
<i>Ages 0-2</i>	
2	Child has access to weapons.
3	Child has access to sharp objects.
10	A child is left unsupervised several hours.
11	A child is left unsupervised overnight.
12	A child is left unsupervised for several days.
16	A child has inadequate hygiene.
22	A child is exposed to domestic violence.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
<i>Ages 3-7</i>	
16	A child has inadequate hygiene.
22	A child is exposed to domestic violence.
26	A child is exhibiting inadequate physical growth.
28	A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
29	A caretaker is unresponsive to a child's educational needs.
<i>Ages 8-11</i>	
3	Child has access to sharp objects.
4	Child has access to small objects.
9	A child is left unsupervised for several minutes.
15	The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
16	A child has inadequate hygiene.
22	A child is exposed to domestic violence.
23	There is a lack of communication and or contact between the caretaker and child.
25	A caretaker shows preferential treatment for other children in the home.
26	A child is exhibiting inadequate physical growth.
27	A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.

Item #

Ages 12-18

- 1 Child has access to toxins.
- 2 Child has access to weapons.
- 3 Child has access to sharp objects.
- 4 Child has access to small objects.
- 5 Child has access to electrical hazards.
- 7 The home is ill equipped to prevent unauthorized entry or exit of people or animals.
- 15 The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
- 16 A child has inadequate hygiene.
- 18 A child has an illness, injury, or medical condition that is not being treated.
- 23 There is a lack of communication and or contact between the caretaker and child.
- 24 A caretaker abandons or rejects the child
- 25 A caretaker shows preferential treatment for other children in the home.
- 26 A child is exhibiting inadequate physical growth.
- 27 A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
- 28 A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
- 29 A caretaker is unresponsive to a child's educational needs.
- 30 A caretaker does not provide shelter for his or her child.

Special Needs

- 1 Child has access to toxins.
- 3 Child has access to sharp objects.
- 4 Child has access to small objects.
- 5 Child has access to electrical hazards.
- 15 The child is not provided with, or does not have access to, food or liquid that provides adequate nutritional value.
- 16 A child has inadequate hygiene.
- 23 There is a lack of communication and or contact between the caretaker and child.
- 25 A caretaker shows preferential treatment for other children in the home.
- 27 A caretaker is unaware of the child's social and of emotional needs or fails to meet these needs.
- 28 A child's school attendance is not in accordance with state law, or they are not receiving an approved home based education.
- 29 A caretaker is unresponsive to a child's educational needs.

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VITA

Graduate College
University of Nevada, Las Vegas

Stephanie Ann Stowman

Local Address:

698 S. Racetrack Rd. #324
Henderson, NV 89015

Degrees:

Bachelor of Science, Psychology and Political Science, 2002
Northern Arizona University

Special Honors and Awards:

Phi Kappa Phi National Honor Society
Golden Key International Honor Society
Psi Chi National Honor Society
Arizona Board of Regents Scholarship
Northern Arizona University Year of Literature Award
University of Nevada, Las Vegas Graduate and Professional Student Association Grant
University of Nevada, Las Vegas Graduate Student Research Forum First Place Poster Award
Nevada State Psychological Association Third Place Poster Award
American Psychological Association of Graduate Students (APAGS) Southern Nevada State Advocacy Coordinator
University of Nevada, Las Vegas Graduate College Summer Scholarship
2005 American Psychological Association Convention Division 37 Poster Award

Publications:

Donohue, B., & Stowman, S. (2005). Behavioral rehearsal. In M. Hersen (Ed.), *Encyclopedia of behavior modification and therapy: Volume II*. Thousand Oaks, CA: Sage.

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Stowman, S., & Donohue, B. (2005). Assessing child neglect: A review of standardized measures. *Aggression and Violent Behavior*, 10, 491-512.

Thesis Title: Relevance of Age and Special Needs in Initial Development Phases of a Child Neglect Scale

Thesis Examination Committee:

Chairperson, Dr. Christopher Kearney, Ph.D.

Committee Member, Dr. Ned Silver, Ph.D.

Committee Member, Dr. Jennifer Skeem, Ph.D.

Graduate Faculty Representative, Dr. Jennifer Keene, Ph.D.