

National Survey of Child and Adolescent Well-Being

No. 18: Instability and Early Life Changes Among Children in the Child Welfare System



Findings from the NSCAW Study

research brief

The youngest children are the most vulnerable to child maltreatment. They are also the most vulnerable to the effects of caregiver and placement instability given their need for consistent and sensitive caregiving to thrive, survive, and have a healthy development. More than one third (34.0%) of all 2010 victims and 79.4% of the children who died as a result of child abuse and neglect were younger than 4 years old.¹ To protect vulnerable children from further harm, some children are placed in out-of-home care. Among children entering foster care in 2010, 48% were aged birth to 5 years old, with 16% younger than 1 year old.² Infants who entered out-of-home care spent 50% more time in out-of-home care than older children—the youngest infants (0 to 2 months old) spent 33% more time in care than infants who entered care from ages 3 to 12 months old.³ The reasons for placement included the most severe neglect and physical maltreatment, abandonment, and a high risk for maltreatment to reoccur.

Interventions that result in changes in the child's primary caregiver disrupt children's attachments and can subsequently generate trauma due to the loss of their primary relationships. Attachment refers to the infant's or young child's emotional connection to an adult caregiver (an attachment figure). A securely attached child develops trust in his or her caregiver and uses this relationship as a base from which to explore, and as a safe haven to which to return when needing comfort, support, nurturance, or protection.⁴ Infants are "hard-wired" to become attached to preferred caregivers, expecting to be cared for by a capable caregiver who can ensure survival. A secure attachment relationship with a caregiver aids in the child's development of emotion regulation and self-confidence, allowing him or her to learn to function autonomously and competently.^{5,6} In contrast, insecure and avoidant attachment have been associated with emotional and internalized problems, whereas avoidant, resistant, and most especially, disorganized attachment have been associated with externalizing problems,⁷ as well as subsequent child psychopathology.⁸

Maltreated children who are removed from their primary caregivers and placed with new caregivers or foster parents must form new attachments. Infants may have already experienced difficult and harsh rearing conditions that make even more challenging their task of resolving and/or repairing attachments to their biological parents while developing new attachments to new caregivers. Subsequent attachment relationships are less likely to be secure and more likely to be insecure or disorganized, compromising the ability of the child to establish healthy relationships and achieve the developmental processes necessary for adaptation.⁹ Infants placed in foster care after being maltreated exhibit behaviors like avoidance, rejection, and opposition to care by new caregivers, pushing away foster parents even when they are distressed.¹⁰ Even responsive foster parents tend to provide little nurturance to children who appear not to need it.¹¹⁻¹³ Once the child and caregiver enter a negative cycle of interactions, there is the risk of foster parents returning the child to the child welfare system (CWS) and the child having subsequent placements with more caregivers. Placement instability among young children adopted after multiple foster placements has been associated with deficits in inhibitory control and more externalizing, oppositional, and aggressive behaviors compared to both adopted children who had experienced one stable placement and children never placed in foster or adoptive care.¹⁴

Thus, multiple changes of caregivers threaten the child's developing ability to maintain trust in the attachment relationships, shattering the developmental expectation that the caregiver will be reliably available as a protection from danger. These expectations may generate a host of negative developmental outcomes including hypervigilance, difficulties in concentrating, recurring traumatic play and nightmares, and constriction of the child's motivation to play, explore, and learn from the physical and interpersonal environment.^{15, 16}

Purpose of the Brief

This brief describes the experience of instability in caregivers and households among young children in the CWS, including children who are placed out of home and children who remain in-home with their families following investigation. The brief addresses the following questions:

- To what extent do infants involved in a maltreatment investigation experience changes in caregivers and households lasting 1 week or longer?
- How many changes in caregivers and households occur during the first 2 years of life and up to the time that children enter the school system for children involved in a maltreatment investigation experience as infants?
- What are the characteristics of these children and their families of origin at the time they were reported to the CWS?
- Are some children at increased risk for experiencing a change or for having a higher number of changes depending on the characteristics of CWS findings?

National Sample of Children Involved in Allegations of Maltreatment

This research brief uses data from the National Survey of Child and Adolescent Well-Being (NSCAW) to describe instability of caregivers and households among infants involved with the CWS. NSCAW is a national longitudinal study of the well-being of 5,501 children 14 years old or younger who were the subjects of child protective services investigations within a 15-month period starting October 1999. Children are included in the sample regardless of whether their reports of maltreatment were substantiated, and whether or not their cases were open to child welfare services. Thus, the sample includes children who remain in-home with their families of origin, as well as children who are placed in out-of-home care.

This research brief focuses on 1,196 children who were infants when they first became involved in investigations for abuse or neglect and were followed up until they were 5 to 7 years old. The data used here were collected from 1999 to 2007 and drawn from interviews of caregivers and caseworkers for all children who were 12 months or younger at baseline in the NSCAW child protective services sample.

Measures of Instability and Risk Factors

A change in a child's caregiver was counted if the child was in a new household for 7 days or more and the

original caregiver did not move to the new household with the child (e.g., if the biological mother moved with the child to a grandmother's house, even if grandmother was identified by the CWS as the new legal caregiver, this move was not counted as a change).¹⁷ We counted the child's caregiver and household at the time of the baseline interview as "0." Instability was defined as a change in the child's caregiver and household at any point after the baseline interview.¹ Information was based on reports provided by caseworkers and caregivers. When caseworkers' and caregivers' reports of placements differed by less than 1 month and were the same type of caregiver/household, they were considered to reflect the same move with priority given to the information provided by the caseworkers to determine the date of the change.

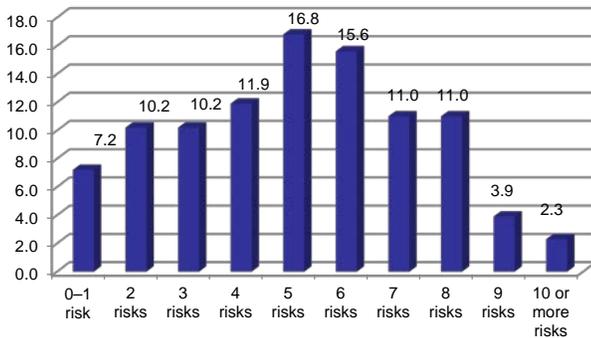
Given that the experience of disruptions in care is likely to co-occur with other stressful or traumatic events, we also examined other indicators.¹⁸ A risk index was created to represent the stressors that could have an impact on young children at the time of the maltreatment report. Fourteen risk indicators were included in the creation of the risk index. Most risk indicators concerned the primary caregiver at the time of the index maltreatment (victim of domestic violence; active abuse of substances like alcohol and/or illegal drugs; mental health problems; childhood history of abuse or neglect; poor parenting skills; arrest for any offense, incomplete high school education; and teen parent). A second set of risk factors included family instability and poverty indicators (four or more children in the household; use of homeless shelter; low social support; receipt of child support payments or income support by anyone in the household; difficulty paying for basic necessities; and high stress in the family). One risk indicator pertained to stressful situations for the child (hospitalized overnight for an injury or illness). A total risk index score was generated by scoring each risk factor as 0 (not present) or 1 (present) and adding them for a total score with a range from 0 to 14 (see Figure 1). About a quarter of children (27.6%) had a risk index score from 0 to 3, 28.7% had a risk score of 4 or 5, 26.6% had a score of 6 or 7, and 17.2% had a score of 8 or more.

¹ Placement at the time of the baseline interview was counted as the start point or "0." If at that time the child was in foster care, that placement was not counted as a change.

Characteristics of Children in the Sample

Approximately half (49.1%) of the infants reported to CWS for maltreatment were male. White children made up the largest group (43.7%), followed by Black (29.6%), Hispanic (21.3%), and “Other (5.4%) children.² At the time of the baseline interview, 26.7% of children were in out-of-home care.

Figure 1. Number of risk factors among infants at the time of the index report of maltreatment



According to caseworkers’ reports, about two thirds (63.1%) of children reported came to the CWS’s attention because of neglect (i.e., failure to provide; failure to supervise). Failure of a caregiver to provide for the child was reported for 36.1%; failure to supervise the child for 27.0%; physical abuse for 17.9%; and emotional, moral/legal, or educational abuse, or abandonment, for 8.6%. About 8.9% were reported for reasons other than abuse or neglect (e.g., for mental health or domestic violence issues). Almost half (43.2%) of these maltreatment cases were *substantiated or indicated*, meaning CWS decided that the allegations of maltreatment were valid (substantiated) or that some evidence of maltreatment existed (indicated), but not enough for substantiation.¹⁹

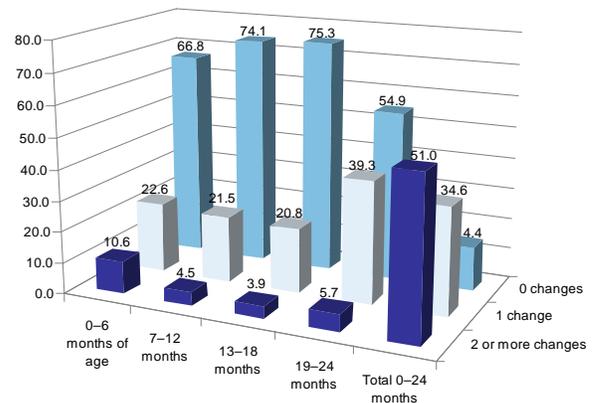
Caseworkers at the baseline interview reported the types of risks that were present in the children’s homes at the time of the investigation. For each type of risk, caseworkers responded “Yes/No.” Almost half (41.2%) of the families had a prior CWS report of maltreatment. Prior reports were assessed at the family level and do not necessarily refer to the NSCAW index maltreatment report (the report that brought the child and family into the sampling frame); therefore, the prior report may be unrelated to the NSCAW sampled child. Other risks that caseworkers identified as present in a substantial

percentage of families included stressors such as unemployment, drug use, poverty, or neighborhood violence (60.8% of families); a history of domestic violence against the primary caregiver (37.5%); trouble paying for basic necessities (35.3%); a history of abuse or neglect of the primary caregiver (33.0%); poor parenting skills (43.2%); family with low social support (30.8%); active drug abuse by the primary caregiver (28.2%); primary caregiver with serious mental health problems (24.1%); active domestic violence (21.7%); primary caregiver with a history of arrests (19.6%); active alcohol use by the primary caregiver (13.4%); and the child having major special needs (13.5%).

Instability During the First 2 Years of Life

A change in caregiver was very common in the first 2 years of life for infants reported to CWS for maltreatment. During the first 6 months of life, 33.2% of children experienced at least one change, whereas during the second 6 months of life, 25.9% experienced at least one change. From 13 to 18 months old, 24.7% of children experienced at least one change, and almost half of the children (45.1%) experienced at least one change from 19 to 24 months (see Figure 2). The bars representing “0 changes” at each 6-month period may give the impression that a fair number of children do not experience any change. However, the bar representing the number of changes that occur across the first 2 years of life provide a very different picture of instability and early life changes among children in the CWS (see last set of columns at the right of Figure 2). Overall, 85.6% of children experienced one or more changes during the first 2 years of life. More than half experienced two or more changes.

Figure 2. Number of changes during the first 2 years of life



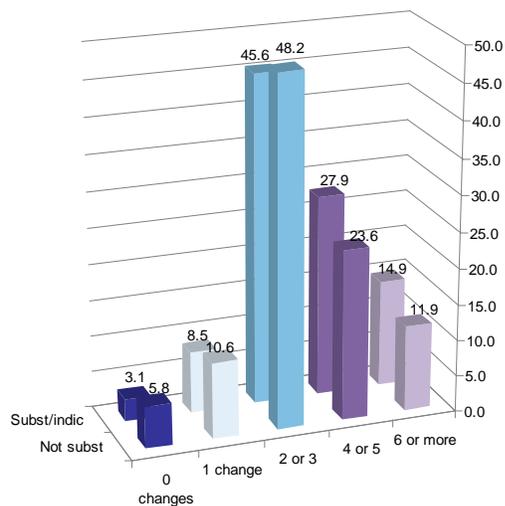
² The “Other” race ethnicity category was mostly composed of Native Americans (55.7%), and Asian/Hawaiian/Pacific Islander (30.4%).

Instability from infancy to school entrance

Of the children who were infants at the time of the report to CWS for maltreatment, 95.4% had at least one change from infancy to 5 to 7 years old; within this group, 9.7% had one change, 47.1% had two or three changes, 25.5% had four or 5 changes, and 13.2% had six or more changes.

Analysis of changes by children's gender, race/ethnicity (Black, White, Hispanic, and Other), placement setting at baseline (in-home, formal kin care, informal kin care, foster care, and group care), and substantiation/indication status of the maltreatment allegation, showed no significant differences among subgroups of children. Figure 3 shows number of changes by substantiation/indication status of the maltreatment allegation, with both groups having similar estimates.

Figure 3. Number of changes from baseline to 5–7 years follow-up by substantiated/indicated status

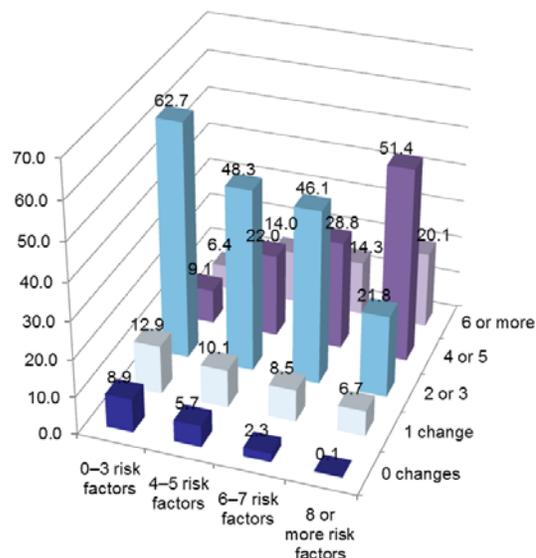


No significant differences by substantiation status in bivariate and multivariate model that controls for child's gender, race/ethnicity, and setting.

Association Between Changes and Risk Factors

As shown in Figure 4, children with a high number of risk factors at the time of the index maltreatment investigation were more likely to have multiple changes over the next 5 to 7 years. For children with three or fewer risk factors, the majority (62.7%) had two or three changes. In contrast, 21.8% of children with eight or more risk factors had only two or three changes. Approximately 36.0% of children with four or five risk factors had four or more changes, 43.1% of children with six or seven risk factors had four or more changes, and 71.5% of children with eight or more risk factors had four or more changes.

Figure 4. Number of changes from baseline to 5–7 years follow-up by number of risk factors at the time of the index maltreatment report



All comparisons between fewer number of risk factors and higher number of risk factors were statistically significant, showing that more risk factors were associated with a higher number of changes.

Summary

Overall, 85.6% of children who were infants at the time of the index maltreatment experienced at least one change of caregiver and household during their first 2 years of life. Almost 40% of children experienced four or more changes between infancy and entering the school system. Importantly, all infants who were investigated for a report of maltreatment were at high risk for instability, regardless of the substantiation status of the maltreatment report, whether the child remained in-home or was placed out of home, or the child's race/ethnicity or gender.

These levels of instability are extremely high. As a point of comparison, in a study based on 2,080 families who participated in the Early Head Start Research and Evaluation Project, the vast majority (89%) of whom were living under the poverty line, only 16% of children had a change of caregiver of a week or longer, mostly related to maternal vacations and visits to relatives (separation was rarely due to the child being removed from the home by the CWS). Early mother-child separation of a week or longer within the first 2 years of Early Head Start children's lives was related to higher levels of child negativity toward the mother (anger, hostility, or dislike toward the mother) at age 3 and

aggression at 3 and 5 years old.¹⁷ High rates of child externalizing behavior and aggression at the time of school entrance has already been reported in previous analysis of the NSCAW infants' sample;²⁰ a future analysis will explore links between children's early instability and other stressors and their social and emotional outcomes.

As described by the National Scientific Council on the Developing Child, stressful events can be harmful, tolerable, or beneficial, depending on the biological stress response of the child and how long the response lasts. Abnormally high levels of cortisol, a hormone associated with the stress response, adversely affect stress responsiveness, emotion, and memory.²¹ Tolerable stress response activates the body's alert system but if it is time limited and the child receives support from caring adults to regain stability, all organs affected by stress can recover. Toxic stress refers to strong, frequent, or prolonged activation of the body's stress management system. Toxic stress can occur in cases of child maltreatment and frequent loss of attachment figures, without adequate adult support. This harmful stress can disrupt the development of critical areas of the brain, with negative outcomes across the lifespan in poor health and cognitive impairment.²¹ Whereas many events, such as receiving an injected immunization, are somewhat stressful, changes in caregiver of a week or more can activate stress responses in young children beyond normal levels.¹⁷

Most infants reported to CWS for maltreatment described in this brief were exposed to multiple risk factors linked to toxic stress, such as physical or emotional abuse, neglect, caregiver substance abuse or mental illness, exposure to violence, and family economic hardship. Children with a higher number of risk factors were significantly more likely to have a higher number of caregiver/household changes at an age when having a stable caregiver is critical for the child's well-being and development. The repeated loss of a young child's main caregiver and the experience of caregivers who are unavailable or neglectful, can not only reach the level of toxic stress but can also be traumatic. Traumatic events are an established risk factor for numerous adverse psychological sequelae in children and adults. Studies have linked childhood traumatic event exposure to increased rates of substance abuse and dependence,²²⁻²⁴ depression,²⁴⁻²⁶ anxiety,^{25; 27} conduct problems,²⁵ schizophrenia,^{28; 29} personality disorders,^{30; 31} posttraumatic stress disorder³²⁻³⁴ and acute stress disorder,^{35; 36} suicide,^{37; 38} and unfavorable psychological adjustment to subsequent traumatic event

exposure.³⁹ These outcomes are not mutually exclusive.^{40; 41} Research has also suggested that adults with a history of recurring childhood trauma are more likely to experience increased emotion regulation difficulties and vulnerability to develop traumatic symptoms when exposed to new traumatic events.⁴²

The impact of maltreatment and instability has been recognized in federal legislation. The 2011 Child and Family Services Improvement and Innovation Act (P.L. 112-34, reauthorizing Title IV-B of the Social Security Act) includes new language that require states to develop plans for identifying and develop mental health oversight plan to "monitor and treat emotional trauma associated with a child's maltreatment and removal" (p.2).³ The new legislation supports the CWS to incorporate effective interventions for maltreated children experiencing toxic stress and trauma.⁴³

Some evidence-based programs are designed to work with children experiencing toxic stress related to maltreatment, removal, and abandonment. These interventions include *Attachment and Biobehavioral Catch-up* (ABC), a home-based approach that targets foster and high-risk birth children's dysregulation and challenging behaviors, helping parents of children aged birth to 3 years old provide nurturing, sensitive care that promotes child regulatory capabilities and attachment formation;¹⁰ the *Bucharest Early Intervention Project*, developed for institutionalized infants and toddlers in Bucharest, Romania, that includes specialized support for foster parents on infant mental health, attachment development, and management of behavioral and emotional problems;⁴⁴ and *Multidimensional Treatment Foster Care for Preschoolers* (MTFC) for children 3 to 6 years old, a family-based intervention directed at child, foster care providers, and permanent caregivers that includes intensive foster parent training and daily support, child services from a behavioral specialist, family therapy, and if necessary medication management.⁴⁵ These evidence-based approaches have been shown to improve attachment, child well-being outcomes and child welfare outcomes for children involved with the CWS.

The data presented in this research brief describe the vulnerabilities among infants reported for

³ [http://www.gahsc.org/nm/2011/pe20111017_ACYF-CB-IM-11-06%20Child%20and%20Family%20Services%20Improvement%20and%20Innovation%20Act%20\(Public%20Law%2020112-34\).pdf](http://www.gahsc.org/nm/2011/pe20111017_ACYF-CB-IM-11-06%20Child%20and%20Family%20Services%20Improvement%20and%20Innovation%20Act%20(Public%20Law%2020112-34).pdf)

maltreatment. The extent of the early experience of caregiver/household changes is several folds that of the general population of children of similar socioeconomic level. The number of caregiver/household changes that these young children in the CWS experience is very high, with more than half of children experiencing two or more changes. The profile of family characteristics provided in the brief provides a portrait of disadvantages that leaves children at high risk for negative developmental outcomes and also at higher risk of experiencing further caregiver/household changes. These data underscore the importance of national efforts to improve social-emotional outcomes for children involved in the CWS. Child welfare agencies are encouraged to recognize the risk that caregiving instability presents for developing children, to promote case planning that recognizes infants' and young children's need for consistent and sensitive caregiving, and to incorporate and implement programs and services that are stress/trauma-informed, and evidence-based.⁴⁶

References

- 1 US Department of Health and Human Services Administration for Children and Families. (2011). *Child Maltreatment 2010*.
- 2 US Department of Health and Human Services. (2011). U.S. Department of Health and Human Services, The AFCARS (Adoption and Foster Care Reporting System) Report # 18 (2010). Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.htm
- 3 Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the infants in out-of-home care? An epidemiological and developmental snapshot. from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf
- 4 Zeanah, C. H., Berlin, L. J., & Boris, N. W. (2011). Practitioner Review: Clinical applications of attachment theory and research for infants and young children. *Journal of Child Psychology and Psychiatry*, 52(8), 819-833.
- 5 Sroufe, L. A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: the roots of maladaptation and competence. *Minnesota Symposia on Child Psychology*, 16, 41-83.
- 6 Matas, L., Arend, R. A., & Sroufe, L. A. (1978). Continuity of adaptation in the second year: relationship between quality of attachment and later competence. *Child Development*, 49(3), 547-556.
- 7 Fearon, R. P., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Lapsley, A. M., & Roisman, G. I. (2010). The Significance of Insecure Attachment and Disorganization in the Development of Children's Externalizing Behavior: A Meta-Analytic Study. *Child Development*, 81(2), 435-456.
- 8 van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology*, 11(2), 225-249.
- 9 Smyke, A. T., Zeanah, C. H., Fox, N. A., Nelson, C. A., & Guthrie, D. (2010). Placement in Foster Care Enhances Quality of Attachment Among Young Institutionalized Children. *Child Development*, 81(1), 212-223.
- 10 Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., et al. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. *Journal of Social Issues*, 62(4), 767-785.
- 11 Dozier, M., Stovall, K. C., Albus, K., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*, 72, 1467-1477.
- 12 Stovall, K. C., & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for 10 foster infants. *Development and Psychopathology*, 12(2), 133-156.
- 13 Stovall-McClough, K. C., & Dozier, M. (2004). Forming attachments in foster care: Infant attachment behaviors during the first 2 months of placement. *Development and Psychopathology*, 16(2), 253-271.
- 14 Lewis, E. E., Dozier, M., Ackerman, J., & Sepulveda-Kozakowski, S. (2007). The effect of placement instability on adopted children's inhibitory control abilities and oppositional behavior. *Developmental Psychology*, 43(6), 1415-1427.
- 15 Chu, A. T., & Lieberman, A. F. (2010). Clinical Implications of Traumatic Stress from Birth to Age Five. In *Annual Review of Clinical Psychology*, Vol 6 (Vol. 6, pp. 469-494).
- 16 Lieberman, A. F., Chu, A. T., Van Horn, P., & Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology*, 23, 397-410.

- 17 Howard, K., Martin, A., Berlin, L. J., & Brooks-Gunn, J. (2011). Early mother-child separation, parenting, and child well-being in Early Head Start families. *Attachment & Human Development, 13*(1), 5-26.
- 18 National Child Traumatic Stress Network. (2011). Complex trauma in children and adolescents. Retrieved July 1, 2011, from <http://www.nctsn.org/trauma-types/complex-trauma>
- 19 DePanfilis, D., & Salus, M. K. (2003). Child Protective Services: A guide for caseworkers from http://www.ssw.umaryland.edu/faculty_and_research/bios/depanfilis/cps.pdf
- 20 Administration for Children and Families. (2008). *From early involvement with child welfare services to school entry: A 5- to 6-year follow-up of infants in the National Survey of Child and Adolescent Well-Being*. Washington, DC: Author.
- 21 National Scientific Council on the Developing Child. (2005). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3. from www.developingchild.harvard.edu
- 22 Liebschutz, J., Savetsky, J. B., Saitz, R., Horton, N. J., Lloyd-Travaglini, C., & Samet, J. H. (2002). The relationship between sexual and physical abuse and substance abuse consequences. *Journal of Substance Abuse Treatment, 22*(3), 121-128.
- 23 Wilsnack, S. C., Vogeltanz, N. D., Klassen, A. D., & Harris, T. R. (1997). Childhood sexual abuse and women's substance abuse: national survey findings. *J Stud Alcohol, 58*(3), 264-271.
- 24 Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of Adolescents. *J Consult Clin Psychol, 71*(4), 692-700.
- 25 Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J., & Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: Differential links to emergent psychopathology. *Journal of Child Psychology and Psychiatry, 51*(10), 1132-1140.
- 26 Salguero, J. M., Fernández-Berrocal, P., Iruarrizaga, I., Cano-Vindel, A., & Galea, S. (2011). Major depressive disorder following terrorist attacks: A systematic review of prevalence, course and correlates. *BMC Psychiatry, 11*.
- 27 Roemer, L., Molina, S., Litz, B. T., & Borkovec, T. D. (1996). Preliminary investigation of the role of previous exposure to potentially traumatizing events in generalized anxiety disorder. *Depression and Anxiety, 4*(3), 134-138.
- 28 Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330-350.
- 29 Morgan, C., & Fisher, H. (2007). Environment and Schizophrenia: Environmental Factors in Schizophrenia: Childhood Trauma—A Critical Review. *Schizophrenia Bulletin, 33*(1), 3-10.
- 30 Herman, J., Perry, J., & van der Kolk, B. (1989). Childhood trauma in borderline personality disorder. *Am J Psychiatry, 146*(4), 490-495.
- 31 Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M., & Bernstein, D. P. (1999). Childhood Maltreatment Increases Risk for Personality Disorders During Early Adulthood. *Arch Gen Psychiatry, 56*(7), 600-606.
- 32 Neria, Y., Nandi, A., & Galea, S. (2008). Post-traumatic stress disorder following disasters: A systematic review. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 38*(4), 467-480.
- 33 Margolin, G., & Vickerman, K. A. (2007). Posttraumatic stress in children and adolescents exposed to family violence: I. Overview and issues. *Professional Psychology: Research and Practice, 38*(6), 613-619.
- 34 Norris, F. H. (1992). Epidemiology of trauma: frequency and impact of different potentially traumatic events on different demographic groups. *J Consult Clin Psychol, 60*(3), 409-418.
- 35 Harvey, A. G., & Bryant, R. A. (2002). Acute stress disorder: a synthesis and critique. *Psychol Bull, 128*(6), 886-902.
- 36 Koopman, C., Classen, C., Cardeña, E., & Spiegel, D. (1995). When disaster strikes, acute stress disorder may follow. *Journal of Traumatic Stress, 8*(1), 29-46.
- 37 Roy, A. (2004). Relationship of childhood trauma to age of first suicide attempt and number of attempts in substance dependent patients. *Acta Psychiatrica Scandinavica, 109*(2), 121-125.

- 38 Wiederman, M. W., Sansone, R. A., & Sansone, L. A. (1998). History of trauma and attempted suicide among women in a primary care setting. *Violence Vict*, 13(1), 3-9.
- 39 Littleton, H. L., Grills-Taquechel, A. E., Axsom, D., Bye, K., & Buck, K. S. (2011). Prior sexual trauma and adjustment following the Virginia Tech campus shootings: Examination of the mediating role of schemas and social support. *Psychological Trauma: Theory, Research, Practice, and Policy*.
- 40 Yehuda, R., McFarlane, A., & Shalev, A. (1998). Predicting the development of posttraumatic stress disorder from the acute response to a traumatic event. *Biological Psychiatry*, 44(12), 1305-1313.
- 41 Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults. *Arch Gen Psychiatry*, 48(3), 216-222.
- 42 Ehring, T., & Quack, D. (2010). Emotion regulation difficulties in trauma survivors: the role of trauma type and PTSD symptom severity. *Behav Ther*, 41(4), 587-598.
- 43 Samuels, B. H. (2011). Addressing trauma to promote social and emotional well-being: a child welfare imperative. In J. Collins, K. Decker & S. HKo (Eds.), *Effectively addressing the impact of child traumatic stress in child welfare*. Arlington, VA: CWLA.
- 44 Zeanah, C., Nelson, C., Fox, N., Smyke, A., Marshall, P., Parker, S., et al. (2003). Designing research to study the effects of institutionalization on brain and behavioral development: The Bucharest Early Intervention Project *Development and Psychopathology*, 15(4), 885-907.
- 45 Fisher, P. A., Gunnar, M. R., Dozier, M., Bruce, J., & Pears, K. C. (2006). Effects of therapeutic interventions for foster children on behavioral problems, caregiver attachment, and stress regulatory neural systems. In B. M. Lester, A. S. Masten & B. McEwen (Eds.), *Resilience in Children* (Vol. 1094, pp. 215-225).
- 46 Administration for Children and Families. (2012). Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services. Retrieved April 23, 2012, from http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf

National Survey of Child and Adolescent Well-Being Research Brief

Suggested citation:

Casanueva, C., Dozier, M., Tueller, S., Jones Harden, B., Dolan, M., & Smith, K. (2012). *Instability and early life changes among children in the Child Welfare System*. OPRE Report #2012-44, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Available at: National Data Archive on Child Abuse and Neglect (NDACAN), Cornell University, ndacan@cornell.edu

Administration for Children and Families (ACF, OPRE)
http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/

This is the eighteenth in a series of NSCAW research briefs focused on children who have come in contact with the child welfare system. Additional research briefs focus on the characteristics of children in foster care, the provision of services to children and their families, the prevalence of special health care needs, use of early intervention services, and caseworker judgment in the substantiation process.

