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The Prevalence of Safe, Stable, Nurturing Relationships Among Children and Adolescents

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Experiencing significant adversity in childhood, such as being exposed to violence and victimization, has damaging effects on a child's general well-being and lifelong health (Chapman et al., 2004; Felitti et al., 1998; Finkelhor, Ormrod, and Turner, 2007; Flaherty et al., 2013; Turner, Finkelhor, and Ormrod, 2006). Developmental, behavioral, and biological research has clearly demonstrated the link between early exposure to stressful events and conditions and impaired neurological, physiological, and psychosocial systems that contribute to a wide array of mental and physical health problems (Shonkoff, Boyce, and McEwen, 2009). Research suggests the need for a more comprehensive approach that considers the intersecting effects of multiple forms of victimization and stressors (Appleyard et al., 2005; Chapman et al., 2004; Dong et al., 2004), together with various protective factors across the social ecology (individual, relational, community, societal) (Merrick, Leeb, and Lee, 2013).

The harmful health effects of childhood exposures to serious adversities, such as physical abuse and neglect, witnessing domestic violence, parental substance abuse, and maternal depression, can accumulate over time (Felitti et al., 1998). On the other hand, social relationships and environments that are secure, supportive, and relatively free of threat can promote healthy child development and encourage adaptive responses to adverse childhood experiences (Shonkoff and Garner, 2012).

To encourage healthy development in children and youth, a better understanding is needed of how exposure to violence and victimization is situated within broader risk contexts as well as those that may be protective or encourage resilience (Merrick, Leeb, and Lee, 2013; Turner, 2010; Turner, Finkelhor, and Ormrod, 2006).

This bulletin describes the study of safe, stable, nurturing relationships

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE

A Message From OJJDP

Children are exposed to violence every day in their homes, schools, and communities. Such exposure can cause them significant physical, mental, and emotional harm with long-term effects that can last well into adulthood.

The Defending Childhood Initiative was launched in September 2010 to unify the Department of Justice's efforts to address children's exposure to violence under one initiative. Through Defending Childhood, the Department is raising public awareness about the issue and supporting practitioners, researchers, and policymakers as they seek solutions to address it. A component of Defending Childhood, OJJDP's Safe Start initiative continues efforts begun in 1999 to enhance practice, research, training and technical assistance, and public education about children and violence.

Under Safe Start, OJJDP conducted the National Survey of Children's Exposure to Violence, the most comprehensive effort to date to measure the extent and nature of the violence that children endure and its consequences on their lives. This is the first study to ask children and caregivers about exposure to a range of violence, crime, and abuse in children's lives.

As amply evidenced in this bulletin series, children's exposure to violence is pervasive and affects all ages. The research findings reported here and in the other bulletins in this series are critical to informing our efforts to protect children from its damaging effects.

(SSNR) among children and youth in the United States using a nationally representative sample. The authors provide a comprehensive assessment of SSNR factors; examine interrelationships among different indicators of safe, stable, nurturing relationships; and investigate the consequences of SSNRs for child and adolescent mental health.

Defining Safe, Stable, Nurturing Relationships and Environments

One especially important domain of risk and resiliency involves social interactions and environmental contexts associated with family and caregiving relationships (Mercy and Saul, 2009; Turner et al., 2012). Children and youth experience much of their world through relationships with parents and caregivers. These relationships are fundamental to the healthy development of physical, emotional, social, behavioral, and intellectual capacities (Centers for Disease Control and Prevention, 2009; Shonkoff, 2010).

Each of the three dimensions of safe, stable, nurturing relationships represents a significant aspect of the social and physical environments that protect children and promote their optimal healthy development. Each can be thought of as being on a relational and environmental continuum or dichotomy.

"Safety" represents the absence of threat, neglect, and violence and refers to the extent to which children are free from fear and harm within their social and physical environments. Acts of physical abuse, child neglect, harsh or hostile parenting practices, and family drug and alcohol abuse, for example, represent markers of an unsafe family environment.

"Stability" refers to consistency and predictability in the child's environment. Frequent residential moves, household changes, inconsistent childcare, and life events that create volatile or stressful family conditions, such as divorce and job loss, can threaten stability. An unpredictable and chaotic family environment can diminish a child's sense that the world is trustworthy, dependable, and fair and can interfere with a caregiver's ability to parent effectively (Conger et al., 2002; Kobak et al., 2006; McLoyd, 1990).

History of the National Survey of Children's Exposure to Violence

Under the leadership of then-Deputy Attorney General Eric Holder in June 1999, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) created the Safe Start Initiative to prevent and reduce the impact of children's exposure to violence. As a part of this initiative, and with a growing need to document the full extent of children's exposure to violence, OJJDP launched the National Survey of Children's Exposure to Violence (NatSCEV) with the support of the Centers for Disease Control and Prevention (CDC). CDC partnered with OJJDP to support the assessment of safe, stable, nurturing relationships and environments as protective factors for vulnerable youth.

NatSCEV is the first national incidence and prevalence study to comprehensively examine the extent and nature of children's exposure to violence across all ages, settings, and time frames. Conducted between January and May 2008, the study measured the past-year and lifetime exposure to violence for children age 17 and younger across several major categories: conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization (including exposure to community violence and family violence), school violence and threats, and Internet victimization.

This survey marked the first attempt to measure children's exposure to violence in the home, school, and community across all age groups from 1 month to age 17, and the first attempt to measure the cumulative exposure to violence over a child's lifetime. The survey asked children and their adult caregivers about the incidents of violence that children suffered and witnessed themselves, as well as other related crime and threat exposures, such as theft or burglary from a child's household, being in a school that was the target of a credible bomb threat, and being in a war zone or an area where ethnic violence occurred. OJJDP directed the development of the study, and the Crimes against Children Research Center at the University of New Hampshire designed and conducted the research. The research provides data on the full extent of violence in the daily lives of children. NatSCEV documents the incidence and prevalence of children's exposure to a broad array of violent experiences across a wide developmental spectrum. The research team asked followup questions about specific events, including where the exposure to violence occurred, whether injury resulted, how often the child was exposed to a specific type of violence, and the child's relationship to the perpetrator and (when the child witnessed violence) the victim.

In addition, the survey documents differences in exposure to violence across gender, race, socioeconomic status, family structure, region, urban/rural residence, and developmental stage of the child; specifies how different forms of violent victimization "cluster" or co-occur; identifies individual-, family-, and community-level predictors of violence exposure among children; examines associations between levels/types of exposure to violence and children's mental and emotional health; and assesses the extent to which children disclose incidents of violence to various individuals and the nature and source of assistance or treatment provided (if any).

"Nurturing" is characterized by availability, sensitivity, and warmth in responding to a child's needs. Nurturing relationships with caregivers contribute to a child's self-esteem, confidence, social competencies, and emotional development (Belsky and Cassidy, 1994; Bowlby, 1979; Harter, 2006; Hennan et al., 1997). The nurturing dimension can range from warm and supportive contexts to those characterized by hostility and rejection. Emotional abuse reduces nurturing relationship qualities, whereas supportive interactions, adequate monitoring, social involvement, and caregivers' demonstrations of warmth increase nurturing (Cicchetti, Rogosch, and Toth, 1998; Goodman and Gotlib, 2002; Lyons-Ruth et al., 2002; Roosa et al., 1993).

These three dimensions—safe, stable, and nurturing—overlap, but each represents central and distinct aspects of a child's relationships and environments that are critical for his or her healthy development. In *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environment*, the Centers for Disease Control and Prevention (2013)

identify strategies to promote safe, stable, nurturing relationships as a key component of the public health approach to preventing childhood exposure to violence and facilitating healthy development and childhood well-being.

The Prevalence, Distribution, and Impact of Safe, Stable, Nurturing Relationships and Environments

Since most young people in the United States develop into well-functioning adults, the majority likely experience safe, stable, nurturing relationships and environments as children. Nevertheless, the number of children who experience deficits in their relationships and environments, and the specific characteristics of those deficits, are not known. Showing how safe, stable, nurturing relationships may be distributed in the juvenile population and the ways that they may differ across various demographic characteristics is an important step in identifying broad components of risk and protection for children.

Co-occurrence of Safe, Stable, Nurturing Relationships Factors

When identifying risky and protective contexts, observers may find that certain components of safety, stability, and nurturing often cluster together or co-occur. However, a better understanding of how different aspects of safe, stable, nurturing relationships and environments are related to one another and generate other components of risk and protection is needed.

Researchers have already shown that children who experience one type of victimization often experience other types (Finkelhor et al., 2012; Finkelhor et al., 2009; Turner, Finkelhor, and Ormrod, 2010). For example, physical abuse and emotional abuse often co-occur (Briere and Runtz, 1990; Dong et al., 2004; Higgins and McCabe, 2001).

Other SSNR factors may also be related. Residential instability, for example, appears to be associated with the neglect of children younger than 10 (Turner et al., 2012). This suggests that, in some

cases, frequent moves and transfers across households (e.g., shuttling from one parent to another or to grandparents, stepparents, aunts and uncles, or more distant relatives) may be associated with a chaotic family context that reduces the ability of parents to respond to the child's basic needs. It is important to note that many forms of family dysfunction, such as intimate partner violence, may precede and give rise to residential instability and transfers of children among households. However, for many children, frequent moves because of circumstances, such as a parent's job transfers or military service, may simply be a normal part of growing up.

The key to identifying these moves as risky or protective is whether they occur within a context of other forms of family dysfunction. An unpredictable and chaotic family environment can diminish a child's sense that the world is trustworthy, dependable, and fair (Conger et al., 2002; Kobak et al., 2006; McLoyd, 1990).

There is ample evidence that violence, abuse, and other forms of major adversity have damaging effects on health and development. Researchers also know that the quality of relationships with caregivers and family environments are important determinants of child well-being. However, the research has yet to fully specify the relative and combined effects of safety, stability, and nurturance on child and adolescent mental health. The goals of the study described in this bulletin are to provide a more comprehensive assessment of SSNR factors, describe their prevalence and distribution among children and youth ages 1 month to 17 years in the United States, and examine their effects on trauma symptom levels.

Findings

The researchers first looked at the percentage of children and youth who scored high and low on each individual indicator of the safety, stability, and nurturing domains for the total sample and across select demographic characteristics.

Components of Safety

Substantial differences across age groups in the component of safety were evident. For example, fewer of the youngest children (from birth to age 4) experienced physical or sexual abuse in the past year (2 percent) compared to the other age groups (ages 5–9, 5 percent; ages 10–13, 5 percent; ages 10–17, 6 percent). The oldest age group (ages 14–17) was more likely to experience harsh parenting (27 percent) than younger age groups (ages 5–9, 10 percent; ages 10–13, 16 percent). For the most part, boys and girls did not differ in the safety indicators, and researchers found few differences between children of lower and higher socioeconomic standing (SES). However, a smaller percentage of children in the highest SES households had family members with drug or alcohol problems (high SES, 2 percent; middle SES, 4 percent; low SES, 6 percent) or a mother with a diagnosed psychiatric disorder (high SES, 11 percent; middle SES, 15 percent; low SES, 21 percent) compared to other SES categories.

Methods

The National Survey of Children's Exposure to Violence II (NatSCEV II) (Finkelhor et al., 2013) was designed to obtain up-to-date incidence and prevalence estimates of a wide range of childhood victimizations and information about parenting practices, social support, and stressful life events. It consists of a national sample of 4,503 children and youth ages 1 month to 17 years in 2011. Employees of an experienced survey research firm conducted the study interviews over the phone.

Sampling Techniques

The primary foundation of the design was a nationwide sampling frame of residential telephone numbers based on random digit dialing (RDD) from which a sample of telephone households was drawn. Two additional samples were obtained to represent the growing number of households that rely entirely or mostly on cell phones: a small national sample of 31 cell phone numbers drawn from RDD methodology and an address-based sample (ABS) of 750 telephone numbers.

For the ABS portion of the survey, a national sample of addresses was mailed a one-page questionnaire to obtain household information. Interviewers then contacted households with children and asked them to participate in the survey. Approximately half of the eligible households obtained through ABS were cell-phone-only households and thus represented an effective way of including households without landlines in the sample.

Methodology

A short interview was conducted with an adult caregiver (usually a parent) to obtain family demographic information. The interviewer then selected the child with the most recent birthday from all eligible children living in the household. If the selected child was 10–17 years old, the main telephone interview was conducted with the child. If the selected child was younger than 10, the interview was conducted with the caregiver "most familiar with the child's daily routine and experiences." The cooperation and response rates averaged across collection modalities were 60 percent and 40 percent, respectively, which are good rates by current survey research standards (Babbie, 2007; Keeter et al., 2006; Kohut et al., 2012).

Assessment of Safe, Stable, Nurturing Relationships

Measures to assess the safety, stability, and nurturing of children's relationships were drawn from several sections of the NatSCEV II survey questionnaire (www.icpsr.umich.edu/icpsrweb/ICPSR/studies/36177) and included items regarding parenting style, parent mental health and substance abuse, social support, recent family events such as residential moves or parent job loss, and the child or youth's experience of victimization in the past year. The questions dealing specifically with child maltreatment asked about whether adults in a child's life struck or physically hurt the child; subjected the child to verbal threats and other mean and hurtful words; neglected the child, left the child alone, or failed to provide a clean or healthy environment for the child; abducted the child or hid the child from the other parent; took drugs or alcohol; or had people in the home who made the child feel unsafe.

Using these items, researchers constructed composite scores for each of the three domains such that higher scores indicated a higher level of safety, stability, and nurturing. Researchers then assigned these scores a cut-off value that they used to create a two-part score for each domain, categorizing children and youth as high or low on each of the three domains.

The variables included in the composite scores for the three domains were as follows:

Safety. Eight variables: Past-year physical or sexual abuse, neglect, or witnessing family violence; parental conflict; harsh parenting style; past-year family drug or alcohol problem; and mother or father ever diagnosed with a psychiatric disorder.

Stability. Four variables: Past-year family adversity, any past-year residential moves, child currently resides in more than one household, and childcare stability (for ages 0–9 only).

Nurturing. Six variables: Family social support (ages 10 and older only), parental involvement (ages 5 and older), parental warmth (ages 5 and older), parental supervision and monitoring (ages 5 and older), nonparent adult social support, and emotional abuse.

Once researchers assigned children to the high or low group for each of the three domains, they further classified the child based on the number of domains on which they scored high or low. The researchers created a variable in which they categorized children as being either high on all three domains, high on two domains but low on one, or low on two or three domains.

Assessment of Mental Health

The researchers assessed mental health using trauma symptom scores from the anger, depression, anxiety, dissociation, and posttraumatic stress scales of two closely related measures—the Trauma Symptoms Checklist for Children (Briere, 1996), shortened to 25 items, which they used with the 10- to 17-year-old self-report interviews, and the Trauma Symptom Checklist for Young Children (Briere et al., 2001), shortened to 28 items, which they used in the caregiver interviews for the 2- to 9-year-olds. For both instruments, researchers asked the respondents to indicate how often they or their children had experienced each symptom within the last month. Response options were offered on a four-point scale from 1 (not at all) to 4 (very often). Researchers summed all item responses for the five scales together to create an aggregate trauma symptom score. The researchers then merged the standardized trauma scores for each age group to construct a unified trauma symptom score for all children.

Safety components also varied substantially by family structure. A smaller percentage of children residing with two biological or adoptive parents experienced neglect (4 percent) than did those in other family structures (parent-partner/stepparent, 11 percent; single parent, 8 percent; nonparent, 15 percent) and were less likely to have witnessed family violence in the past year (two biological/adoptive parents, 5 percent; parent-partner/stepparent, 10 percent; single parent, 13 percent; nonparent, 15 percent). Children residing with two biological or adoptive parents were also less likely to have a family member with a drug or alcohol problem (two biological/adoptive parents, 2 percent; parent-partner/stepparent, 5 percent; single parent, 8 percent; nonparent, 13 percent). The percentage of children experiencing harsh or hostile parenting was lower in households with two biological/adoptive parents (14 percent) compared to stepfamily arrangements (26 percent), households with single parents (21 percent), or nonparent arrangements (34 percent).

Components of Stability

A greater percentage of younger children (ages 0–4, 20 percent; ages 5–9, 18 percent) experienced a residential move in the past year than did older adolescents (ages 14–17, 13 percent), but the youngest children were also the most likely to reside in only one household (ages 0–4, 95 percent). These components of stability also differed by family structure—children residing with two biological or adoptive parents were the least likely to have moved or lived in multiple households. The percentage of children with high childcare stability was greatest in families with two biological parents (88 percent) and lowest in single-parent families (81 percent).

Components of Nurturing

A general pattern showing higher nurturing in younger age groups was evident, although the data are somewhat limited because many of the nurturing indicators were not measured for infant and preschool-aged children (because some indicators are not relevant for younger children).

The youngest children (0–4 years) had the lowest percentage of emotional abuse experiences (2 percent), while older adolescents (14–17 years) had the greatest percentage of exposure to this form of abuse (14 percent). The two youngest groups (ages 0–4 and 5–9) had higher percentages of nonparental adult support (67 percent for each) than the two older age groups (10–13 and 14–17), with the oldest adolescents having the least nonparental adult support (44 percent).

Among school-aged children and youth (ages 5–17), the oldest adolescents had the lowest percentages experiencing high supervision (24 percent), while the 5- to 9-year-old group had the most supervision (78 percent). Fewer older adolescents reported high parental involvement (27 percent) and parental warmth (44 percent), while the 5- to 9-year-old age group had the greatest percentages experiencing these forms of nurturing (48 percent and 65 percent, respectively). Similarly, among 10- to 17-year-olds, a lower percentage of older adolescents reported high family support (48 percent) than did younger adolescents (60 percent).

These age differences might be expected in most families as children become more involved with school and other activities and interests outside the home (including summer and afterschool jobs for older adolescents), interact more and form friendships and other attachments with persons outside the family, and seek greater independence from their parents.

Interrelationships Among Indicators of Safe, Stable, Nurturing Relationships

When researchers examined associations among all the indicators of safe, stable, nurturing relationships, they discovered interrelationships within and across the three domains. Within the safety domain, the strongest associations were between parental conflict and witnessing family violence and between parental conflict and harsh parenting. Family drug and alcohol problems were strongly related to witnessing family violence and neglect. Within the stability domain, the strongest association was between the number of residential moves and currently living in more than one household. Within the nurturing domain, the strongest association was between family support and parental warmth. Supervision was also strongly related to family support, parental warmth, and parental involvement. Although many of these interrelationships may appear to be self-evident, they illustrate the cumulative nature of both harms and protective factors within the family and the way risk and protective factors cluster within families.

Across the three domains, parental conflict and harsh parenting (from the safety domain) were strongly, negatively related to both family support and parental warmth (nurturing domain). Family adversity (stability domain) and emotional abuse (nurturing domain) were quite strongly associated with almost every safety indicator.

These interrelationships illustrate that factors and conditions that contribute to poor safety, stability, and nurturing within the family often co-occur, creating a broad context of risk for children. Thus, multiple problems that arise from detrimental caregiver characteristics and behavior characterize risky family environments, and family victimization often occurs against a backdrop of parental

dysfunction, family adversity, residential instability, and problematic parenting practices. These findings confirm the importance of a more comprehensive approach in assessing children's exposure to violence and victimization, even when considering only within-family exposures.

More information about these findings is available at www.ojjdp.gov/pubs/249197-appendix.pdf.

Categorizing Children on the Safe, Stable, Nurturing Relationships Continuum

The table below presents individual indicators in high and low groups on the safety, stability, and nurturing domains. It also shows the three domains combined into a total SSNR variable and divided into high, medium, and low groups. SSNR group differences are presented by age, gender, family structure, and SES (0 to 4-year-olds were dropped because many of the individual indicators were not relevant to this age group).

The low-safety group had a higher percentage of older youth and children in nontraditional family structures. Youth living in households with no biological parents (e.g., with foster parents or relatives) are particularly overrepresented in the low-safety group, followed by those in single-parent and then stepfamily structures.

A higher percentage of the younger group (ages 5–9) experienced low stability compared to the oldest group (ages 14–17). Although all nontraditional family structures are overrepresented in the low-stability group, stepfamily households are particularly overrepresented. This may be due to the greater likelihood of two or more sets of parents being actively involved in the child's upbringing, leading to greater movement between households. Although there were no significant differences in safety or nurturance among children of lower or higher SES, a greater percentage of the lowest SES group experienced low stability.

When the researchers combined the safety, stability, and nurturing domains into high (high on all three domains), medium (high on two domains), and low (high on one or no domain) SSNR groups, the high SSNR group had

Percentages of Each Demographic Group Who Scored High or Low on Each Domain (Ages 5 to 17)

	Safety		Stability		Nurturing		Low SSNR	Med SSNR	High SSNR
	Low	High	Low	High	Low	High	High on zero to one domain	High on two domains	High on three domains
Gender									
Male	11.4	88.6	14.4	85.6	12.1	87.9	5.5	25.9	68.6
Female	12.6	87.4	13.7	86.3	14.3	85.7	7.9	23.8	68.3
Age group									
5–9	8.7	91.3**	17.0	83.0*	3.1	96.9***	3.3	21.8	74.8***
10–13	12.0	88.0	13.6	86.4	14.1	85.9	7.4	23.4	69.2
14–17	15.6	84.4	11.1	88.9	24.1	75.9	9.9	29.8	60.3
Family structure									
Two parents	7.4	92.6***	6.4	93.6***	13.0	87.0	3.9	18.7	77.4***
Parent and stepparent or partner	12.1	87.9	30.1	69.9	18.0	82.0	9.5	38.7	51.8
Single	16.6	83.4	20.0	80.0	12.6	87.4	9.2	29.2	61.6
Nonparent	29.2	70.8	27.3	72.7	10.6	89.4	14.9	36.8	48.3
Socioeconomic status									
Low	12.3	87.8	19.1	81.0*	13.0	87.0	8.0	26.9	65.2
Medium	12.4	87.6	13.4	86.6	12.8	87.2	6.2	25.3	68.4
High	10.1	90.0	10.4	89.6	15.0	85.0	6.8	21.0	72.2

Source: NatSCEV II

N = 3,382

SSNR = Safe, stable, nurturing relationships

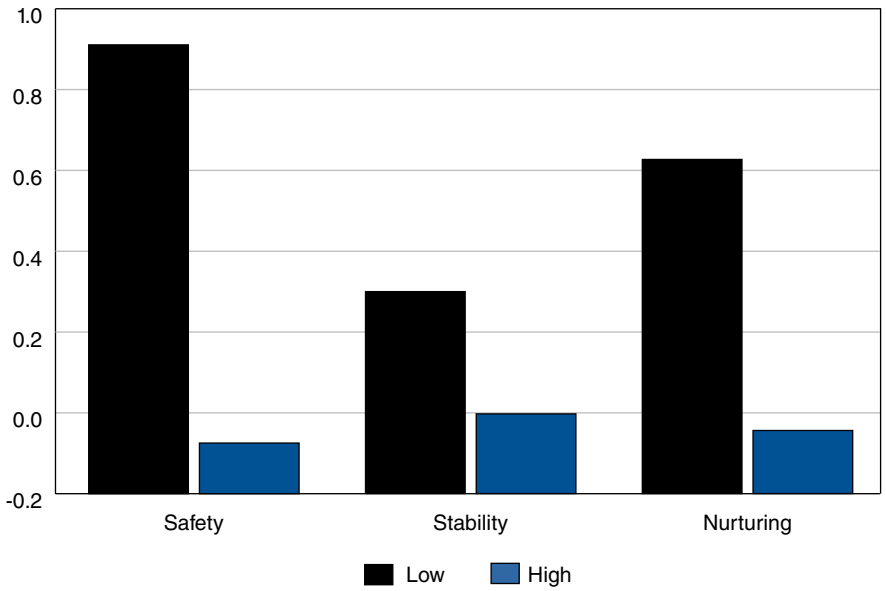
Chi-squared tests for significance: * $p < .05$, ** $p < .01$, *** $p < .001$

substantially greater percentages of younger children and those residing with two biological/adoptive parents, while the low SSNR group had larger percentages of older youth and children residing in nontraditional family structures, particularly in nonparent households.

Safe, Stable, Nurturing Relationships and Child and Adolescent Mental Health

Figure 1 displays average distress symptom levels for children and youth (ages 5–17) in low and high safety, stability, and nurturing groups. Children in each of the low groups had significantly and substantially higher symptom levels than those in the high group. The difference between low- and high-safety groups was particularly large. Figure 2 displays average symptom scores for the combined SSNR groups. There were substantial differences across groups, showing a clear linear pattern—the low SSNR group had a very high average symptom level, the high SSNR group had a very low symptom level, and the medium group fell approximately halfway in between.

Figure 1. Mean Distress Symptom Scores by Low and High SSNR Domain Groups (Ages 5 to 17)



Source: NatSCEV II

N = 3,282

SSNR = Safe, stable, nurturing relationships

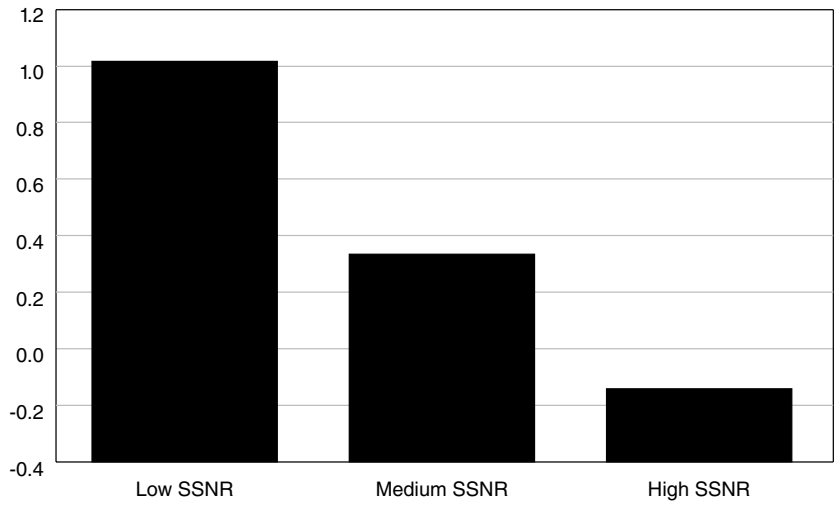
Discussion

Although most children enjoy safe, stable, and nurturing relationships with their caregivers, not all do, and evidence suggests the likelihood of having positive caregiver relationships varies according to sociodemographic factors.

According to the research, adolescents appear to have lower levels of safe, stable, nurturing relationships than younger children. This may, in part, reflect more conflictual relationships with parents that may increase the risk of physical and emotional maltreatment. However, some part of the age association may simply reflect normal developmental reductions in parental supervision, instrumental forms of support, and certain overt expressions of affection as adolescents grow up, become more independent, and often prepare to leave the parental household.

As shown in the table, family structure appears to be importantly related to safe, stable, nurturing relationships. Homes without a biological parent present had

Figure 2. Mean Distress Symptom Scores by SSNR Group (Ages 5 to 17)



Source: NatSCEV II

N = 3,282

SSNR = Safe, stable, nurturing relationships

significantly lower levels of safety and stability but had relatively high levels of nurturing, possibly suggesting that some children may have transferred to nonparent households because of safety problems involving parents. All forms of maltreatment and parental mental disorder and drug and alcohol problems were highest in households without a biological parent. Parenting issues may be especially problematic in stepparent and parent-partner households, as evidenced by high levels of harsh parenting. Girls also appeared to be at slightly greater risk than boys of having low overall levels of safe, stable, nurturing relationships.

Implications for Policy and Practice

The large number of relatively strong associations among the indicators of safe, stable, nurturing relationships, both within and across the safety, stability, and nurturing domains, indicates that children often experience multiple advantages or disadvantages. Consistent with findings on adverse childhood experiences (ACE study) and polyvictimization (Edwards et al., 2003; Turner, Finkelhor, and Ormrod, 2010), some children are exposed to multiple sources of risk that are cumulative in their damaging effects, while others experience mostly safe, stable, nurturing relational and environmental contexts. Children with multiple sources of risk and those who lack multiple components of safe, stable, nurturing relationships and environments should thus be identified as targets for intervention.

The researchers' findings show that the mental health advantages associated with safe, stable, nurturing relationships are quite robust. The three domains all contribute to child well-being, as the significantly lower levels of distress symptom scores among children who experience high levels of these resources and environments evidence. However, the difference in symptom scores is greatest between the high- and low-safety groups, followed by nurturing, and then stability. Therefore, it appears that the safety domain may be the most important component, accounting for more of the mental health advantage associated with safe, stable, nurturing relationships than the other two domains.

It may be that conflicts and adverse events and conditions, which are primary components of the safety measures, more strongly affect child symptomatology than do positive relationships and circumstances. That is, the absence of toxic family contexts (e.g., sexual and physical abuse, neglect, and witnessing family violence; parental conflict; harsh parenting style; family drug and alcohol problems; and parental psychiatric disorders), rather than the presence of constructive ones, may be most important in preventing distress. This interpretation is consistent with research showing that family risk factors and poor parenting qualities are most strongly related to child mental health problems, while family protective factors and positive parenting better predict positive child outcomes, such as social and leadership skills (Frick, 1994; Prevatt, 2003; Shelton, Frick, and Wooton, 1996).

This provides support for public health policy that emphasizes the prevention of violence, victimization, and other aspects of the family context that reduce safety for children. Although a broad program to promote all aspects of safe, stable, nurturing relationships is ideal, maltreatment prevention, reduction of harsh parenting, and treatment of disorder and drug and alcohol problems in the family are likely to be more feasible targets of intervention and may also yield greater benefits than increasing nurturing behavior, for example. These findings suggest that programs targeting maltreatment prevention, in particular by promoting protective factors, are important and might also be expanded to identify other protective relationships and environments outside of the home, such as in schools and communities. Although safety is a particularly important domain, findings show that an increase in any domain of safe, stable, nurturing relationships is likely to lead to an improvement in child well-being, and greater increases will result in progressively better outcomes.

Conclusion

According to this nationally representative study, almost 1 in 4 children and adolescents ages 5–15 in the United States lived in family environments with only modest levels of safety, stability, and nurturance, while about 1 in 15 had consistently low levels across multiple domains. A shortage of safe, stable, nurturing relationships appears to most heavily burden older adolescents and children living in nontraditional family structures. These deficits in the basic foundations of healthy child and adolescent development have crucial implications for the future functioning of these young people.

The mental health benefits of favorable conditions in each of the SSNR domains and the damaging effects of adverse conditions are clear; however, the particular importance of safety should be highlighted. Relationships and environments that are free of violence and threats are paramount to child and adolescent well-being. Strategies focused on helping families maintain stable and nurturing home environments are important, too, but these results

underscore the importance of having a specific focus on reducing exposure to violence and other family conditions that threaten a child's safety—such as harsh parenting and family drug and alcohol problems—as a core component of prevention and intervention efforts to protect children and promote their healthy development.

References

Appleyard, K., Egeland, B., van Dulmen, M.H.M., and Sroufe, L.A. 2005. When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of Child Psychology & Psychiatry* 46(3):235–245.

Babbie, E. 2007. *The Practice of Social Research,* 11th ed. Belmont, CA: Wadsworth.

Belsky, J., and Cassidy, J. 1994. Attachment: Theory and evidence. In *Development Through Life: A Handbook for Clinicians,* edited by M. Rutter and D. F. Hay. Oxford, England: Blackwell, pp. 373–402.

Bowlby, J. 1979. *The Making and Breaking of Affectional Bonds.* London: Tavistock.

Briere, J. 1996. *Trauma Symptoms Checklist for Children.* Professional manual. Odessa, FL: Psychological Assessment Resources.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., and Ernst, V. 2001. The Trauma Symptom Checklist for Young Children: Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect* 25(8):1001–1014.

Briere, J., and Runtz, M. 1990. Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse & Neglect* 14(3):357–364.

Centers for Disease Control and Prevention. 2009. *Preventing Child Maltreatment Through the Promotion of Safe, Stable, and Nurturing Relationships Between Children and Caregivers.* Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention. 2013. *Essentials for Childhood: Steps To Create Safe, Stable, and Nurturing Relationships.* Atlanta, GA: Centers for Disease Control and Prevention.

Chapman, D.P., Whitfield, C.L., Felitti, V.J., Dube, S.R., Edwards, V.J., and Anda, R.F. 2004. Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders* 82(2):217–225.

Cicchetti, D., Rogosch, F.A., and Toth, S.L. 1998. Maternal depressive disorder and contextual risk: Contributions to the development of attachment insecurity and behavior problems in toddlerhood. *Development and Psychopathology* 10(2):283–300.

Conger, R.D., Wallace, L.E., Sun, Y., Simons, R.L., McLoyd, V.C., and Bordy, G.H. 2002. Economic pressure in African American families: A replication and extension of the family stress model. *Developmental Psychology* 38(2):179–193.

Dong, M., Anda, R.F., Felitti, V.J., Dube, S.R., Williamson, D.F., Thompson, T., Loo, C., and Giles, W.H. 2004. The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect* 28(7):771–784.

Edwards, V.J., Holden, G.W., Felitti, V.J., and Anda, R.F. 2003. Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences Study. *American Journal of Psychiatry* 160(8):1453–1460.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., and Marks, J.S. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine* 14(4):245–258.

Finkelhor, D., Ormrod, R.K., and Turner, H.A. 2007. Poly-victimization: A neglected component in child victimization trauma. *Child Abuse & Neglect* 31:7–26.

Finkelhor, D., Shattuck, A., Turner, H.A., and Hamby, S.L. 2012. Improving the Adverse Childhood Experiences Study Scale. *Archives of Pediatrics and Adolescent Medicine* 167(1):70–75.

Finkelhor, D., Turner, H.A., Ormrod, R., and Hamby, S.L. 2009. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics* 124(5):1–13.

Finkelhor, D., Turner, H.A., Shattuck, A.M., and Hamby, S.L. 2013. Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics* 167(7):614–621.

Flaherty, E.G., Thompson, R., Dubowitz, H., Harvey, E.M., English, D.J., Proctor, L.J., and Runyan, D.K. 2013. Adverse childhood experiences and child health in early adolescence. *JAMA Pediatrics* 167(7): 622–629.

Frick, P.J. 1994. Family dysfunction and the disruptive behavior disorders: A review of recent empirical findings. In *Advances in Clinical Child Psychology,* vol. 16, edited by T.H. Ollendick and R.J. Prinz. New York, NY: Plenum, pp. 203–226.

Goodman, S.H., and Gotlib, I.H. 2002. *Children of Depressed Parents: Mechanisms of Risk and Implications for Treatment.* Washington, DC: American Psychological Association.

Harter, S. 2006. Self-processes and developmental psychopathology. In *Developmental Psychopathology: Vol. 1 Theory & Method,* 2d ed., edited by D. Cicchetti and D.J. Cohen. Hoboken, NJ: John Wiley & Sons, pp. 370–418.

Hennan, M.R., Dornbusch, S.M., Herron, M.C., and Herting, J.R. 1997. The influence of family regulation, connection, and psychological autonomy on six measures of adolescent functioning. *Journal of Adolescent Research* 12(1):34–67.

Higgins, D.J., and McCabe, M.P. 2001. Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior* 6(6):547–578.

Keeter, S., Kennedy, C., Dimock, M., Best, J., and Craighill, P. 2006. Gauging the impact of growing nonresponse on estimates from a national RDD telephone survey. *Public Opinion Quarterly* 70(5):759–779.

Kobak, R., Cassidy, J., Lyons-Ruth, K., and Ziv, Y. 2006. Attachment, stress, and psychopathology: A developmental pathways model. In D*evelopmental Psychopathology: Vol. 1 Theory & Method,* 2d ed., edited by D. Cicchetti and D.J. Cohen. Hoboken, NJ: John Wiley & Sons, pp. 333–369.

Kohut, A., Keeter, S., Doherty, C., Dimock, M., and Christian, L. 2012. *Assessing the Representativeness of Public Opinion Surveys.* Washington, DC: Pew Research Center.

Lyons-Ruth, K., Lyubchik, A., Wolfe, R., and Bronfman, E. 2002. Parental depression and child attachment: Hostile and helpless profiles of parent and child behavior among families at risk. In *Children of*

Depressed Parents: Mechanisms of Risk and Implications for Treatment, edited by S.H. Goodman and I.H. Gotlib. Washington, DC: American Psychological Association, pp. 89–120.

McLoyd, V.C. 1990. The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development* 61(2):311–346.

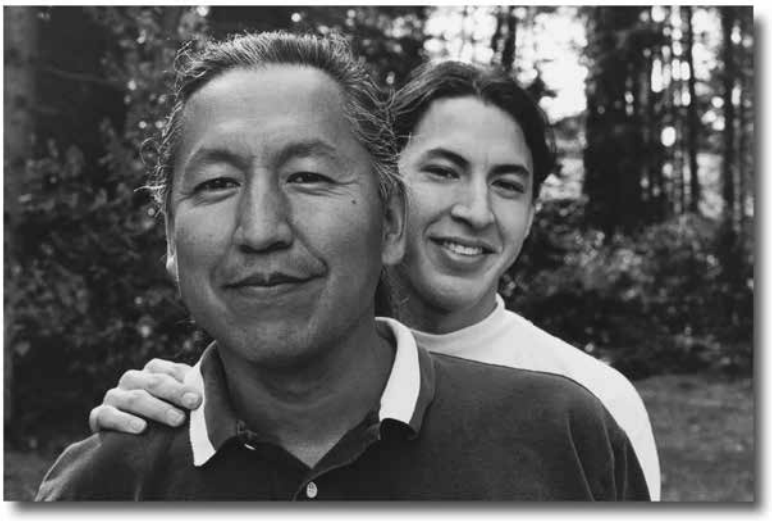
Mercy, J.A., and Saul, J. 2009. Creating a healthier future through early interventions for children. *Journal of the American Medical Association* 301(21):2262–2264.

Merrick, M.T., Leeb, R.T., and Lee, R.D. 2013. Examining the role of safe, stable, and nurturing relationships in the intergenerational continuity of child maltreatment—Introduction to the special issue. *Journal of Adolescent Health* 53(4 Suppl.):S1–S3.

Prevatt, F.F. 2003. The contribution of parenting practices in a risk and resiliency model of children's adjustment. *British Journal of Developmental Psychology* 21(4): 469–480.

Roosa, M., Michaels, M., Groppenbacher, N., and Gersten, J. 1993. Validity of children's reports of parental alcohol abuse. *Journal of Studies on Alcohol and Drugs* 54(1):71–79.

Shelton, K.K., Frick, P.J., and Wooton, P.J. 1996. Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child Psychology* 25(3): 317–329.



Shonkoff, J.P. 2010. Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development* 81(1):357–367.

Shonkoff, J.P., Boyce, W.T., and McEwen, B.S. 2009. Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *Journal of the American Medical Association* 301(21):2252–2259.

Shonkoff, J.P., and Garner, A.S. 2012. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 129(1):e232–e246.

Turner, H.A. 2010. Stress process applications in child victimization research. In *Advances in the Conceptualization of the Stress Process: Essays in Honor of Leonard I. Pearlin,* edited by W.R. Avison, C.S. Aneschensel, S. Schieman, and B. Wheaton. New York, NY: Springer, pp. 207–228.

Turner, H.A., Finkelhor, D., and Ormrod, R.K. 2006. The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine* 62(1):13–27.

Turner, H.A., Finkelhor, D., and Ormrod, R. 2010. Poly-victimization in a national sample of children and youth. *American Journal of Preventive Medicine* 38(3): 323–330.

Turner, H.A., Finkelhor, D., Ormrod, R., Hamby, S.L., Leeb, R.T., Mercy, J.A., and Holt, M.A. 2012. Family context, victimization, and child trauma symptoms: Variations in safe, stable, and nurturing relationships during early and middle childhood. *American Journal of Orthopsychiatry* 82(2):209–219.

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