

National Survey of Child and Adolescent Well-Being

No. 13: Depression Among Caregivers of Young Children Reported for Child Maltreatment



Findings from the NSCAW Study

research brief



Depression is a serious psychiatric disorder with symptoms that can impair physical, social, emotional, and cognitive functioning. Depression is common among mothers of young children and is a significant risk factor for child maltreatment.¹ Moreover, depression among mothers has been associated with a variety of adverse outcomes in their children's infancy and childhood.² Depression may disrupt a mother and child's early relationship, which is critical to the healthy development of the child.^{3,4}

Infants often react to depressed mothers with anger, distress, withdrawal behavior, avoidance, and disruptions in the ability to regulate their own emotions. Consequently, infants of depressed mothers tend to cry more than babies of nondepressed mothers. They tend to be drowsy and fussy, less relaxed, less sociable, and more insecurely attached to their mothers, as well.⁵⁻⁸ Subsequently, they tend to have poorer mental, motor, and language skills development; less capacity to concentrate; fewer abilities across a broad spectrum of emotional skills; more negative responses to their environment; and more behavioral difficulties than children of nondepressed mothers.^{2,6,7,9} Children of depressed mothers are also at increased risk for psychiatric illness.¹⁰

It is important to note that depression is a treatable illness. Therapeutic interventions and antidepressant medications have been shown to improve mothers' responsiveness to their infants, enhancing overall mother-child interaction.^{11,12}

Despite the high prevalence of maternal depression in families involved in the child welfare system (CWS), scarcely any research examines variations among individual mothers' depression outcomes across time. In a nationally representative sample from the National Survey of Child and Adolescent Well-Being (NSCAW), a probability study of children involved in investigations or assessments by child welfare services in 1999 and 2000,^{13,14} Burns et al. found that 40% of mothers of older children (aged 2 years or older) who had been involved in a CWS investigation of alleged child

maltreatment suffered from depression at some point during the 3 years after the investigation.¹⁵ In addition, Burns et al. found high levels of clinical need among the children of these depressed caregivers. Using data from the same national CWS study, Libby et al. reported rates consistent with the Burns et al. findings and reported a link between clinically significant behavior difficulties in children and their caregivers' mental health and substance abuse problems. Moreover, caregivers' mental health and substance abuse problems were linked with impaired parenting.¹⁶

To address the lack of information about depression across time among the mothers of young children reported to CWS, this research brief examines CWS population rates of depression longitudinally, as well as average individual change over time, among caregivers of young children. The following questions are addressed:

- What percentage of the caregivers of young children involved with CWS suffer from depression?
- How persistent is depression across time in the population?
- What family and environmental characteristics predict a caregiver's having depression at the time of contact with CWS (baseline) and afterward?
- What family and environmental characteristics predict individual changes in depression over time?

National Sample of Cases Involving Allegations of Maltreatment

To explore caregivers' depression across time, we used the child protective services sample component ($N = 5,501$) of NSCAW. NSCAW used a random sample of agencies and children within agencies to produce the most accurate national estimates possible. Survey data were collected from caseworkers, children, parents and other caregivers, and teachers. Data were collected at baseline (an average of 4 months after the index maltreatment investigation) and at four follow-up points.

This research brief reports on the female caregivers of 1,244 children who were living at home at baseline and at all follow-up points. Because of the importance of maternal depression for caregiver-child attachment and early childhood development, this brief focuses on children who were younger than 5 years old when they were involved in the index investigations of maltreatment. The data used here were collected between 1999 and 2006 and drawn from standardized measures of caregiver depression at baseline and at 12, 18, and 36 months, as well as at the 5- to 6-year follow-up. Also used are baseline caseworker data on maltreatment, data on caregiver and family problems, and caregivers' data on child and family characteristics.

For this research, caregiver depression is identified through a screening instrument for major depression, the World Health Organization's Composite International Diagnostic Interview Short Form (CIDI-SF).^{17,18} Here, average individual depression trajectories and average individual trajectories by various independent predictors were analyzed. For instance, a mother's reporting being a victim of intimate-partner violence (IPV) was a risk factor for depression as assessed with the physical violence scale of the Conflict Tactics Scales.^{19,20} We tested for differences in average individual depression trajectories between caregivers who were victims of IPV and caregivers who were not victims of IPV. Other caregiver characteristics used as predictors were age, education, race/ethnicity, children's age, children's race/ethnicity, marital status, and poverty level. Family income and number of adults and children in the household determined poverty level, in accordance with the U.S. Census Bureau guidelines.²¹ Additional variables considered in the analyses included caseworkers' reports at baseline on multiple family risks (i.e., caregiver history of childhood abuse or neglect, caregiver substance abuse, poor parenting skills, high stress in the family, and low social support).

The Caregivers and Their Children: Characteristics

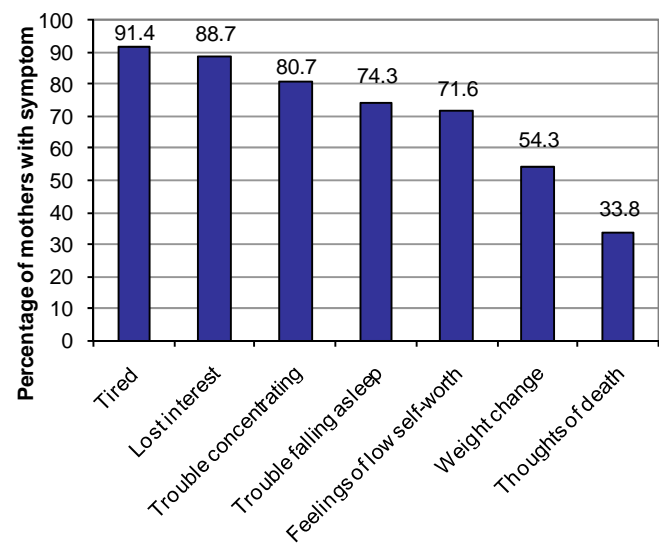
Eighty-five percent of the caregivers were younger than 35 years old, 12.2% were 35 to 44 years old, and 2.4% were 45 or older. Most female caregivers were biological mothers (95.5%), 2.9% were grandmothers, 1.0% were aunts, and fewer than 1% were adoptive mothers or stepmothers. Half of caregivers were White (50.3%), followed by African American (23.2%) and Hispanic (15.5%). In terms of marital status, 22.7% were married, 26.9% were separated or divorced, and 50.4% had never married.

Slightly more than half (53.2%) of the children were males; the mean age of children at baseline was 1.9 years. For each index report to CWS, one form of maltreatment was identified as the most serious. The most common forms were lack of adult supervision (32.2%), caregiver's failure to provide for the child (22.4%), and physical abuse (25.1%). Less than one fifth (18.4%) of the reports to CWS were *substantiated*, meaning the CWS decided the allegations of child maltreatment were valid.

What Percentage of Caregivers of Young Children Involved with CWS Have Symptoms of Depression?

A quarter of caregivers had a score indicating major depression at baseline. Although only some caregivers met the strict criteria used to define major depression, more than a third of caregivers (37.0%) met a broader criterion of having felt sad, blue, or depressed for 2 or more consecutive weeks during the 12 months before the assessment. Individuals who reported depressed mood also reported high levels of corresponding depressive symptoms, such as fatigue, losing interest in most things, and having trouble concentrating or sleeping (Figure 1).

Figure 1. Depressive symptoms among caregivers of children younger than 5 years old at baseline



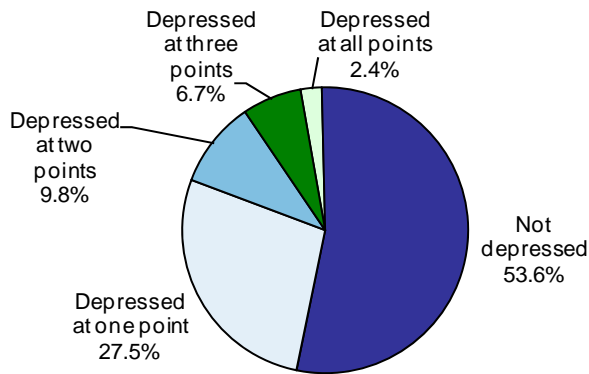
How Persistent Is Depression Across Time in the Population?

At the 18-month follow-up (Wave 3), 23.6% of caregivers had depression; at the 36-month follow-up (Wave 4), 22.6% had depression; and at the 5- to 6-year follow-up (Wave 5), the percentage was almost the same as in previous follow-ups (21.6%). These changes were

not statistically significant, indicating that the odds of having depression for an individual in this population remained almost constant over the entire time period.

Across all data collection points 46.4% of caregivers had a score indicating major depression at some point in time. Of particular relevance to the child's development, many caregivers' episodes of depression recurred. Although only a small percentage of caregivers (2.4%) were depressed at all points in time, 9.8% were depressed at two points, and 6.7% had three episodes; 27.5% of all caregivers were depressed only at one point. All together, 18.9% of this population had major depression at more than one point in time, which is 40.8% of all those who had any major depression during the study period (Figure 2).

Figure 2. Number of depressive episodes across time among caregivers of children younger than 5 years old at baseline



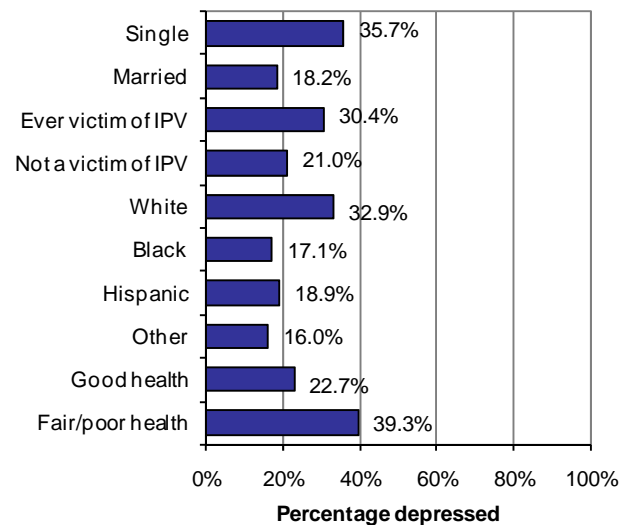
What Family and Environmental Characteristics Predict Depression at First Contact with CWS (Baseline) and Afterward?

Of all the factors analyzed for their potential relationship to depression at baseline (including the maternal factors of age, marital status, level of education, employment, health, history of childhood maltreatment, and IPV; the child-related factors of sex, race/ethnicity, and type of maltreatment; and the familial factors of poverty, high stress levels, low social support, and urbanicity), two were significantly associated with caregiver depression: IPV and caregivers' health.

Four factors were associated with caregiver depression after baseline: IPV, health, marital status, and the child's race/ethnicity. At baseline, caregivers who reported ever having been victims of physical abuse by an intimate partner were more likely to be depressed

(30.4%) than caregivers who had never been victims of IPV (21.0%). Caregivers who reported having fair or poor health were more likely to be depressed (39.3%) than caregivers who reported excellent, very good, or good health (22.7%). Caregivers who were single, widowed, or divorced were also more likely to be depressed (35.7%) than married caregivers (18.2%). In terms of race/ethnicity, the percentage depressed was 32.9% for caregivers of White children, 18.9% for caregivers of Hispanic children, 17.1% for caregivers of Black children, and 16.0% for caregivers of other children (Figure 3).

Figure 3. Factors associated with major depression among caregivers of children younger than 5 years old at baseline



Note: Statistical testing of differences in depression at baseline were significant by intimate-partner violence (IPV) status ($p = .02$), health ($p = .007$), and child's race/ethnicity ($p = .02$). Marital status was of borderline significance at baseline ($p = .06$) and statistically significant at follow-ups ($p < .05$).

Key Findings

- Between 22% and 25% of caregivers had a score indicating major depression at some point in time.
- Having been a victim of IVP, fair or poor health, being single, and being White were associated with symptoms of major depression.

What Do These Findings Mean?

About a quarter of caregivers of young children were found to have a score indicating an episode of major depression within the 12 months preceding any given data collection point. For adults aged 18 years or older, national data derived from the CIDI indicate much lower rates of major depression in the 12 months preceding assessment. Both the proportion of U.S.

adults who had a major depressive episode in the previous year (6.7%) and the proportion of U.S. adults 18 years old or older who had any mood disorder in the previous 12 months (9.5%) were about one third the proportion of caregivers of young children in NSCAW who were depressed during the 12 months preceding any point at which data collection occurred.²² Moreover, the percentage ever having suffered from major depression (46.3%) was almost 3 times the national estimate of adult lifetime prevalence of depression (16.6%).²³

National data for mothers of toddlers also indicate lower rates of depression. Rates of depression were about half (12.1%) among the general population of mothers of young children, with only 7.8% of the mothers in the general population showing depression after 18 months, a significant drop that contrasts with the persistent depression found among mothers of young children in the CWS.²⁴ Despite this contrast, at least one previous study has reported the risk of persistent depression among the general population of mothers of young children: a study in Connecticut found that 17% of the general population of mothers of young children were depressed at baseline and 18% were depressed at the one-year follow-up, with almost 50% of depressed mothers at baseline showing depression at the one-year follow-up.²⁵ The high rate of depression among caregivers of young children reported to CWS is not only a serious public health problem for the caregivers, but also a risk to the healthy development of their young children.

The most prevalent symptoms of depression among the caregivers of young children (i.e., fatigue, lack of interest in most activities, difficulty concentrating, difficulty sleeping, and feelings of worthlessness) can directly affect the quality of parenting. These symptoms, in an overwhelmed caregiver who may have difficulties performing the daily tasks associated with raising a young child, may exacerbate the risk of child maltreatment. Previous studies have established that the early relationship between the infant and his or her mother is critical for the healthy development of the child.³⁴ In a healthy relationship, the mother acts as an organizer of the infant experience, conferring predictability, stability, and a sense of security from which the infant gradually learns emotional and behavioral self-regulation.²⁴

Research has extensively described how depression interferes with the emotional sensitivity and responsiveness of mothers toward their infants and

young children.^{9,26} Depressed mothers are more helpless, hostile, critical, disorganized, avoidant, and impatient, as well as less competent, than nondepressed mothers.^{2,25} Moreover, studies have found that depressed mothers tend to have difficulties managing distressed infants, perceive parenting as difficult, tend to be inconsistent and feel irritated by the young child's needs, and sometimes report thoughts of harming their children.¹⁰ All of these factors subtend a hostile interaction and can eventually lead to the physical abuse or neglect of the child.^{1,27,28} Maternal depression has also been associated with increased negativity and poorer communication within families in general.²⁹

The association between clinical depression and IPV highlights two critical public health problems. First, we know that the consequences of IPV for women's physical and mental health include stress, generalized anxiety, abdominal pain, dysthymia, somatization, depression, phobias, and substance abuse.³⁰⁻³² Second, we know that the impact of IPV extends beyond mothers to their children. The impact of IPV on the mental health of the new generation may last a lifetime.³³⁻³⁵ Clinical and community studies have found that the overlap between IPV and child abuse may be between 30% and 75%.³⁶ Research suggests that between 3 and 10 million children in the United States are exposed to IPV each year.³⁷ Some local studies have reported that children were at home during 50% to 85% of IPV episodes and that most of these children were younger than 5 years old.^{33,38} Because young children lack the skills to protect themselves, sometimes they are "caught in the crossfire." As the results show, many of them likely endure the double exposure to IPV and maternal depression, which increases their risk of developmental problems.

Being single was also associated with depression at baseline, a risk factor that suggests that isolation, lack of social support, and the burden of providing and being solely responsible for young children may play a role in maternal depression and that interventions may need to take these features into account.

The degree to which CWS should facilitate service access for caregivers with depression is an important area for future research and policy consideration. Symptoms of depression in the caregivers of young children reported for maltreatment likely reflect the complex and overwhelming reality surrounding many families with a history of CWS involvement. The demands and challenges these families face are unlikely to disappear with time. As children grow, many of the

problems that have surrounded their lives since early childhood may continue to impinge on their well-being and continued development. Among the many risk factors affecting maltreated children, maternal depression is at least amenable to treatment. The results of this research brief suggest that, in order to help young children reported for maltreatment, the mental health of their caregivers will likely need to be addressed, as well.

Notes

- ¹ Kotch, J. B., Browne, D. C., Dufort, V., & Winsor, J. (1999). Predicting child maltreatment in the first 4 years of life from characteristics assessed in the neonatal period. *Child Abuse & Neglect*, 23(4), 305-319.
- ² Petterson, S., & Albers, A. (2001). Effects of poverty and maternal depression on early child development. *Child Development*, 6, 1794-1813.
- ³ Ainsworth, M., & Eichberg, C. (1991). Effects on infant-mother attachment of mother's unresolved loss of an attachment figure or other traumatic experience. In P. Marris, J. Stevenson-Hinde & C. Parkes (Eds.), *Attachment across the life cycle*. New York: Routledge.
- ⁴ Bowlby, J. (1973). *Attachment and loss* (Vol. 2). New York: Basic Books.
- ⁵ Field, T., Healy, B., Goldstein, S., Perry, S., Bendell, D., Schanberg, S., et al. (1988). Infants of depressed mothers show "depressed" behavior even with non-depressed adults. *Child Development*, 59(6), 1569-1579.
- ⁶ Murray, L., & Cooper, P. J. (1997). Postpartum depression and child development. *Psychological Medicine*, 27(2), 253-260.
- ⁷ Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development*, 67(5), 2512-2526.
- ⁸ Weinberg, M. K., & Tronick, E. Z. (1998). Emotional characteristics of infants associated with maternal depression and anxiety. *Pediatrics*, 102(5 Supp. E), 1298-1304.
- ⁹ NICHD Early Child Care Research Network. (1999). Chronicity of maternal depressive symptoms, maternal sensitivity, and child functioning at 36 months. *Developmental Psychology*, 35(5), 1297-1310.
- ¹⁰ Burke, L. (2003). The impact of maternal depression on familial relationships. *International Review of Psychiatry*, 15, 243-255.
- ¹¹ Carter, A., Garrity-Rokous, E., Chazan-Cohen, R., Little, C., & Briggs-Gowan, M. (2001). Maternal depression and comorbidity: Predicting early parenting, attachment security, and toddler social-emotional problems and competencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(1), 18-26.
- ¹² Field, T. (1998). Maternal depression effects on infants and early interventions. *Preventive Medicine*, 27, 200-203.
- ¹³ Administration for Children and Families. (2005). *National Survey of Child and Adolescent Well-Being: CPS sample component, Wave 1 data analysis report*. Washington, DC: Author.
- ¹⁴ NSCAW Research Group. (2002). Methodological lessons from the National Survey of Child and Adolescent Well-Being: The first three years of the USA's first national probability study of children and families investigated for abuse and neglect. *Children and Youth Services Review*, 24(6/7), 513-541.
- ¹⁵ Burns, B., Mustillo, S., Farmer, E., McCrae, J., Kolko, D., Libby, A., et al. Caregiver depression, mental health service use, and child outcomes. Manuscript in preparation.
- ¹⁶ Libby, A., Orton, H., Barth, R., & Burns, B. (2007). Alcohol, drug, and mental health service need for caregivers and children involved with child welfare. Manuscript in preparation.
- ¹⁷ Kessler, R. C., Andrews, G., Mroczek, D., Ustun, T. B., & Wittchen, H.-U. (1998). The World Health Organization Composite International Diagnostic Interview Short Form. *International Journal of Methods in Psychiatric Research*, 7, 171-185.
- ¹⁸ The CIDI-SF contains 16 items based on the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. To meet the diagnostic requirement for major depression, the respondent has to report three or more symptoms of depression and endorse all questions in at least one of the following areas: (1) having 2 or more weeks of dysphoric mood, (2) having 2 or more weeks of anhedonia (lack of enjoyment of any activity), and (3) using medication for depression.
- ¹⁹ Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scale. *Journal of Marriage and the Family*, 41(1), 75-88.

- ²⁰ With the Conflict Tactics Scale, mothers were asked whether they had experienced any of nine different types of physically violent acts by their partner (e.g., having something thrown at them; being pushed, grabbed, or shoved, etc.). Women were classified as being victims of IPV if they reported having experienced one or more of these acts during the previous 12 months or earlier by a current or former date, spouse, or cohabiting partner.
- ²¹ Dalaker, J. (2001). *Poverty in the United States: 2000*. Retrieved from http://ict.cas.psu.edu/resources/Census/PDF/C2K_Poverty_in_USA.pdf
- ²² Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-709.
- ²³ Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-768.
- ²⁴ Demos, V. (Ed.). (1982). *The role of affect on early childhood: An exploratory study*. Baltimore, MD: Baltimore University Park.
- ²⁵ Lovejoy, M., Graczyk, P., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review* 20(5), 561-592.
- ²⁶ A "sensitive" mother is able to read quickly and appropriately the infant's cues to determine whether he or she needs more or less contact, stimulation, and interaction. Maternal sensitivity is critical to the child's emotional development because the child is learning not only to express emotion, but also when and how to use these expressions. The adequate maternal "reading" of the infant's expression sends a clear message to the infant that emotions are a vehicle of communication and will be acknowledged and attended to. Through this interactive process the infant learns to self-regulate the intensity and expression of his or her emotion.
- ²⁷ Cassell, D., & Coleman, R. (1995). Parents with psychiatric problems. In P. Reder & C. Lucey (Eds.), *Assessment of parenting: Psychiatric and psychological contributions* (pp. 169-181). New York: Routledge.
- ²⁸ Kotch, J. B., Browne, D. C., Ringwalt, C. L., Dufort, V., Ruina, E., Stewart, P. W., et al. (1997). Stress, social support, and substantiated maltreatment in the second and third years of life. *Child Abuse & Neglect*, 21(11), 1025-1037.
- ²⁹ Leschied, A., Chiodo, D., Whitehead, P., & Hurley, D. (2005). The relationship between maternal depression and child outcomes in a child welfare sample: Implications for treatment and policy. *Child and Family Social Work*, 10, 281-291.
- ³⁰ Eisenstat, S., & Bancroft, L. (1999). Primary care: Domestic violence. *New England Journal of Medicine*, 341(12), 886-892.
- ³¹ Martin, S. L., Clark, K. A., Lynch, S. R., Kupper, L. L., & Cilenti, D. (1999). Violence in the lives of pregnant teenage women: Associations with multiple substance use. *American Journal of Drug & Alcohol Abuse*, 25(3), 425-440.
- ³² Roberts, G. L., Lawrence, J. M., Williams, G. M., & Raphael, B. (1998). The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health*, 22(7), 796-801.
- ³³ Fantuzzo, J. W., & Mohr, W. K. (1999). Prevalence and effects of child exposure to domestic violence. *Future of Children*, 9(3), 21-32.
- ³⁴ Hall, D., & Lynch, M. A. (1998). Violence begins at home: Domestic strife has lifelong effects on children. *British Medical Journal*, 316(7144), 15-51.
- ³⁵ Lieberman, A. F., & Van Horn, P. (1998). Attachment, trauma, and domestic violence. Implications for child custody. *Child & Adolescent Psychiatric Clinics of North America*, 7(2), 423-443, viii-ix.
- ³⁶ Edleson, J. L. (1999). The overlap between child maltreatment and women battering. *Violence Against Women*, 5, 134-154.
- ³⁷ Salcido, L., Weithorn, L., & Behrman, R. (1999). Domestic violence and children. *Future of Children*, 9(3), 4-20.
- ³⁸ Brookoff, D., O'Brien, K. K., Cook, C. S., Thompson, T. D., & Williams, C. (1997). Characteristics of participants in domestic violence. Assessment at the scene of domestic assault. *Journal of the American Medical Association*, 277(17), 1369-1373.

National Survey of Child and Adolescent Well-Being Research Brief

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 13th in a series of NSCAW research briefs focused on children who have come in contact with the child welfare system (CWS). 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, caseworker judgment in the substantiation process, and multiple outcomes for infants followed from CWS initial contact to school entry.