Initial Promise of Child-Parent Psychotherapy in Improving Stress & Postpartum Depression Among Mothers Experiencing Homelessness

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BACKGROUND

- Individuals experiencing homelessness are more likely to suffer from PTSD, depression, anxiety, substance abuse, and other severe mental disorders (Bassuk et al., 1997).
- It is not known how women experiencing homelessness may be at risk for postpartum depression.
- Current theoretical models suggests that significant stress, like experiencing homelessness and parenting, can be a risk factor for postpartum depression (PDD) (Beck, 2001; Polmanteer et al., 2019).
- Most studies evaluating interventions for PPD emphasize treatments directly addressing the mother; few have examined an attachment-based approach (i.e., Child-Parent Psychotherapy; CPP).
- This study examined the risk for PPD in a shelter population, the feasibility and acceptability of CPP in shelter setting, and CPP's effects on parenting stress and PPD.

RESEACH QUESTIONS

1) What is the rate of clinically-elevated PPD symptoms among mothers experiencing homelessness?
2) Can CPP be implemented and accepted in a shelter setting?
3) How does engagement in CPP affect parenting stress and PDD symptoms? Does the change in parenting stress predict changes in PPD symptoms?

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METHOD

Participants

182 mother-infant dyads (Mean infant age = 2.5 months, SD = 2.0 months; 45.6% female)
Race & Ethnicity: 70.9% Black/African-American, 28.0% White, 1.0% multiracial, 29.1% Hispanic/Latino
Language: 70.9% English only, 6.6% Spanish only, 20.8% multilingual, 1.7% other
Educational Level: 50.0% some high school, 36.3% high school equivalent, 11.0% some college education, 2.1% college graduate, 0.5% trade school

Intervention

- Child-Parent Psychotherapy (CPP) is a relationship-based intervention for children ages 0-5 years that targets a history of trauma (Lieberman et al., 2005).
- Components off CPP include facilitating developmental progress, providing psychoeducation, encouraging positive behavior, interpreting the child's and parent's feelings and actions, providing emotional support and assistance with daily living (e.g., crisis intervention, case management, and service referrals).
- There are 3 phases: assessment and engagement, core intervention, and recapitulation and termination.

Measures

Intervention Completion, Attendance, & Satisfaction

- Intervention attendance and completion rates were tracked via electronic health records. Mothers reported their degree of satisfaction with CPP on a 5-point Likert scale regarding, (a) improvements in the parent-child relationship, (b) general feeling about the CPP program, and (c) how likely the parent was to recommend CPP to others according to the Therapy Attitude Inventory (TAI; Brestan et al., 1999).

Parenting Stress

- Mothers completed the Parenting Stress Index – Short Form (PSI-SF; Abidin & Brunner, 1995) prior to the start of and following the end of the intervention. The PSI-SF includes 36 items that assess self-report parenting stress; the overall raw score was used.

Postpartum Depression

- Mothers completed the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) prior to the start of and following the end of the intervention. The EPDS consists of 10 4-point scale items that assesses self-report PPD symptoms. Continuous scores range from 0 to 30 and clinical cut-off scores for high-risk of PDD is set at a sum score of 11 (Levis et al., 2020).

RESULTS

Intervention Fidelity

- Procedural Fidelity (*M* = 99%, range 83%-100%)
- Content Fidelity (*M* = 95%, range 74%-100%)

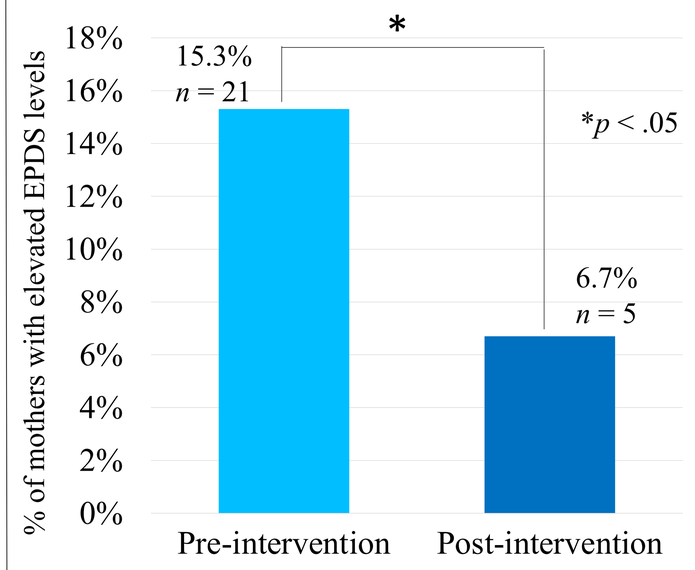
Intervention Completion & Attendance

- 12% never started intervention
- Of those who started the intervention, 45% (*n* = 70) completed
- 53% (*n* = 86) eventually completed (> 16 weeks)

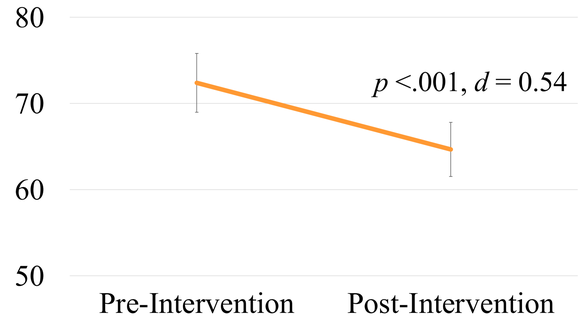
Intervention Satisfaction

- 68% reported improvement in the parent-child relationship (*M* = 4.33, *SD* = .93)
- 94% reported satisfaction with CPP (*M* = 4.83, *SD* = .51)
- 93% reported they would recommend CPP to others (*M* = 4.75, *SD* = .70)

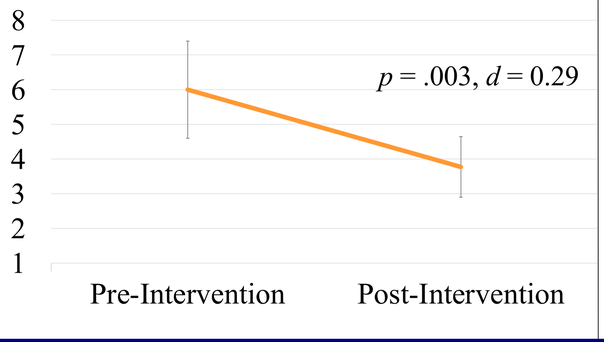
Pre- to Post-Intervention Clinically Elevated PPD



Parenting Stress Index



Edinburgh Postnatal Depression Scale



Linear and Logistic Regressions of PSI and EPDS

	B(95%CI)	R^2	R^2 Change	F Change	χ^2
Linear Regression					
Step 1		.12	.12	5.01**	
Pre PPD	.24 (.08, .40)**				
Pre Stress	-.02(-.08, .04)				
Step 2		.26	.14	13.62***	
Pre PPD	.21(.06, .35)**				
Pre Stress	-.07(-.13, -.01)*				
Post Stress	.12(.05, .18)***				
Logistic Regression					
Step 1		.06	-	-	1.77
Pre PPD	1.47(-18.51, 20.08)				
Pre Stress	-.03(-.11, .01)				
Step 2		.18	-	-	3.51
Pre PPD	1.65(-18.55, 25.38)				
Pre Stress	-.08(-.18, -.04)*				
Post Stress	.08(.00, .26)*				

Note. *p<.05, **p<.01, ***p<.001. Negelkerke R^2 reported for logistic regression models.

DISCUSSION & IMPLICATIONS

- This study highlighted the significance of studying PPD given that 15.3% of the women experiencing homelessness at this shelter experienced clinically elevated PPD rates.
- Additionally, this study adds to the literature evaluating shelter-based adaptations to evidence-based parent interventions as time limited CPP was successfully implemented within the homeless shelter as evidenced by high fidelity rates and high satisfaction ratings by the mothers.
- CPP, as an attachment-based early intervention program, was also effective in reducing parenting stress and PPD symptom severity. Finally, greater reductions in parenting stress predicted greater reductions in PPD continuously and categorically.
- Future research should include a comparison group and include follow-up data to evaluate the maintenance of the improvements seen in parenting stress and PDD symptoms following CPP.