

Parental Depression

Objective and Self-Perceived Resources as Predictors of Depression Among Low-Income Urban and Non-Urban Adolescent Mothers

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Although rates of teen pregnancy have declined in the United States in recent years (Alan Guttmacher Institute, 1999), depression rates among low-income teen mothers suggest that adolescent childbearing is still an important social issue. Depression among adolescent mothers is related to rapid repeat pregnancy (Gilmore et al, 1997), less economic success (Danzinger et al., 2000), and poor physical health (Prodromidis, 1994).

It seems likely that various resources are related to depression (Colletta, 1983; Hudson et al., 2000; Turner et al., 2000). Resources can be either identified objectively or perceived by the individual on a more subjective level. It seems logical that both categories of resources may impact mental health, with a teen mother's perception of her situation accounting for variance in depression beyond what objective resource measures can predict.

The purpose of this study was to determine the effect of resource adequacy on depression among adolescent mothers in urban and non-urban settings. Self-perceived resource adequacy includes perceptions of resources such as time, money, housing, and someone to talk to. Objective measures of resources, including education level and income, also were used as predictors. It was hypothesized that teen mothers with fewer self-perceived resources would have more symptoms of depression than teen mothers with more self-perceived resources while controlling for objective resources. It was also predicted that teen mothers with fewer objective resources would have more symptoms of depression than teen mothers with more objective resources when controlling for self-perceived resources. In addition, the cultural context of teen mothers (urban vs. non-urban) was explored using hierarchical linear modeling.

This study uses data collected as part of the National Early Head Start Research and Evaluation Project. Only teen mothers ($N = 523$) from the Early Head Start dataset were included in this study. Self-perceived resources, using the Family Resource Scale (Dunst & Leet, 1987), and objective resources were assessed approximately 6 months after enrollment. Depression was assessed using the CES-D (Radloff, 1977) at 14 and 36 months after the birth of the child.

High rates of depression were found among teen mothers. For instance, at 14 months, approximately 18% of participants scored at 23 or over, indicating probable depression, whereas 27% of participants scored at 16 or over, indicating possible depression. Self-perceived resources accounted for significant variance in depression at both points while controlling for education and income. However, education and income were not significant while controlling for self-perceived resources. HLM showed that environment (urban vs. non-urban) did not predict depression.

Among the teen mothers in this study, perceptions of resource adequacy are important predictors of depression—perhaps even more important than objective indicators. This is a key finding, as interventionists working with adolescent mothers should be focused on not only objective resources (i.e., income, education) but the more subjective resources as perceived by the young woman. The identification of depression among low-income teen mothers is an important goal, as addressing the mental health needs of the mother may lead to improved family and child outcomes.

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Early Head Start in New York City: A Relationship-Based Model in Action

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Healthy mother-child interactions are characterized by mothers' sensitivity and positive responsiveness (Lewis, 2000). These interactions are likely to be negatively impacted by maternal depression, which has been related to mothers' increased intrusiveness and decreased sensitivity with their children (Field, Healy, & LeBlanc, 1989). Relationship-based interventions have demonstrated positive impacts on parenting behaviors. Interventions targeted specifically towards depressed mothers' parenting skills and mothers' feelings of self-efficacy and understanding of their children's cues have also proven successful with respect to mothers' ability to become more sensitive to their children (Gelfand, Teti, Seiner, & Jameson, 1996). However, little is known about how to address parenting and mental health with diverse, low-income mothers. We examined the impacts of participation in relationship-based Early Head Start (EHS) programs among low-income, Latino mothers for 1.5 years on maternal responsiveness among depressed and nondepressed mothers.

EHS programs in this study implemented a relationship-based approach in center-based classes and home visits for mothers and infants, conducted by a support worker who provided mothers with a supportive and trusting relationship. Support workers came from the same community as mothers, providing a safe relationship to seek guidance and advice. They served as mothers' liaisons to the community and sources of social support.

Observational measures of parenting behaviors and maternal self-report interview responses were collected at enrollment in EHS and again after 18 months of participation. Mother-child dyads were videotaped during structured play interactions when mothers were asked to demonstrate 3 toys to their children. Interactions were coded for 6 parenting dimensions, including Intrusiveness, Participatory Activity, Flexibility, Positive Expressivity, Didactiveness, and Autonomy Support. Maternal mental health was assessed using self-report measures, including the Center for Epidemiological Studies - Depression Scale (CES-D; Radloff, 1977), the Short Form of the Parenting Stress Index (PSI-SF; Abidin, 1986), and the Vaux Social Support Record (SSR; Vaux, 1985).

After participating in EHS for 18 months, mothers displayed improved interactions with their children. Mothers became less intrusive during dyadic structured play interactions, and levels of participation and activeness increased. Mothers reported changes in mental health, including decreased feelings of stress and depression related to parenting. Mothers showed a significant change in the number of people who gave them advice.

In addition to the changes displayed by the group as a whole, there were important differences in the parenting behaviors among mothers who entered EHS as depressed in comparison with those who entered the program as not depressed. Depressed mothers showed greater changes in parenting dimensions than nondepressed mothers, who were expected to display changes which were comparatively more stable over the intervention's 18-month period. Specifically, mothers

decreased their intrusiveness and negative interaction behaviors. Depressed mothers were more likely to change more quickly as a result of EHS intervention's goal to improve depression status via mothers' receiving much-needed resources. Findings are discussed with respect to the short-term impact of relationship-based models in Early Head Start and the contribution of this model to positive changes in maternal mental health.

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The Role of Parental Depression and Home-School Connection on Parents' Satisfaction with Head Start Services

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Previous research has demonstrated that parental depression negatively impacts parent involvement (e.g., Kohl et al., 2000; Oyserman et al., 2002) and overall endorsement of the school (Kohl et al., 2000). Specifically, interpersonal difficulties, lack of motivation, and negative feelings associated with depression have been hypothesized as factors leading to less engagement with school activities and positive appraisal of the school (Kohl et al., 2000), impacting the “home-school connection” (HSC) (e.g., Christenson, 2004). The research questions were: 1) Do parental depression and family HSC affect parents' satisfaction with the Head Start program? 2) Does HSC moderate the influence of depression on program satisfaction?

Two cohorts participated in a study of parent involvement (n=202). Families were enrolled in three Head Start centers in a mid-sized city in the Southeastern United States. The majority of the families were African American. Most parents graduated from high school (37.6%) or completed some college (40.6%). Parents reported their depressive symptoms on a shortened version of the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). Chronicity of depressive symptoms across the Head Start year was defined as endorsement of clinically significant symptom levels (e.g., CES-D score > 16) at both, either, or neither fall and spring assessment (chronic =12.4%, sometimes = 25.7%, and never = 61.9%). Approximately 38.1% of parents reported moderate or severe depressive symptoms during a portion or all of the Head Start year.

The spring interview included two reports of HSC using the Family Involvement Questionnaire (FIQ; Fantuzzo et al., 2000), which measures three aspects of parent involvement (home, school, and conferencing), and teachers' ratings of connectedness with the family (subsampling only, n=139) (Waanders et al., under review). Parents rated their satisfaction with child- and family-related Head Start services, and with their child's teacher (FACES Parent Interview, ACYF, 2001).

Never depressed parents had higher home, school, and conferencing scores compared to sometimes depressed parents. Among depressed parents, those with low home involvement were more dissatisfied with the teacher, and to a lesser extent with child-related services. Parents with chronic depression were more dissatisfied with the teacher, but not with child- or family-services. Overall, parents engaging in more conferencing activities were more satisfied with the teacher; parents with increased home involvement were more satisfied with family services. Parents with more school involvement were more satisfied with all three indicators.

Given the high prevalence of depression in the sample, these findings provide preliminary evidence that parental depression may not globally impact parents' engagement in and overall experience in Head Start. Increasing home involvement may be important for depressed parents who may: have fewer social supports and lower motivation; feel less efficacious and more

helpless to impact their child's life; and direct negativity toward the teacher. Positive interactions with staff and other parents may provide needed social support, and conferencing and school-based activities may increase parenting mastery. These benefits may increase program satisfaction and improve parent-teacher relations. Head Start staff should consider barriers for depressed parents and dually emphasize home- and school-based activities.

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Depressive Symptoms in HIV-Infected Mothers of HIV-Exposed Noninfected Infants, Toddlers and Preschoolers

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Introduction. Due to changes in the care of pregnant HIV-positive women that were widely instituted in the U.S. in 1994, an estimated 97% of children born to infected mothers will not be HIV-infected (Lindegren, et al., 1999). However, HIV-positive mothers may be at increased risk of depression, even when their children are not infected (Kotchick, Forehand, Brody, Armistead, & Morse, 1997).

We investigated depressive symptoms in HIV-positive biological mothers of infected and non-infected infants, toddlers and pre-schoolers. We included a comparison group of non-infected foster mothers from the same neighborhoods and similar socio-economic circumstances. We hypothesized that mothers of infected children would exhibit more depressive symptoms than other groups, but that mothers of non-infected children would also show elevated levels of depressive symptoms relative to foster mothers, and foster mothers of infected children would show higher levels of depressive symptoms than foster mothers of non-infected children.

Methods. Families came from the catchment area of our clinic, which has a population that is 97% African American, with 46% born in the West Indies. The majority are unemployed. In this study 83% of the families were either on or in application for Medicaid; 2% had health insurance other than Medicaid.

180 caregivers participated: 90 HIV-positive biological mothers and 90 HIV-negative foster mothers. Children's ages ranged from 4 to 57 months.

Caregivers were divided into four groups: (1) mothers of noninfected children (n=34), (2) mothers of infected children (n=56), (3) foster mothers of noninfected children (n=37) and (4) foster mothers of infected children (n=53). Each caregiver filled out either the Beck Depression Inventory (Beck-I) (Beck, A.T., & Steer, R.A., 1987) or the Beck Depression Inventory, Second Edition (Beck-II) (Beck, A.T., Steer, R.A., & Brown, G.K., 1996).

Results. On the BDI-I, scores for depressive symptoms are categorized as follows: 0-9 Minimal; 10-16 Mild; 17-29 Moderate; 30-63 Severe (Beck, A.T., & Steer, R.A., 1987, p. 1).

On the BDI-II, scores tend to be higher than on the BDI-I, and they are categorized as follows: 0-13 Minimal; 14-19 Mild; 20-28 Moderate; 29-63 Severe (Beck, A.T., Steer, R.A., & Brown, G.K., 1996, p. 11).

To analyze BDI-I and BDI-II scores together, we transformed BDI-I scores to the comparable BDI-II scores (Beck et al., 1996, p. 26).

Mothers scored higher on the BDI (mean=13.38, s.d.=11.50) than did foster mothers (mean=3.64, s.d.=5.53). The Kruskal-Wallis one-way analysis of variance showed this difference to be very highly significant ($H=48.6$, $p<.001$).

Contrary to expectation, mothers of infected children did not show significantly more depressive symptoms than mothers of noninfected children (means=13.48 and 13.21, respectively, a non-significant difference). Foster mothers of infected children did not show significantly more depressive symptoms (mean=2.62, s.d.=4.36) than foster mothers of noninfected children (mean=5.11, s.d.=6.66, $p<.02$).

Conclusion. Our data support the hypothesis that HIV-positive mothers of infants, toddlers and pre-schoolers are at increased risk for depression, regardless of the HIV status of their children. Further, HIV status of the children was unassociated with maternal depression for foster mothers and HIV positive biological mothers.

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