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A Clinical Trial of In-Home CBT for Depressed Mothers in Home Visitation

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Despite negative outcomes for depressed mothers and their children, no treatment specifically designed to address maternal depression in the context of home visitation has emerged. In-Home Cognitive Behavioral Therapy (IH-CBT) is an adapted treatment that is delivered in the home, focuses on the needs of new mothers, and leverages ongoing home visiting to optimize engagement and outcomes. This study examined the efficacy of IH-CBT using a randomized clinical trial. Subjects were 93 new mothers in a home visiting program. Mothers with major depressive disorder identified at 3 months postpartum were randomized into IH-CBT and ongoing home visitation ($n=47$) or standard home visitation (SHV; $n=46$) in which they received home visitation alone and could obtain treatment in the community. Depression was measured at pre- and posttreatment, and 3-month follow-up using interviews, clinician ratings, and self-report. Mothers receiving IH-CBT showed improvements in all indicators of depression relative to the SHV condition and these gains were maintained at follow-up. For example, 70.7% of mothers receiving IH-CBT were no longer depressed at posttreatment in terms of meeting criteria for major depressive disorder compared to 30.2% in the SHV

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group. These findings suggest that IH-CBT is an efficacious treatment for depressed mothers in home visitation programs.

Keywords: home visitation; maternal depression; cognitive behavioral therapy; adapted treatment

HOME VISITATION IS A PROMISING prevention strategy for young children and their mothers (Sweet & Appelbaum, 2004). Originally designed to prevent child abuse and neglect, home visitation programs have broadened to encompass multiple approaches to optimize child health and development (Boller & Strong, 2010). Although there is significant variability in the formats and strategies used by home visitation models, they typically share common elements: (a) enrollment early in the child's life (or prenatally), (b) engagement of mothers early in their roles as parents, (c) strengthening of individual and family protective factors and mitigating risk factors to promote normative development, (d) frequent contact between home visitors and families, and (e) extended program duration (up to 3 years) to ensure that home visitors are present during developmental transitions in which new needs of children and families emerge.

There are up to 500,000 children and their mothers served by home visiting programs in the USA (Astuto & Allen, 2009). Mothers served by home visitation are typically socially isolated, impoverished, and underemployed. As a result, home visitation programs spend considerable time working directly with mothers to address such issues as stress and coping, health, social functioning, and educational advancement. By strengthening functioning in these domains, mothers are more available to their children, better able to meet child needs, and are amenable to the psychoeducational approaches used by home visitors. Maternal depression negatively impacts these areas, and is recognized as a major public health problem. Indeed, research shows that between 28% and 61% of mothers in home visitation report clinically elevated levels of depression during the course of service (Ammerman et al., 2010). Several studies have found that depression is linked with poorer outcomes in home visitation (Ammerman et al., 2012; Duggan et al., 2009). Furthermore, home visitors report being unprepared to work with depressed mothers (Tandon, Parillo, Jenkins, & Duggan, 2005), that depressed mothers are harder to engage during home visits and are less able to benefit from services (Stevens et al., 2005), and that depression makes it more difficult to implement program curricula (Administration on Children Youth and Families, 2002).

Clinical trials suggest that home visitation alone provides little to no benefit in reducing maternal depressive symptoms (Duggan, Fuddy, Burrell, et al., 2004), or that symptom reduction is short-lived (Landsverk et al., 2002) or occurs only after services have ended (Chazan-Cohen et al., 2007). Thus, during the important first years of the child's life these mothers and their offspring are at risk to experience the negative effects of depression and less able to take advantage of the services provided by home visitors. One of the goals of home visitation is to link mothers to other needed resources in the community, including mental health treatment. Yet, home visitors often fail to identify depression (Duggan, Fuddy, McFarlane, et al., 2004). Even though depression screening has become standard in home visitation programs, mothers infrequently obtain mental health treatment even when the need is recognized (Tandon et al., 2008). When mothers obtain treatment, the competing time demands in complex health systems preclude adequate collaboration between clinicians and home visitors, which in turn potentially undermines treatment effectiveness. No effective interventions have been developed that address this problem in home visitation.

In order to be effective, treatment for depressed mothers in home visitation needs to accommodate the unique features of the setting (e.g., the home), population (e.g., low income, new mothers), and context (e.g., concurrent services provided by home visitors). In fact, it is widely acknowledged that the attenuated effectiveness observed when evidence-based treatments are applied in real-world settings is attributable in part to the failure to attend to such accommodations (Conner-Smith & Weisz, 2003; Weisz et al., 2012). In response, Ammerman et al. (2007) systematically adapted cognitive behavioral therapy (CBT) in order to optimize its effectiveness for depressed mothers receiving home visitation. Although there are several treatments that have been found to be effective for depressed mothers (Cohen et al., 2010), and there have been successful efforts to provide intervention in the home setting (Leis, Mendelson, Tandon, & Perry, 2009), CBT was selected because (a) it is theoretically and practically compatible with home visiting and different home visiting models, (b) it has a strong foundation of evidence for efficacy, and (c) it is widely trained and as a result an adapted version could be more readily disseminated and adopted by home visiting programs. In-Home Cognitive Behavioral Therapy (IH-CBT) is implemented by therapists who provide treatment concurrently with ongoing home visitation. IH-CBT combines the core principles and techniques of CBT (J. Beck, 2011) with a set of procedures and strategies that promote engagement,

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