Video-Call Cognitive Behavioral Therapy and Parenting Stress

Name

Institution Affiliation

Abstract

Parenting-associated stress has adverse impacts on the well-being of parents, children, and the family system. Daily parenting demands could be exciting periods full of happiness and joy. However, parenting can be a source of irritation and frustration for most parents. The nurturing of young children presents challenges, particularly around mealtimes and bedtimes. Parenting young children might also incorporate many feelings and behaviors. Problems found in the nurturing of older children include difficult attitudes, substance use, curfews, technology use, and dating. Although every event in isolation can be inconsequential, it is the consolidation of events over time undergone together with other bases of life stress, such as relationship disagreements and unemployment, which can contribute to substantial parenting stress. The buildup of tension can result in significant complications for parents and children. A parent might handle minor stresses such as child behavior problems, overbearing loss, financial accountabilities, and relationship discord. Still, these independent stressors amass and have a tremendous impact on the parent. There are few analyses on the efficiency of cognitive-behavioral therapy offered via the phone in eliminating parenting stress. This study will explore the impact of video call-based cognitive-behavioral therapy on parenting stress at 42 days and six months postnatal.

Introduction

The transition to parenthood is a developmental life event that demands significant changes. The challenging role of nurturing a newborn child and overwhelming changes in responsibilities and relationships can result in increased parenting stress, which has negative influences on the well-being of parents, children, and the family system. A fitting description for parenting stress can be physical and psychological problems acquired from parenting accountabilities. A survey of 75 new parents in Italy demonstrated increased levels of stress during the first month after delivery (Cronin, Becher, Christians, Maher, & Dibb, 2015).

Another study done in Canada involving 94 pregnant women revealed that they undergo a significant degree of parenting stress at three and six months postnatal. Increased stress levels can influence the parent-child relationship adversely, contributing to insecurities in children and an impact on their social growth (Ngai, Wong, Chung, & Leung, 2016). Moreover, there is a link between factors such as maternal depression and adverse parental behavior and high levels of parenting stress (Visser et al., 2015). These elements result in child abuse and heightened occurrences of mistreatment. The first weeks of motherhood are times of increased tension as women experience firsthand the actualities of childcare demands that question their parenting skills (Wolff, Jandasek, Michel, Becker, & Spirito, 2017).

Literature Review

Studies on parents that have children with disabilities and chronically ill children have revealed that the most frequent impacts on the parents are compulsive thoughts, a poorer quality of life, a depressive mood, stress related symptoms, uncertainty, evasion, and fear (Ammerman et al., 2014). Other investigations have demonstrated that parents can undergo considerable stress concerning their child's heart disease even long after the heart operation (Kingston & Tough, 2013). Additionally, the parents in the survey usually experienced significant stress with

older children. Almost 36% of mothers with diabetic children experience burnout contrasted with 20% of mothers with healthy children (Kingston & Tough, 2013).

Moreover, studies reveal that a parent's mental health also influences the child's development, adjustment, and health. As a result, parental stress might be a risk factor for the child's development and health (Madigan, Vaillancourt, McKibbon, & Benoit, 2015). CBT (cognitive-behavioral therapy) is a series of interventions that have the fundamental principle that cognitive factors maintain psychological distress and mental disorders. The central principle of the treatment method states that maladaptive perceptions result in the continuance of behavioral and emotional issues (Hofmann, 2012). These maladaptive perceptions incorporate personal schemas, or beliefs, about existence, the future, and the self, leading to automatic and specific views in certain circumstances. The central model suggests that therapeutic approaches to modifying these maladaptive perceptions contribute to adjustments in problematic behaviors and emotional distress (Hofmann, 2012).

Since these initial concepts, there has been a development of a variety of disorder-precise CBT procedures. These protocols tackle different behavioral and cognitive maintenance factors of the various disorders (Tutus, Keller, Sachser, Pfeiffer, & Goldbeck, 2017). Whereas these disorder-precise treatment procedures indicate substantial variations in some of the specific treatment methods, they have the same approach and core model of therapy (Hofmann, 2012).

In harmony with the psychiatric model, the general objective of treatment is the enhancement of functioning, remission of the disorder, and symptom reduction (Weiss, Viecili, & Bohr, 2014). To accomplish this goal, it is pertinent that the patient is an active participant in a cooperative resolution procedure to examine and contest the legitimacy of maladaptive perceptions and to adjust maladaptive behavioral patterns (Hofmann, 2012). As a result, modern

CBT is a set of interventions that consolidate a diversity of behavioral, cognitive, and emotion-centered. While these approaches increasingly accentuate cognitive factors, there is an appreciation of behavioral, physiological, and emotional elements due to their function in the maintenance of the condition (Hofmann, 2012).

CBT (Cognitive behavioral therapy) for parents with children that have a chronic illness is a successful way of eliminating the children's pain (McQuillan & Bates, 2017). Still, there are no suggestions that cognitive interventions incorporating the parents had an impact on the child's functional capacity (Anclair & Hiltunen, 2014). CBT interventions provided to parents were mostly restricted in duration/time. In other instances, psychological support was via the internet, and there was no physical contact with the therapist (Anclair & Hiltunen, 2014). Telephone-based CBT has confirmed its success as treatment mode for the advancement of perinatal well-being. A pilot study of telephone-based depression control among 22 young mothers in the U.S. revealed that their depression symptoms declined over time from six weeks to six months postnatal. The intervention incorporated 11 phone calls to help mothers with their problem solving and to remove obstacles to treatment (Ngai, Wong, Chung, & Leung, 2016).

Furthermore, a similar U.S. study demonstrated that telecare therapy that emphasized on problem-solving abilities and cognitive restructuring was successful in the enhancement of depressive symptoms in 20 women diagnosed with postnatal depression.

A randomized controlled trial of the effectiveness of a culturally adjusted CBT among Chinese parents that had children with developmental challenges was conducted. The trial discovered that the CBT group indicated a substantial decrease in parenting stress associated with an enhancement in general well-being (Yen et al., 2013). A Cochrane appraisal of 36 studies focusing on the influence of group-centered parent training initiatives on maternal mental

health showed that such programs, supported by behavioral, cognitive, or CBT reinforcement, resulted in a statistically substantial advancement in parental stress 28 days after the birth (Crnic & Ross, 2017).

Moreover, a meta-analysis of nine studies that dealt with the psychological management of parental functioning and maternal depression showed that psychotherapies incorporating interpersonal, cognitive-behavioral, psychodynamic therapy/counseling had slight effects on parenting distress and maternal depression. The evidence proposed that parenting interventions centered on CBT that emphasize on cultivating problem-solving capacities and adjusting dysfunctional thoughts, can decrease parental stress and enhance positive parenting (Battagliese et al., 2015).

Aim and Hypotheses

Hypothesis

Video-call cognitive behavioral therapy is effective in managing the stress related to postnatal depression in American mothers.

Aim

The transition to parenthood is a developmental life event that demands significant changes. The challenging role of nurturing a newborn child and the overwhelming changes in responsibilities and relationships can result in increased parenting stress, which has negative influences on the well-being of the parents, children, and the family system. There are few analyses on the success of cognitive-behavioral therapy provided by video-call in decreasing parenting stress. Provided the adverse long-term outcomes of such stress on child development and parents, the objective of this randomized-controlled trial will be to assess the impact of

video-call cognitive behavioral therapy contrasted with postnatal care on parenting stress, at 42 days and six months postnatal.

Method

Design and Participants

The collection of the research data is done as a component of a bigger randomized controlled trial to determine the effect of video call CBT on postpartum depression. The recruitment of participants is conducted at the postpartum units of three major hospitals in Seattle from September 2017 to February 2019.

The inclusion criteria shall encompass first-time bearers, married postnatal women that are 18 or older, no complications after delivery, conceiving a single full-term healthy baby (5-min Apgar score more than seven), able to speak and read English, at risk of postpartum depression (Edinburgh Postnatal Depression Scale score of more than nine), and Seattle residents.

Exclusion of participants will be based on whether they are under anti-psychotic medications or antidepressants and if they received regular follow-ups with a therapist. The sample inclusion criteria will be used to reduce the possible confounding impact of factors, such as those having preterm infants on the study results or single mothers.

Procedures

Approval for the study will be sought from the Institutional review board of Seattle University/ The Pacific Hospital Preservation & Development Authority and the ethics review committees of three study hospitals. Mothers that satisfy the study criteria will be recruited on the second or third postnatal day at the postpartum units. Written informed approval will be

acquired from every participant after the goals and processes of the study have been adequately understood.

Mothers at risk of postpartum depression will be randomly assigned to control groups or video-call CBT. The assignment will be organized beforehand by the author applying a limited randomization scheme with a random number table, with the findings placed in sequentially numbered, impervious and sealed envelopes. A study assistant will open the envelopes having the group allocations after the mothers have provided their consent.

Participants will be required to complete the evaluation of parenting stress. These assessments will be mailed to them and sent back in pre-addressed stamped envelopes, at the 42-day and six-month postnatal. This activity will be performed by a study assistant that is unaware of the participants' assigned groups. Financial incentives will be offered as a way of appreciating participation in the study.

Materials: Parenting Stress Index Short Form (PSI-SF)

The PSI-SF is a self-report assessor of parenting stress with 36 items. The measure comprises three subscales: Parent–Child Dysfunctional Interaction (PCDI), Difficult Child (DC), and Parental Distress (PD) (Ngai, Wong, Chung, & Leung, 2016). The PD assesses levels of agony arising from personal factors, such as life restrictions related to child-nurturing, disagreements with a partner, and depression. The PCDI determines parents' displeasure with communications with their children and the extent to which they find their children intolerable. The DC gauges parents' views of their children's self-regulatory capacities (Ngai, Wong, Chung, & Leung, 2016).

Every subscale incorporates 12 items graded on a five-point scale. The total stress score recapitulates the three subscale scores and ranges from 36 to 180, with higher scores signifying

greater stress in parenting responsibility. A total stress raw score in the ≥90th percentile shows clinically substantial levels of stress.

Results

Standard and mean errors for both of the group's total scores on PSI and subscales of DC, PD, and DCI fields at the 42-day and six-month points will be presented in a table. Four separate GLMMs (Generalized Linear Mixed Model) will run for the three subscale scores and the total PSI score at both time points.

Significant differences are expected between the control groups and the video-call CBT on the total PSI score and each domain at 42 days postnatal (mean difference in PD, 2.73 [95% CI, 1.23–4.22], p b 0.001, d = 0.36; mean difference in DC, 2.78 [95% CI, 1.28–4.27], p b 0.001, d=0.37; mean difference in PCDI, 3.92 [95% CI, 2.59–5.25], p b 0.001, d = 0.59; mean difference in PSI, 9.42 [95% CI, 5.85–12.99], p b 0.001, Cohen's d = 0.52).

Mothers in the video-call CBT group are expected to report considerably less tension associated with parenting, reduced stress in their parenting responsibilities, recognize their babies to be substantially less challenging at the 42-day point than those in the control group, and undergo less impairment in their interactions with the infant. The effect sizes are anticipated to be average, ranging from 0.36 to 0.59. In six months, the video-call CBT group is expected to demonstrate a considerably lower score on parenting stress than the control group (mean difference in PSI 3.58 [95% CI, 0.07–7.09], p = 0.046, d = 0.20). Still, it is anticipated that there will be no variations between the groups in the three PSI subscales.

Conclusion

The study will indicate that the provision of video-call CBT in the shift to motherhood might enable a positive adjustment and relieve parenting stress for the mother at risk of

postpartum depression. Preliminary results of enhancement in maternal cognitions of the parenting stress and the parenting experience widen the existing literature that has been published over the past ten years concerning the success of CBT for mothers and their infants. The focus of CBT in enhancing problem-solving skills and contesting dysfunctional thoughts may assist to reduce the pressures of the transition and decrease parenting stress. These types of interventions might be particularly relevant to a child's growth in families where there is a compromise of early parenting by high levels of depression and parental stress.

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