Research paper

Factors associated with depression among homeless mothers. Results of the ENFAMS survey

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ABSTRACT

Purpose: Women are disproportionately likely to suffer from depression. This is especially true for those who experience socioeconomic hardship, such as homelessness. In France, among homeless mothers many are migrant. However, it is not clear whether risk factors associated with depression are specific for this group or the same as in the general population. Our objective was to describe socio-demographic, relational, living and housing conditions and health factors associated with depression among homeless mothers.

Methods: The ENFAMS survey, conducted via face-to-face bilingual interviews with a representative sample of homeless families in the Paris region (January-May 2013, n = 733 mothers). Mothers reported their socio-demographic characteristics, housing conditions including residential mobility, as well as physical and mental health. Depression was ascertained using the Composite International Diagnostic Interview (CIDI). Factors associated with mother’s depression were studied in weighted Poisson regression models with robust error variance.

Results: The prevalence of depression among participating mothers was 28.8%. In multivariate analyses, depression was associated with fluency in French (PR = 1.88 95% CI 1.40; 2.51), suicide risk (PR = 2.26, 95% CI 1.82; 2.82), post-traumatic stress disorder (PR = 1.97, 95% CI 1.50; 2.60), and unmet health needs (PR = 1.68, 95% CI 1.09; 2.57).

Conclusions: Homeless mothers have high levels of depression and associated psychiatric comorbidities. Associated risk factors appear to be both specific for this group and shared with mothers in the general population. Improvements in the monitoring of mental health difficulties as well as access to appropriate medical care in this vulnerable population may help improve health and social outcomes.

1. Introduction

Depression is a major public health problem, especially among women. In France, 7.2% of women in the general population experience major depression at any point in time (Chan Chee et al., 2009). Although treatable, depression often goes unnoticed and underdiagnosed (Grant et al., 2013; Suglia et al., 2011). Risk factors of depression include biological as well as environmental risk factors which sometimes interact (Gertz et al., 2011; Caspi et al., 2005; Gillespie et al., 2005; Kendler et al., 2002). Specifically, genetic vulnerability (e.g. the serotonin transporter gene) (Caspi et al., 2003; Eley et al., 2004) alone or in interaction with the environment (Gertz et al., 2011; Caspi et al., 2005; Gillespie et al., 2005; Kendler et al., 2002, 2005; York et al., 2005), neurobiological factors (e.g. stress can alter the development of the hypothalamic-pituitary-adrenal axis, hypothalamic and extrahypothalamic corticotropin releasing hormone, monoaminergic, and gamma-aminobutyric acid/benzodiazepine systems) (Kaufman et al., 2000; Phillips et al., 2003a, 2003b), personality traits (Boyle et al., 1991), life stress (Gillespie et al., 2005; Monroe and Harkness, 2005; de Kloet et al., 2005; Willner, 2017; Kendler et al., 2003, Kessler, 1997), a disturbed family environment (e.g. prenatal stress, parental care, overprotection and disciplinary practices) (Huizink et al., 2004; Parker, 1979; Holmes and Robins, 1988), exposure to violence (Caspi et al., 2002), somatic health problems (e.g. diabetes) (Holt et al., 2014), substance abuse (Caspi et al., 2005; Kessler et al., 1996) represent the main sources of risk. Poverty, defined as economic and material deprivation, is associated with high levels of stress and negative life circumstances (Cutler and Nolen-Hoeksema, 1991; Kessler and Magee, 1993), pervasive powerlessness, and social isolation (Henderson, 1992), all known to contribute to emotional distress and depression.
Mothers who experience material hardship and particularly homelessness appear disproportionately exposed to several of these risk factors and may be additionally exposed to specific situations of vulnerability, which contribute to their risk of depression. This makes homeless mothers an especially vulnerable group (Zabkiewicz et al., 2014; Bassuk et al., 1998; Weinreb et al., 2006; Laporte et al., 2010) for this mental health problem (half of homeless mothers suffered from depression).

Families are currently the fastest growing segment of the homeless population (Bassuk et al., 2014). In 2013, an estimated 10,280 homeless families (approximately 35,000 people including 17,660 children) were accommodated by social services in the Paris region (Vandentorren et al., 2016). These estimates do not take into account families housed by friends or relatives, implying that the overall number of persons without stable accommodation is probably higher. It is important to note that a majority of these families are migrant. This recent increase (Guyavarch and Le Mener, 2010) is due to several factors. First, levels of poverty and the cost of living in the Paris region simultaneously increased in recent years, amplifying difficulties in access to housing, especially among vulnerable groups. Second, increasing numbers of families who apply for political asylum are referred to homeless shelters due to insufficient capacity in specific facilities, which automatically leads to a higher number of homeless persons. As in many large European cities, in Paris the proportion of persons who have asked for political asylum and are homeless has increased (38% in 2001, 52% in 2012) (An overview of housing exclusion in europe, 2015).

Given these changing circumstances, there is need to update knowledge about characteristics of homeless mothers, specifically in terms of depression, the most frequent mental health problem in this population (Laporte et al., 2015). Our aims were: 1) to describe the prevalence of depression in homeless mothers; 2) to identify socio-demographic and health characteristics associated with depression in this vulnerable group.

2. Materials and methods

2.1. Sample

The ENFAMS survey (a French acronym for “ENfants et FAMillies Sans logement” – “Homeless children and families”) (Vandentorren et al., 2016) was conducted by the Observatoire du Samu Social (Observatory of the Social Emergency Service – a non-governmental organization which provides shelter to persons who are homeless in Paris area) from January to May 2013. The aim of the study was to describe the socio-demographic characteristics and health of homeless families in the Paris region (approximately 12 million inhabitants). Following guidelines established by France’s National Institute of Statistics (INSEE), a person is considered to be homeless on any given day if he or she spent the previous night on the street or in a sheltered accommodation. In our study, inclusion criteria were: to be a member of a family composed by an adult and at least one child under 13 years of age, to speak one of the 17 survey languages and to be accommodated in: 1) emergency shelters that are generally short-term and provide only basic services (e.g. breakfast); 2) social hotel; 3) long-term rehabilitation centers in which persons can stay up to several months and which provide a larger number of services (e.g. access to a kitchen); 4) reception centers for asylum-seekers (Buckner et al., 2004). Emergency shelters and social hotels are considered to be short-term, whereas long-term rehabilitation centers and centers for asylum-seekers are long-term.

First, among the 796 accommodations for homeless persons in the region at the time of the survey, 251 were randomly selected stratifying on facility type (82% participation rate). Second, families with at least one child under 13 years of age were randomly selected: 801 (65% participation) took part in the study (Vandentorren et al., 2016). Participants were identified using time-location sampling (Vandentorren et al., 2016; Leon et al., 2015).

Families which did not participate in the ENFAMS survey were characterized by younger maternal age (33 vs. 38 years), a higher proportion of men (15.3 vs. 4.6%), and a higher proportion of families with two or more children (31.7 vs. 23.1%) (Vandentorren et al., 2016). Reasons most frequently cited to explain non-participation were: lack of interest (17%), lack of time (14%) or the other parent’s lack of written consent (11%).

The ENFAMS study was approved by the French National Committee overseeing ethical data collection (CNIL), and two ethics boards (the Comité de Protection des Personnes - CPP - in Île-de-France and the Comité Consultatif sur le Traitement de l’Information en matière de Recherche dans le domaine de la Santé – CCTIRS).

2.2. Measures and questionnaires

Study data were collected in face-to-face interviews conducted by bilingual trained interviewers and psychologists in 17 different languages. Additionally, blood samples and anthropometric measures were collected by study nurses. The study outcome was depression in the preceding 12 months ascertained using the Composite International Diagnostic Interview (Kessler et al., 1998).

Based on prior scientific literature, factors examined as potentially associated with depression included:

- socio-demographic and familial characteristics: age; region of birth (Europe vs. not Europe); administrative status (French citizenship/resident status in France, undocumented, asylum seeker or with a resident permit); family status (i.e. living with a partner, number of children and their age); exposure to domestic violence in the preceding 12 months ascertained with 14 questions used by the National Institute of Demography (INED) (Hamel et al., 2014) (e.g. “did your spouse or partner/ex-partner prevent you from accessing household money for the everyday expenses? Threaten to target your children or to take your children away? Insult or abuse you?”, yes vs. no); contacts with family (once or more per year; yes vs. no); employment/schooling status (yes or no); educational level (< high school degree: yes vs. no); monthly income (< poverty line of 964 euros/month/pers yes vs. no); health insurance (complete, incomplete, none); food insecurity in the preceding 12 months (assessed using the French version of the US Household Food Security Module (Martin-Fernandez et al., 2013; Radimer, 2002); yes vs. no); fluency in French (yes vs. no); social support (ascertained by two items investigating whether the person knew someone living in France at the time of arrival and whether this person helped: yes vs. no); material support from an non-governmental organization, friends or family (e.g. food vouchers, clothes, money: yes vs. no); reason for departure from country of origin (violent cause: yes vs. no);

- living and housing conditions: ever spent the night on the street (yes vs. no); time since the family arrived in France (dichotomized at the median value: < 3 years: yes vs. no) and time since homelessness (assessed with the question: “In France, when did you find yourself for the first time homeless, in a homeless shelter (CHRS, CADA …) or in a hotel that an association paid for?”; dichotomized at the median value: < 2 years: yes vs. no); type of shelter (short vs. long-term); residential instability (i.e. time in the last shelter, dichotomized at the median value: < 6 months: yes vs. no); housing quality (< 2 persons per room: yes vs. no);

- physical health characteristics: serious health problem(s) that disrupt daily life (yes vs. no); anemia (ascertained in study blood samples: yes vs. no); obesity measured by study nurses (BMI > 30: yes vs. no); pregnancy at the time of the interview (yes vs. no); female
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