

Background

Family dysfunction and child maltreatment as well as subsequent maladaptation occur disproportionately often in families exposed to psychosocial risk. As families' situations are diverse, epidemiological data concerning risk factors and their interactions is needed to design early interventions that meet the specific needs of families in various risk constellations. In Germany, however, there is a paucity of such data.

Consequently, the German National Centre on Early Prevention plans a large-scale national prevalence study on psychosocial risk for families with children from zero to three. In order to identify the optimal strategy for targeting parents exposed to psychosocial risks, two large pilot studies tested a bespoke risk inventory in two different German cities. The risk inventory was delivered by means of two different survey types with the main objective of identifying the best way to motivate people from all social groups to respond to a prevalence study.

Method

Pilot studies: In two comparable German cities, parents with children aged zero to three were asked to complete a questionnaire on psychosocial risk factors covering the domains family demographics (e.g. poverty, low education or dependence on social welfare), child characteristics (e.g. low birth weight, child unwanted or dysregulation) and family characteristics (e.g. low attachment, parental psychopathology, experienced stress or previous contact with child protection services). The questionnaire includes 84 items and takes about 30 to 45 minutes to complete.

Recruitment was either via registration office data (city 1) or via pediatricians (city 2). For analysis, first pilot study data on risk prevalence is given, including objective, subjective and psychological risk factors. Additionally, the importance of parents' gender and education will be highlighted.



City 1

- Registration office data
- Target sample: about 15,000 children 0-3
- All children which were born between 01.01.2011 and 31.12.2013
- Mix of methods: via telephone (CATI) and self-completion questionnaire via mail (PAPI) or internet (CAWI)
- Conducted telephone interviews: 493; questionnaires: 3,680; online: 601
- 4,656 Participants (= 30% response rate); 13.8 % fathers

City 2

- Contact via pediatricians
- Early screening program for infants and young children 0-3
- Self-Completion of the questionnaire in pediatricians' practices
- Additional risk assessment provided by pediatricians
- 20 Participating pediatricians (= 61% of eligible pediatricians)
- Overall cap at 1,500 participating families
- 1,605 completed questionnaires (= 56% of the families); 8.5% fathers

First results from the two pilot-cities

Risk factors and education

Objective risk factor	Proportion within total sample size	Primary caregiver with low education (ISCED)	Primary caregiver with high education (ISCED)
Depressive symptoms	22.7%	30.1%	18.4%
Experience of partnership violence – ever	10.1%	18.5%	6.0%
Experience of partnership violence – current	1.4%	3.4%	0.9%
Help offer from youth welfare service	4.8%	13.0%	2.9%
Preterm birth	10.9%	14.4%	8.8%
Second parent not living in household	11.2%	30.1%	4.5%
Subjective risk factor			
Baby's regulation problems	22.4%	19.7%	24.7%
Experience of deficient parental competence	10.1%	9.5%	10.2%

ISCED = International Standard Classification of Education

Risk factors and parents' gender

Risk factor	Proportion mothers	Proportion fathers	Significance (Chi ²)
Depressive symptoms	23.6%	17.1%	.000
Experience of partnership violence – ever	10.8%	4.5%	.000
Experience of partnership violence – current	1.4%	0.8%	.212
Help offer from youth welfare service	4.8%	4.6%	.792
Preterm birth	10.8%	8.6%	.065
Second parent not living in household	12%	4.7%	.000

Psychological risk factors and education

Psychological risk factor (scale)	Mean, low education (ISCED)	Mean, high education (ISCED)	t	df	d
Everyday life stress (PSS)	7.40	5.89	11.29*	3309	.47
Quality of partnership (DAS-4)	5.71	4.61	7.94*	3144	.35
Negative experiences in childhood	3.06	1.92	11.02*	3343	.45
Negative educational attitudes	.16	.04	11.37*	3329	.47
Deficient social support	2.07	1.62	7.21*	3369	.29

Conclusion

Comparison of designs: Both designs proved to be feasible, succeeding in reaching all demographic groups with some differences in detail. While there is an underrepresentation of potentially burdened families in city 1 (registration office data), a slight overrepresentation was observed in city 2 (contact via pediatricians).

Prevalence: With regard to selected risk factors, we observe prevalence rates between 1.4% and about 22% (*depressive symptoms* and *regulation problems*).

Education and gender: The importance of the primary caregiver's education shows up: in all analyzed objective (6) and psychological risk factors (5) we observe higher values in the lower education group – up to four and a half and even seven times more likely (*help offer from youth welfare service* and *second parent not in household* respectively). But a different picture emerges with regard to two subjective risk factors: higher education is now associated with higher values. Concerning parents' gender, we observe higher degrees of risk for mothers as primary caregivers than for fathers in the same role, with prevalence rates increasing up to threefold (*second parent not living in household*).

