Introduction

• Since The National Center on Minority Health and Health Disparities (NCMHD) was established by the mission of the Minority Health and Health Disparities Research and Education Act of 2009, Public Law 109-552, there has been a steady increase in the demand for research amongst underrepresented populations. Nevertheless, there remains a shortage of research examining these populations despite initiatives driven by several national organizations (George, Duran, & Norris, 2013). Therefore, the population continues to be at risk and is underserved (Rivas-Drake, Camacho, & Guillaume, 2016), further perpetuating problematic inequity in empirical research. Studying underrepresented populations is imperative to achieving more generalizable conclusions in developmental research as well as cultivating culturally, socioeconomically, and ethnically sensitive interventions and policies (Knight et al., 2009).

• However, retaining underrepresented and economically disadvantaged families in longitudinal research presents unique methodological challenges to researchers leading to elevated attrition rates. This is especially true amongst high-risk families and higged rates of transient housing, unstable phone service, and other stressful life events (Zook et al., 2010).

• Existing literature reports wide differences in the retention of participants in longitudinal developmental research. Despite some extraordinary exceptions (Pittsburg Girls Study; Project Competence Study), researchers have found high attrition rates.

• Few studies have provided a thorough record and report of specific tracking measures and procedures. Some existing studies highlight researcher efforts including developing trust through the continuity of interviewers across waves and cooperation with referring agencies (e.g., Gregory, Lohr, & Gilchrist, 1992), offering participant-specific incentives (Katz et al., 2001), implementing a tracking database and assigning a tracking coordinator (McCuller et al., 2002), maintaining multiple procedures. Some existing studies highlight researcher efforts including developing trust through the continuity of interviewers across waves and cooperation with referring agencies (e.g., Gregory, Lohr, & Gilchrist, 1992), offering participant-specific incentives (Katz et al., 2001), implementing a tracking database and assigning a tracking coordinator (McCuller et al., 2002), maintaining multiple procedures.

• Results showed that less maternal education significantly predicted more changes in participants phone numbers. Additionally, lower income to needs, higher anxiety and PTSD—Avoidance, along with less perceived social support (trend) significantly predicted greater changes in participants’ re-contact person, explaining 19% of the variance. Lastly, higher anxiety and less perceived social support significantly predicted changes in participants’ re-contact persons’ contact information, explaining 19% of the variance.

• Final multiple regression analyses were conducted using significant (p < .05) and marginally significant (p = .10) variables from preliminary regression analyses as predictors (see Table 2).

• Less physically active and perceived social support both significantly predicted greater changes in participants’ phone numbers across the study, explaining 18% of the variance.

• Lower income to needs, higher anxiety and PTSD—Avoidance, along with less perceived social support (trend) significantly predicted greater changes in participants’ re-contact persons, explaining 27% of the variance.

Discussion

• Maintaining contact and minimizing attrition rates among high-risk participants in developmental research poses unique methodological challenges to researchers.

• Moreover, effective tracking methods have rarely been detailed and published in existing literature apart from publications that are methodological in nature. Results of the current study provide a comprehensive record of extensive, multimodal tracking efforts in order to: 1) decrease phone visits. Furthermore, 21% of women were still unable to locate a primary re-contact person at some point; 5% did not provide one during any tracking period. Due to difficulty reaching participants, researchers contacted 61% of re-contact people by phone, and 67% by home visits. Researchers from the present study coded extensive tracking efforts and procedures by 99% (T2), 94% (T3), and 88% (T4).

• Researchers coded data on phone calls, home visits, letters, and e-mails to participants and their re-contact person/people (up to 3 individuals whom the participant indicated they knew who would be able to locate her). They also coded contact information changes and days spent attempting to contact participants during each tracking period and across the entire study.

• On average, researchers spent 10 days per tracking period attempting to contact participants (M = 15.10, SD = 8.61, Range = 4 – 42) with an average of three calls per tracking period (M = 3.32, SD = 2.02, Range = 1 – 12). Sixty percent of women (60%) were sent a letter throughout the study to assist with contact. As technology advanced with time, e-mail also emerged as a helpful tracking method, used with 34% of women at one or more tracking periods.

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• Participants received 15 calls on average throughout the study (M = 15.10, SD = 8.61, Range = 4 – 42) with an average of three calls per tracking period (M = 3.32, SD = 2.02, Range = 1 – 12). Sixty percent of women (60%) were sent a letter throughout the study to assist with contact. As technology advanced with time, e-mail also emerged as a helpful tracking method, used with 34% of women at one or more tracking periods.

• Though the study, 21% of women were still unable to locate a primary re-contact person at some point; 5% did not provide one during any tracking period. Due to difficulty reaching participants, researchers contacted 61% of re-contact people by phone, and 67% by home visits.

• Results showed that less maternal education (β = -.24, p < .05) and less perceived social support (trend) significantly predicted more changes in participant phone numbers. In addition, lower income to needs (β = -.28, p < .01) and greater PTSD—Avoidance (β = -.33, p < .05) significantly predicted more changes in participants’ re-contact individuals across the study, with greater anxiety (β = -.23, p < .06) and less perceived social support (β = -.14, p < .10) trending toward significance.

• Lastly, less perceived social support (β = -.19, p < .05) significantly predicted greater changes in participants’ re-contact persons’ contact information, with greater anxiety (β = -.21, p < .10) trending toward significance.

• Bivariate correlations revealed significant relationships between several demographic risk variables and tracking outcomes (see Table 1). Subsequently, variables that were significantly related to participant phone number changes, number of re-contact person phone changes, and number of changes in re-contact persons’ contact information were further examined using multiple regression. Results showed that less maternal education (β = -.24, p < .05) and less perceived social support (trend) significantly predicted more changes in participant phone numbers.

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• Multiple regression analyses were conducted using significant (p < .05) and marginally significant (p = .10) variables from preliminary regression analyses as predictors (see Table 2). Less physically active and perceived social support both significantly predicted greater changes in participants’ phone numbers across the study, explaining 18% of the variance.

• Lower income to needs, higher anxiety and PTSD—Avoidance, along with less perceived social support (trend) significantly predicted greater changes in participants’ re-contact persons, explaining 27% of the variance.

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Results

• Method

Participants

120 women followed from pregnancy through the first two years of their child’s life; age range: 18-42 yrs., M = 26, SD = 8.

Race

• 47% African-American, 36% Caucasian, 13% Bircial, 4% Other (see Figure 1)

Maternal Status

• 64% single/never married, 28% married, 4% divorced, 4% separated

Education

• 20% had a high school diploma or less, 44% some college, 36% college degree

Income

Median monthly household income = $1500,

73% received services from WIC, and 76% had public health insurance

Procedures

• A community sample of pregnant women was recruited for a prospective longitudinal study on parenting. Data collection occurred during the mothers’ third trimester of pregnancy (T1), and at 3, 6, 12, and 18 months (T2), 1 year (T3), and 2 years (T4) postpartum.

Measures

• Maternal age, education, and household income were assessed at T1 using a demographics questionnaire.

• Incarceration-to-needs ratio was defined as the family’s income divided by the poverty threshold for that composition of family.

• Maternal depression was measured at T1 (α = .76) using the Brief Symptom Inventory, Anxiety and Hostility Scales (BSI-A 

• PTSD symptoms were assessed at T1 (α = .87) using the PTSD Checklist—Civilian version (Weathers et al., 1994).

• Maternal anxiety and hostility were assessed at T1 (α = .77) using the Brief Symptom Inventory, Anxiety and Hostility Scales (BSI-A

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• Maternal education was measured at T1 (α = .76) using the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, &amp; Sagovsky, 1987).

• The Perceived Social Support Scale (Procidano & Heller, 1983) was used at T1 to assess for total perceived social support (r = .91).

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