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An Examination of the Relationship between Maternal Depression and Barriers to Child Mental Health Services

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Abstract

Objective—Maternal depression is a common, chronic set of disorders associated with significant burden to caregivers, children and families. Some evidence suggests that depression is associated with perceptions of barriers to child mental health treatment and premature termination from services. However, this relationship has not yet been examined among a predominantly low-income sample, which is at disproportionately high risk of depression, child mental health problems, and treatment drop out. Accordingly, the purpose of this study is to examine the relationships between caregiver depression and perceived barriers to treatment

Methods—Three hundred twenty (n=320) children between the ages of 7 to 11 and their caregivers were assigned to either the 4 Rs and 2Ss for Strengthening Families, which is a multiple family group intervention, or services as usual (SAU) consisting of typical outpatient mental health services. Caregiver depression was measured by the Center for Epidemiologic Depression Scale; perceived barriers to treatment were assessed via the Kazdin Barriers to Treatment Scale.

Results—Clinically significant levels of depressive symptoms at baseline were significantly associated with greater scores in all four barriers to treatment subscales (stressors and obstacles competing with treatment, treatment demands and issues, perceived relevance, relationship with therapist) at post-test

Conclusions—Addressing maternal mental health, and attending to stressors that impede poverty-impacted families from child services is critical for the health and functioning of caregivers, and to ensure that children with mental health problems receive treatment.

Introduction

Depression is a group of common, chronic and impairing disorders that are widely considered to be a public health problem due to their prevalence and burden (Ertel et al., 2011; Kessler et al., 2003; World Health Organization, 2017). Adult women are

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approximately two times more likely to experience depression than men (Kessler, 2003) and among them, mothers are at the greatest risk for an episode of depression. The National Epidemiologic Survey of Alcohol and Related Conditions, for example, found that approximately 10% of over 8,000 women caring for a child 18 years of age or younger met criteria for major depressive disorder (MDD) within the prior year, and this rate was almost twice as high as the prevalence of MDD across the total sample of women (n=24,575, 6.9%; Ertel et al., 2011).

When mothers experience depression, the entire family is affected. Some of the many deleterious effects associated with caregiver depression includes absenteeism from work, reduced productivity and unemployment (Lerner & Henke, 2008; World Health Organization, 2017); co-morbid mental health, substance use and health disorders such as heart disease, diabetes and stroke (Bruce & Mussolino, 2000; Frasure-Smith & Lesperance, 2006); and an increased risk of suicide. Caregiver depression also undermines the quality of parenting, resulting in decreased parental involvement and warmth, and an increased risk of child maltreatment (Cummings et al., 2005; Lovejoy et al., 2000). And, caregiver depression increases the risk of serious mental health problems among the child, including depression, behavior problems and anxiety (Hammen, Shih, & Brennan, 2004; Lovejoy et al., 2000). To this point, one of the largest existing meta-analyses of maternal and child mental health, which comprised 193 studies, found that maternal depression was significantly and consistently associated with child internalizing and externalizing problems, as well as general psychopathology (which is defined as both internalizing and externalizing symptoms and/or disorders) among youth (Goodman et al., 2011).

Although children exposed to maternal depression are at heightened risk for mental health problems, access to care remains a serious problem, as only 20% of all children in need of mental health treatment receive services (Kataoka, Zhang & Wells, 2002). With few exceptions, children are dependent upon their parents to initiate and utilize treatment in a meaningful way (deHaan et al., 2013; Eapen & Ghubash, 2004; Nock & Kazdin, 2001; Thurston et al., 2015); therefore, it is necessary to consider obstacles to utilization at the caregiver level. To this end, Staudt (2007), who drew from existing health and mental health models of help seeking, as well as theoretical models pertaining to motivation, readiness, and behavior change, identified five areas supported by research that influenced their child's receipt of services: 1) the caregiver's perception of the relevance of treatment in addressing their child's difficulties and perceived acceptability of services, 2) perceptions and beliefs about treatment, 3) family stressors, which may distract caregivers from engaging in treatment, 4) logistical or external obstacles, including lack of transportation and childcare; cost; schedule conflicts; and, 5) the caregiver's therapeutic alliance with their child's provider. Ingoldsby (2010) adds provider and organizational-level factors including agency wait lists, staff turnover, geographic location, and language also affect service receipt among youth in need.

Across these categories, McKay and Bannon (2004) argue that perceptual obstacles are particularly powerful impediments. According to Staudt (2007), perceptual impediments include negative views about mental health and the treatment system, such as the caregiver's mistrust and concerns about stigma (Contractor et al., 2012; McKay & Bannon, 2004), as

well as what Nock and Kazdin (2001) refer to as therapeutic expectancies, meaning the perceived relevance, helpfulness and acceptability of treatment for the child (Choi & Kovshoff, 2013; Kazdin, Holland, Crowley, & Breton, 1997; Morrissey-Kane & Prinz, 1999; Nock & Kazdin, 2001; Staudt, 2007).

While there is a fairly voluminous literature about barriers to child mental health services, a less explored area is how caregivers with depression perceive barriers to their child's treatment. There is reason to believe that caregiver depression is associated with obstacles to help-seeking: The depression-distortion hypothesis, which derives from cognitive theory, surmises that caregivers who are depressed are more likely to have distorted views about their child's symptoms and treatment due to maladaptive thoughts Reck et al. (2016). A recent set of studies provides support in this theory; in one, caregiver depression was associated with greater perceived externalizing problems amongst male children and internalizing problems amongst female children (Gartstein et al., 2009), while in a second study, caregivers with depression rated their children as having greater problem behaviors prior to treatment than caregivers without depression (Timmer et al., 2011). Additionally, depression was associated with perceived therapeutic change, although in a deviation from prior studies, Timmer et al. found that caregivers with depression reported greater improvement in their child's behavior post-treatment than caregivers without depression.

Research conducted by Kazdin and colleagues examined the relationship between depression and both number and type of barriers to access. In the first study, caregiver depression was correlated with a greater number of perceived barriers to care (Kazdin et al., 1997), and the caregiver's perception of the relevance of their child's treatment was predictive of premature termination. A subsequent study by Kazdin and Wassell (2000) found two specific types of barriers-perceived treatment demands and low relevance of their child's treatment, were associated with less therapeutic progress among youth.

Viewed as a whole, this literature lends support for the need to increase the field's understanding of the relationship between caregiver depression and perceptions of barriers to child mental health treatment. This study aims to examine the relationships between perceptions of barriers to treatment and caregiver depression. Examinations among families of low socioeconomic status (SES) is particularly salient considering mothers living in low SES communities evidence greater rates of depression than mothers across higher income groups at rates of up to 25% (Bringewatt & Gershofi, 2010; Gelaye et al., 2016): Moreover, children living in poverty are at higher risk for mental health problems, but are less likely to remain in mental health services (Ingoldsby, 2010; McKay & Bannon, 2004; Slopen, Fitzmaurice, Williams, & Gilman, 2010). Given perceived barriers has been shown to predict premature termination from treatment for youth (Kazdin et al., 1997), understanding this association among families at high risk for depression and drop out is of particular import.

Method

Data were obtained from female caregivers who participated in a National Institute of Mental Health-funded study of a multiple family group model, entitled the 4 Rs and 2 Ss for strengthening families (4R2S), between 2006–2010 in New York City. Participants (n=320)

were recruited from New York State Office of Mental Health-licensed clinics (n=11) and randomized at the clinic level to either receive services as usual or the 4Rs and 2 Ss For Strengthening Families (approximately 11–80 participants per clinic). Participants included English- or Spanish-speaking adult (18 years and older) primary caregivers of a child between 7 and 11 years of age who met criteria for Oppositional Defiant Disorder (ODD) as measured by the Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992). Approximately half of the total sample received the 4 Rs and 2 Ss group intervention (54%) and the remaining 46% received services as usual within their clinic.

Intervention

The 4 Rs and 2 Ss for Strengthening Families (4 Rs and 2 Ss) is a multiple family group model that draws from group therapy techniques, systemic family therapy and behavioral parent training. It was developed using a common elements approach (Chacko et al., 2015), to identify techniques and procedures that are common to already existing evidence-based protocols for specific problem areas (Chorpita, Becker, & Daleiden, 2007). As such, the 4 Rs and 2 Ss for Strengthening Families integrates family processes and parenting skills linked to conduct problems from the empirical literature (Chacko et al., 2015; McKay et al., 2011). The intervention is delivered in a group format once weekly for the course of 16 weeks. The group is comprised of between 6–8 families of children ages 7 to 11. It is expected that the identified child participate with his/her primary caregiver each session; however, other important family members can also be invited to join the groups, including siblings, grandparents, and other caretakers in the extended family.

Each session focuses on a targeted skill that is referred in the curriculum as the 4 Rs (Rules, Responsibility, Relationships, and Respectful Communication) and 2Ss (Stress and Social support) (McKay et al., 2011). For example, the session on Respectful Communication outlines a discussion regarding words and phrases that can be used to get a family member's attention, which is followed by modeling the appropriate use of families' posture, mouths, and ears for active listening. Families then engage in a role play exercise to practice skills that were learned.

The model is manualized and co-facilitated by a mental health professional and student intern or family peer partner, who is a trained caregiver of a child with mental health problems who has had experience navigating the mental health system. Group facilitators receive monthly supervision from the developers of the model. Each group session follows a prescribed format, beginning with the facilitators presenting content on the topic area (for example, in the session on respectful communication, the facilitators guide a discussion regarding what respectful communication means, why this is important, and how families can know if they are listening to one-another). Next, the caregiver and their child complete a learning activity together, and the end involves the assignment of "road work to practice what was learned in the session" (for example, having caregivers and children ask one-another how their day was, and writing down the response). Each family receives their own manual to follow along during the session, and practice the session content between sessions (see Chacko et al., 2015 and Gopalan et al., 2015, for a description of the intervention).

Measurement

Demographic characteristics were collected via a sociodemographic questionnaire used in prior studies that assessed contextual familial factors (e.g. gender, race, ethnicity, age, etc.). As part of the eligibility screening for participation, child Oppositional Defiant Disorder was measured by the Disruptive Behavior Disorders Rating Scale Oppositional Defiant Subscale (DBD OD; Pelham et al., 1992). The DBD OD includes 8 items with ratings on a 4-point Likert scale including: not at all (1), just a little (2), pretty much (3), and very much (4). Total scores range from 8 to 32 and a total of 4 or more items endorsed as “pretty much” or “very much” meets criteria for an Oppositional Defiant Disorder and inclusion in the study. Internal consistency among the total sample was good with a Cronbach’s α of .70 at the time of screening.

Caregiver depression was measured using the Center for Epidemiologic Studies Depression Scale 7-item Short Form (CESD-SF; Levine, 2013; Radloff, 1997) at baseline (n=320). The CESD-SF is a free and publically available screening tool consisting of 7 items that assess the frequency of depressive symptoms occurring in the past week (0 = rarely/none of the time, 1 = some or a little of the time, 2 = occasionally or a moderate amount of time, 3 = most or all of the time). CESD-SF scores are summed and range from 0–21, with a score of 8 and above considered to measure clinically significant depressive symptoms (Levine, 2013). Internal consistency among the total sample was good with a Cronbach’s α of .82 at baseline.

Barriers to treatment were measured using the Kazdin Barriers to Treatment (KBT) scale (Kazdin et al., 1997) at post-test (16 weeks after baseline; n = 250). The KBT is a self-report measure completed by parents that assesses factors and problems that affect family participation and attendance. Few studies to date have examined sub scales of the KBT (Girio-Herrera, Owens, & Langberg, 2013; Salloum et al., 2016). Subscales within the KBT include stressors and obstacles competing with treatment, treatment demands and issues, perceived relevance of treatment, and relationship with therapist. Sample items include: *Transportation to the clinic for a session* (stressors and obstacles), *Treatment lasted too long* (treatment demands and issues), *Treatment did not seem to be working* (treatment relevance), *I do not feel the therapist supported me or my efforts* (relationship with therapist). Items of the sub scales were rated on a scale from 1 to 5: never a problem (1), once in a while (2), sometimes a problem (3), often a problem (4), and very often a problem (5). Subscale items were summed with higher scores indicating greater presence of problems and barriers to treatment. The Cronbach’s α at post-test for the sub scales of the KBT were .87 for obstacles and stressors, .82 for treatment demands and issues, .80 for perceived relevance of treatment, and .84 for relationship with therapist. In addition to these subscales, critical events (e.g. changed jobs, moved) were assessed for in the KBT measure separate from the subscales above. Therefore, critical event items were included for descriptive purposes in the current study and couldn’t be included with subscales in analysis of the study’s aim.

Lastly, similar to critical events, attendance was also explored descriptively. Attendance was measured by records of sessions attended by participants, later translated into a total number and percentage of sessions attended.

Data Analysis

Data were examined using SPSS 24. Univariate and bivariate explorations of both demographic and clinical characteristics were completed to describe and better understand the sample. Differences in barriers to treatment subscale scores (stressors and obstacles competing with treatment, treatment demands and issues, perceived relevance, and relationship with therapist) at 16 week post-test were examined by clinically significant levels of depressive symptoms (dichotomous) at baseline utilizing a multivariate analysis of variance (MANOVA).

Institutional Review Board approval was obtained.

Results

Table 1 presents the demographic characteristics of the sample and differences by status of clinically significant levels of depression. Two-hundred and seventeen children were male (70%) and most often were identified as Black/African-American ($n=95$, 31%), and Hispanic/Latino ($n=156$, 51%). On average, children were 8.87 years of age ($SD = 1.42$). Caregivers, on average, were 36.46 years of age ($SD= 8.73$) and most often identified as Black/African-American ($n=96$, 30%) and Hispanic/Latino ($n=168$, 53%). The majority of caregivers identified as the child's mother ($n=252$, 81%), single ($n=137$, 44%) and reported an income of less than \$9,999 a year ($n=125$, 42%). Caregivers on average reported a score of 7.79 ($SD= 4.71$) on the CESD and almost half of participants met the cutoff for having a clinically significant level of depressive symptoms ($n= 151$, 48%; $CESD > 8$). There were no significant differences in child or caregiver age, child or caregiver race, caregiver marital status, caregiver education, caregiver employment, or family income by cutoff for caregiver depressive symptoms (meeting vs. not meeting clinical cutoff) at baseline as examined by Independent Samples T-Test and Chi-Square tests. Thus, demographic factors were not controlled for in the MANOVA below.

As for descriptive data on critical events, the most commonly reported life events among participants during the study were: losing a job or having a change in income ($n=44$, 18%), child moving out of the home ($n=39$, 16%), moving too far from the clinic ($n= 26$, 10%), getting separated or divorced ($n=22$, 9%), and insurance not covering treatment ($n=22$, 9%). In preliminary investigations, no significant differences were found in the total number of critical events experienced by caregivers (sum of incidence for each item) for caregivers with differing levels of depression (clinically significant vs. non-clinically significant).

Table 2 illustrates multivariate analysis of variance (MANOVA) results, means, and standard deviations of all barriers to treatment subscales. Findings indicate that scores for stressors and obstacles competing with treatment ($F(1, 224) = 18.47$; $p < .001$; partial $\eta^2 = .08$), treatment demands and issues ($F(1, 224) = 12.10$; $p < .01$; partial $\eta^2 = .05$), perceived relevance ($F(1, 224) = 7.40$; $p < .05$; partial $\eta^2 = .03$), and relationship with therapist ($F(1, 220) = 6.10$; $p < .05$; partial $\eta^2 = .03$) were significantly different for caregivers with differing levels of depression (clinically significant vs. non-clinically significant). In other words, caregivers who met cutoff for having clinically significant levels of depression reported, on average, higher scores of stressors and obstacles competing with treatment,

treatment demands and issues, perceived relevance, and problematic relationship with therapist.

Attendance

The majority of participants attended 7.78 sessions ($SD= 5.61$), equating to 48.9% of treatment ($SD= 37.10$). Of participants who met cutoff for clinically significant levels of depression, an average of 8.96 sessions ($SD= 5.24$) were attended, equating to completion of 58.47% of treatment ($SD= 34.13$). There was no significant difference in number of sessions or percentage of sessions attended by status of clinically significant depression. Thus, it attendance was not included in the MANOVA.

Discussion

The purpose of this study was to examine the relationships between maternal depression and perceived barriers to child mental health treatment among a sample of poverty-impacted families of children with serious externalizing behavioral difficulties. Examining the role of maternal depression is intended to facilitate the identification of families at the greatest risk for premature termination and optimally reduce poor therapeutic outcomes for youth due to treatment drop out.

The main finding of this study was that caregivers who met criteria for clinically significant levels of depression reported greater barriers to treatment in all areas, including the presence of stressors and obstacles competing with treatment, treatment demands and issues, the perceived relevance of treatment and the caregiver's relationship with their child's therapist. This finding is consistent with studies by Kazdin and colleagues (Kazdin et al., 1997; Kazdin & Wassell, 2000), in that caregiver depression was associated with both a greater number and specific types of barriers to access. Yet this study extends our knowledge about barriers to help seeking as it is the first to examine the relationship between obstacles to access and depression in a sample of caregivers who are impacted by poverty. Given that rates of depression are extremely high among female caregivers who live in poverty, and that their children are disproportionately likely to experience mental health problems themselves yet are the least likely to access services, this study provides several courses of action in which to support poverty- impacted families and ensure they receive needed services.

First, the results indicate the need to engage the caregiver in child mental health treatment. Pre-treatment engagement strategies that demystify and clarify expectations about treatment, address previous, potentially negative interactions with the mental health system, identify logistical obstacles to help-seeking, and begin the process of building therapist trust, for example, have been shown in previous studies of poverty-impacted families to retain children in treatment beyond the initial treatment appointment (Cavaleri et al., 2006, 2007). These steps are necessary in order to address perceptual barriers including the perceived relevance of and satisfaction with treatment, which in turn would optimally improve engagement in care and therapeutic outcomes.

Second, the detection and treatment of maternal depression is paramount for the health and wellbeing of the family. In order to facilitate detection, national organizations and experts

including the US Preventive Services Task Force, the American Congress of Obstetrician and Gynecologist Committee on Obstetric Practice, and the American Academy of Pediatrics, have recommended universal screening for depression, and optimally in settings mothers are likely to frequent such as pediatric and gynecology/obstetric settings (Dossett et al., 2014).

However, screening efforts are uneven-providers cite competing priorities and lack of knowledge and comfort in identifying depression as barriers to detection (Chaudron et al., 2004; Ferro et al., 2000; Heneghan et al., 2007). Yet even if a caregiver receives screening, caregivers, and particularly low-income women, are unlikely to seek treatment on their own due to their own logistical and perceptual barriers to help seeking (Abrams et al., 2009; Ward et al., 2009). In response, there have been efforts to provide treatment for maternal depression in the context of child mental health services. The literature on integration of maternal and child health services indicates that such models reduce stigma and facilitate greater participation due to the convenience of co-location of pediatric and maternal mental health services as well as greater comfort with their pediatric provider (Dossett et al., 2014).

Programs that successfully integrate maternal mental health into existing child health systems are described in the literature and can serve as models to be replicated and evaluated (Rahman et al., 2013; Weiss-Laxer et al., 2015). For example, a pilot study conducted by Kimmel et al. (2017) evaluated maternal mental health services in an urban pediatric practice using an on-site mental health team that collaborated with full-time case management. Results show successful maternal engagement in mental health treatment and improved child outcomes, suggesting that the primary care setting provides an important venue to engage parents in mental health treatment.

And third, in order to best support the child, we must assess for and address environmental stressors that impact the family. In New York, for example, peer advocates, who are caregivers who have the lived experience of caring for a child with mental health problems, have worked alongside the public mental health service system for over two decades. Peers provide advocacy, emotional support, tangible assistance, and linkages to services to support families of children with mental health needs (Hoagwood et al., 2010). Adjunctive services such as those provided by peers may serve to facilitate engagement in treatment for youth through decreasing stressors and strengthening the family.

Limitations

Limitations of the study are important to note when interpreting these findings. First, we focused on barriers to treatment from the caregiver's perspective and future research should also include assessment of providers delivering the treatment. Knowing more about provider- and organizational-level characteristics and how they relate to barriers reported by caregivers may also aid in our understandings of barriers. Second, self-selection bias and social-desirability are of concern since participants were not randomly selected to participate. As participants volunteered to be screened for involvement after hearing about the study, findings should be interpreted with consideration of these potential threats to internal validity. Lastly, given this study is cross-sectional, it is unclear whether depression

and barriers to treatment will continue to relate over the course of the child's duration in treatment.

Limitations notwithstanding, this study offers preliminary insight into the multiple obstacles families encounter when navigating mental health services, and that caregivers with depression are especially likely to view a range of factors, from logistical barriers to the caregiver's relationship with their child's therapist, as problematic. More research is needed in several areas, to understand how depression may influence barriers to treatment, and critically, whether it is the barrier itself, and/or its severity, that is predictive of premature termination. Moreover, there is a need to understand and address barriers to the detection and treatment of maternal mental health in naturalistic settings (Dossett et al., 2014), for the health of both mother and child.

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Highlights

- Caregiver depression is common, costly, and associated with adversities to the child, caregiver, and family
- Caregiver depression is associated with the quantity and type of barriers to access.
- Caregivers who met criteria for clinically significant levels of depression reported greater barriers to treatment in all areas, including the presence of stressors and obstacles competing with treatment treatment demands and issues, the perceived relevance of treatment and the caregiver's relationship with their child's therapist
- The results indicate the need to engage caregivers in child mental health treatment, as well as their own mental health treatment in order to reduce the occurrence of untreated depression and its effect upon the child.

Table 1.

Demographic characteristics of all participants and by status of clinically significant levels of depression

	All Participants (n=320)		Non-Clinically Significant Depression (n=161)		Clinically Significant Depression (n=151)	
Characteristic	n	%	n	%	n	%
Child age (M ± SD)	302	8.87 ± 1.42	132	8.92 ± 1.46	102	8.91 ± 1.36
Caregiver Age (M ± SD)	310	36.46 ± 8.73	132	37.63 ± 9.01	107	35.68 ± 7.21
Child Gender						
Male	217	69.6	97	72.4	71	67.0
Female	95	30.4	37	27.6	35	33.0
Child Race						
American Indian/Alaska Native	8	2.6	3	2.3	2	1.9
Asian/Pacific Islander	1	0.3	0	0	1	0.9
Black/African American	95	31.0	50	38.2	30	28.3
White	25	8.2	8	6.1	11	10.4
Child Ethnicity						
Hispanic/Latino	156	48.8	64	48.9	52	49.9
Non-Hispanic/Latino	164	51.3	74	51.1	55	50.1
Primary Caregiver						
Mother	252	81.3	105	78.9	89	84.8
Father	6	1.9	2	1.5	2	1.9
Grandparents	14	4.5	11	8.3	1	1.0
Mother and father	24	7.7	9	6.8	9	8.6
Caregiver Race						
American Indian/Alaska Native	3	1.0	2	1.5	1	0.9
Asian/Pacific Islander	2	0.6	1	0.7	1	0.9
Black/African American	96	30.5	52	38.5	24	22.4
White	30	9.5	11	8.1	12	11.2
Caregiver Ethnicity						
Hispanic/Latino	168	53.3	66	48.9	58	54.2
Non-Hispanic/Latino	152	47.5	69	51.1	49	45.8
Caregiver Marital Status						
Single	137	44.1	63	47.4	44	41.5
Married/common law/domestic partner	105	33.8	44	33.1	38	35.8
Divorced	14	4.5	4	3.0	6	5.7
Separated	44	14.1	16	12.0	15	14.2
Widowed	7	2.3	5	3.8	2	1.9
Caregiver Education						
8 th Grade or Less	32	10.3	6	4.5	16	15.1

	All Participants (n=320)		Non-Clinically Significant Depression (n=161)		Clinically Significant Depression (n=151)	
Some high school	81	29.3	43	32.6	26	24.5
Completed high school/GED	168	24.8	35	26.5	26	24.5
Some College	70	22.5	26	19.7	25	23.6
Completed college	21	6.8	10	7.6	9	8.5
Some or completed graduate school	20	6.4	12	9.1	4	3.0
Caregiver Employment						
Full-time	75	24.1	38	28.4	23	21.7
Part-time	54	17.4	21	15.7	22	20.8
Student	17	5.5	8	6.0	9	8.5
Retired	8	2.6	7	5.2	0	0
Disabled	37	11.9	15	11.2	11	10.4
Unemployed	104	33.4	38	28.4	36	34.0
Family Income						
Less than \$9,999	125	41.9	57	44.2	42	41.2
\$10,000 to \$19,999	81	27.2	26	20.1	29	28.4
\$20,000 to \$29,999	47	15.8	20	15.1	22	21.6
\$30,000 to \$39,999	23	7.7	13	10.1	6	5.9
\$40,000 to \$49,000	4	1.3	2	1.6	1	1.0
Over \$50,000	18	6.0	11	8.5	2	2.0

Note: There were no significant differences in characteristics ($p < .05$) by status of clinically significant level of depression as examined by Independent Samples T-Tests and Chi-Square tests.

Table 2.

Means, Standard Deviations, and MANOVA results for Barriers to Treatment Subscales by Clinically Significant Levels of Depression.

	Clinically Significant Depression (n=151)		Non-Clinically Significant Depression (n=161)		$F(1,224)$	p	Partial Eta Squared
	M	SD	M	SD			
Stressors and obstacles	31.85	10.56	26.55	6.85	18.47	.000	.081
Treatment demands and issues	14.27	5.31	12.13	3.11	12.10	.001	.052
Perceived relevance of treatment	12.32	5.21	10.75	3.15	7.40	.010	.030
Relationship with therapist	7.62	3.28	6.79	1.78	6.10	.017	.026