



## An examination of the relationship between maternal depression and barriers to child mental health services

Mary C. Acri<sup>a,\*</sup>, Lindsay A. Bornheimer<sup>b</sup>, Emily Hamovitch<sup>b</sup>, Kate Lambert<sup>b</sup>

<sup>a</sup> New York University Medical Center, The McSilver Institute for Poverty, Policy, and Research, USA

<sup>b</sup> The McSilver Institute for Poverty, Policy, and Research, USA

### 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.

### 1. 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, Rich-Edwards, & Koenen, 2011; Kessler 2003; World Health Organization, 2017). Adult women are 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 8000 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 (Jonas & Mussolino, 2000; Frasure-Smith & Lespérance, 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, Keller, & Davies, 2005; Lovejoy, Graczyk, O'Hare, & Neuman, 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 (de Haan et al., 2013; Eapen & Ghubash, 2004; Nock & Kazdin, 2001; Thurston, Phares, Coates, & Bogart, 2015); therefore, it is necessary to consider obstacles to utilization at the

\* Corresponding author at: New York University Medical Center, The McSilver Institute for Poverty, Policy, and Research, One Park Avenue, 7th floor, New York 10023, USA.

E-mail address: [mary.acri@nyumc.org](mailto:mary.acri@nyumc.org) (M.C. Acri).

<https://doi.org/10.1016/j.childyouth.2018.08.004>

Received 28 March 2018; Received in revised form 4 August 2018; Accepted 6 August 2018

Available online 08 August 2018

0190-7409/© 2018 Published by Elsevier Ltd.

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 Jr \(2004\)](#) 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 Jr, 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, Nonnenmacher, and Zietlow \(2016\)](#). A recent set of studies provides support in this theory; in one, caregiver depression was associated with greater perceived externalizing problems among male children and internalizing problems among female children ([Gartstein, Bridgett, Dishion, & Kaufman, 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 & Gershoff, 2010](#); [Gelaye, Rondon, Araya, & Williams, 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 Jr, 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.

## 2. 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 and 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 4 Rs 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.

### 2.1. 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 and 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).

Download English Version:

<https://daneshyari.com/en/article/6832835>

Download Persian Version:

<https://daneshyari.com/article/6832835>

[Daneshyari.com](https://daneshyari.com)