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Depression Self-Stigma as a Mediator of the Relationship between Depression Severity and
Avoidance

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Abstract

This study examined the extent to which self-stigmatizing attitudes mediated the relationship between depression severity and avoidance. Participants were 167 community members with elevated depressive symptoms who completed a questionnaire packet that included measures of depression severity, self-stigma, treatment stigma, previous stigmatizing experiences, and behavioral avoidance. Self-stigma, treatment stigma, and stigmatizing experiences were found to partially mediate the relationship between depression severity and avoidance. Findings from the current study support a model in which an individual experiences depressive symptoms, which leads to stigmatizing experiences and an increase in the salience of stigmatizing attitudes about depression, which in turn leads to avoidance. Depression self-stigma plays an important role in exacerbating avoidance behaviors within the context of depressive symptoms. Future research would benefit from examining depression self-stigma as a mediator between depression severity and treatment seeking.

Depression Self-Stigma as a Mediator of the Relationship between Depression Severity and Avoidance

Self-stigma is defined as negative attitudes about mental illness and its treatment that are held by the individual with the stigmatized condition (Corrigan, 2005). Self-stigma has recently been cited as a major public health concern, contributing to decreased treatment seeking, lowered self-esteem, and lowered self-efficacy (Corrigan, 2005; Satcher, 1999; Sirey et al., 2001) for conditions such as Schizophrenia, Bipolar Disorder, and Major Depression. Major Depression, in particular, has major public health consequences, affecting approximately 25 million Americans annually (Keller, 1994) and resulting in an annual economic burden of approximately 44 billion dollars due to factors such as service provision, work absenteeism, and treatment costs (Antonuccio, Thomas, & Danton, 1997). In fact, Major Depression has been identified by the World Health Organization as the most burdensome disease among middle aged adults throughout the world (Murray & Lopez, 1996). It is important, therefore, to develop an understanding of the self-stigma of depression and the role self-stigma plays as an obstacle to treatment seeking and in exacerbating the severity and chronicity of depression.

One model for understanding the relations between self-stigma, depression, and outcomes is provided by the Behavioral Activation (BA) theory of depression (Kanter, Busch, & Rusch, in press; Martell, Addis, & Jacobson, 2001). This theory postulates that negative life events (e.g., discrete events such as divorce or loss of a job, or multiple smaller events, life stressors, and daily hassles) trigger an initial experience of depressive symptoms, which are not disordered in and of themselves but only become problematic when they evoke a broad class of avoidance behaviors (e.g., calling in sick to work, staying in bed, avoiding social interaction, and increasing drug or alcohol use). These avoidance responses are negatively reinforced by short-term

reductions in aversive emotional experiences but leave the original negative events unaddressed and may create additional negative events. This fosters a cycle of negative events, negative affect, and avoidance that spirals into depression.

In fact, the link between depression severity and avoidance is well-established (Ottenbreit & Dobson, 2004). Avoidant coping and avoidant problem-solving styles predict depressive moods (Blalock & Joiner, 2000; Londahl, Tverskoy, & D’Zurilla, 2005), current depressive episodes (Kuyken & Brewin, 1994) and the maintenance of depressive episodes (Holahan & Moos, 1986). Behavioral treatments for depression, such as BA, have gained considerable empirical support (e.g., Dimidjian et al., 2006; Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Jacobson et al., 1996), lending credence to the view that depression may be maintained by negatively reinforced avoidance behavior and alleviated by goal-directed activation.

While there is clear evidence to support the relationship between depression and avoidance, the role of stigma as a potential mediator of the relation between depressive symptoms and increased avoidance behaviors has yet to be explored. An initial barrier to this research was the lack of a clear understanding of how stigma develops and unfolds specifically with respect to depression. Recently, however, Kanter et al. (2008) empirically identified several constructs that are consistent with the larger literature on mental illness stigma but specific to depression self-stigma. First, they identified a set of negative attitudes and beliefs about others with depression held by individuals (e.g., “Other people with depression are morally weak”), labeled *public stigma*. Second, they identified the process of internalization of these public attitudes into self-stigma, labeled *general self-stigma*. This included a set of negative attitudes and beliefs about depression held by the depressed individual, including negative stigmatizing attitudes perceived by the depressed individual to be held by others (e.g., “Others view me as

morally weak because I am depressed”) as well as these attitudes internalized by the depressed individual him/herself (e.g., “People’s attitudes about depression make me feel worse about myself”). Third, they identified a related but separate set of negative attitudes and beliefs, specifically about receiving treatment for depression, labeled treatment stigma. Fourth, they identified a set of past experiences in which the depressed individual felt stigmatized because of disclosing or experiencing depression, labeled *stigmatizing experiences*. Fifth, they identified a distinct tendency of the depressed individual to hide his or her depression from others in a variety of contexts, labeled *secrecy*.

Kanter et al. (2008) found that these constructs significantly related to each other but did not model or empirically assess the nature of these relationships. Using these constructs, here we propose one possible model of stigma as mediator of the relation between depression and avoidance as per the BA theory. Specifically, as an individual begins to experience depressive symptoms, a process of self-stigmatization may occur. In this process, the negative public stereotypes about depression (i.e., public stigma), such as that depressed individuals are morally weak, irresponsible, or flawed, may become more salient to and internalized by the individual (i.e., general self-stigma). Negative public stereotypes about receiving treatment for depression, such as that treatment seeking individuals are less respectable and less competent, become more salient as well (i.e., treatment stigma). In addition, negative reactions of others to the individual, once he/she becomes depressed and/or seeks treatment, may exacerbate the process of self-stigmatization (i.e., stigmatizing experiences). As a result, the individual may become secretive about his or her depression and avoidant in a variety of contexts, in an effort to conceal the depressive experience from others and avoid the repercussions of stigma, such as being labeled

as unpredictable, unreliable, dependent, unintelligent, and responsible for his or her illness (see Overton & Medina, 2008; Corrigan, 2005).

The end result is that the individual avoids seeking treatment and social support (Corrigan & Matthews, 2003; Corrigan & Wassel, 2008; Vogel, Wade, & Hackler, 2007). Self-stigma and stigmatizing experiences create a context in which this avoidance is negatively reinforced by removal of the potential negative social and occupational consequences that result from revealing the stigmatized condition. This establishes the cycle proposed by BA: Over time, concealment and label avoidance may contribute to employment difficulties, marital discord, poor health outcomes, increased depression severity and chronicity, and suicide (e.g., Corrigan, 2002; Coryell et al., 1995). Similarly, self-stigma may make depressive symptoms more aversive (and thus more likely to be avoided) because it may lead individuals to feel guilty and weak for experiencing depressive symptoms.

The purpose of the current study was to use this theoretical model as a framework for assessing the extent to which self-stigmatizing attitudes and stigmatizing experiences mediate the relation between depression severity and avoidance. A community sample with elevated depressive symptoms was employed (rather than a clinical sample), to provide a better representation of the individuals for whom treatment seeking is an issue and for whom self-stigma (if the model is correct) may exacerbate a spiral into deeper depression. As described above, the *general self-stigma*, *treatment stigma*, and *stigmatizing experiences* subscales from Kanter and colleagues' (2008) Depression Self-Stigma Scale (DSSS) were employed as mediator variables, and measures of behavioral avoidance in both social and nonsocial realms (using the Cognitive Behavioral Avoidance Scale [CBAS]; Ottenbreit & Dobson, 2004) were incorporated as dependent variables to explore relations between stigmatizing attitudes, depression severity

and avoidance as per the BA theory. It was expected that the DSSS subscales would mediate the relationship between depression severity and CBAS subscale scores. We also explored whether the mediation results would differ between those with a history of treatment for depression and those with no history of depression treatment.

Method

Participants and Procedures

This research was approved by the University of Wisconsin-Milwaukee Institutional Review Board. Participants consisted of 167 community members who were recruited through newspaper advertisements and postings in community buildings. These advertisements asked, “Have you been feeling sad, down, or blue? Do you think you are suffering from depression? If you are, we would like you to complete a confidential survey...” The mean age of the sample was 37.99 years ($SD = 13.79$; Range: 18-79) and 66.5% of the sample was female. With regard to ethnicity, 67.7% identified as Caucasian, 20.4 % as African American, 4.2 % as Mexican American, 0.6% as Asian American, and 7.1 % identified as other. Regarding income, 37.0% identified as lower class, 28.5% identified as lower middle class, 24.2% identified as middle class, 9.1% identified as upper middle class, and 1.2% identified as upper class. Participants first read an informed consent document stating that by completing the study questionnaires, they are agreeing to being at least 18 years old and that they have read and understood the informed consent document. Most participants (58.3%) completed the questionnaires online, while the rest (46.2%) completed the questionnaires using pencil-and-paper. After completing the questionnaires, participants received \$20.

Measures

Center for Epidemiologic Studies Depression Scale (CES-D). The CES-D (Radloff, 1977) is a 20-item self-report measure of type and severity of depressive symptoms. Items are rated on a 4-point scale with higher scores indicating greater depression severity. The CES-D has shown good validity and good internal consistency in a depressed sample ($\alpha = .92$; Segal, Coolidge, Cahill, & O'Riley, 2008).

Depression Self-Stigma Scale (DSSS). The DSSS (Kanter et al., 2008) is a 32-item self-report measure of stigma related to depression designed to be completed by depressed individuals. The DSSS includes five subscales: General Self-Stigma, Public Stigma, Secrecy, Treatment stigma, and Stigmatizing experiences. Subscales used in the current analyses will be described in detail below.

The General Self-Stigma subscale assesses negative stigmatizing attitudes held by the respondent, and perceived negative stigmatizing attitudes of others that have been internalized by the respondent. The General Self-Stigma subscale includes 9 items with total scores ranging from 9 to 63. This subscale has shown good convergent validity and internal consistency ($\alpha = .93$; Kanter et al., 2008). Example items include, "Others view me as unable to handle responsibility because I am depressed", "Others view me as morally weak because I am depressed", and "Since becoming depressed, I worry about people discriminating against me." Items are rated on a 7-point scale with higher scores indicating greater levels of stigma.

The Treatment Stigma subscale assesses negative stigmatizing attitudes about receiving treatment for depression. The Treatment Stigma subscale includes 4 items with total scores ranging from 4 to 28. This subscale has shown good convergent validity and internal consistency ($\alpha = .79$; Kanter et al., 2008). Example items include, "Receiving treatment for depression carries social stigma", "People tend to like less those who are receiving professional help for

depression”, and “It is advisable to hide from people that he/she has been treated for depression.” Items are rated on a 7-point scale with higher scores indicating greater levels of treatment stigma.

The Stigmatizing Experiences subscale assesses past experiences of the respondent in which they felt stigmatized because of disclosing or experiencing depression. The Stigmatizing Experiences subscale includes 6 items with total scores ranging from 6 to 42. This subscale has shown good convergent validity and internal consistency ($\alpha = .92$; Kanter et al., 2008). Example items include, “I regret having told people that I am depressed”, “I have been hurt by how people reacted to learning that I am depressed”, and “People I cared about stopped calling after learning I was depressed.” Items are rated on a 7-point scale with higher scores indicating greater levels of stigmatizing experiences.

Cognitive Behavioral Avoidance Scale (CBAS). The CBAS (Ottenbreit & Dobson, 2004) is a 31-item self-report measure of cognitive, behavioral, social and nonsocial dimensions of avoidance, resulting in four subscales (cognitive-social, cognitive-nonsocial, behavioral-social, and behavioral-nonsocial) and a total avoidance score. The behavioral subscales (i.e., Behavioral-Social and Behavioral-Nonsocial) will be used for analyses. Items on the Behavioral-Social subscale include, “I find that I often want to leave social gatherings”, “I turn down opportunities to socialize with the opposite sex”, and “I tend to remain to myself during social gatherings or activities”. Items on the Behavioral-Nonsocial subscale include, “Rather than try new activities, I tend to stick with the things I know”, “I quit activities that challenge me too much”, and “Rather than getting out and doing things, I just sit at home and watch TV”. Items are rated on a 5-point scale with greater scores indicating greater avoidance. These subscales have shown good convergent validity, divergent validity, and internal consistency ($\alpha = .91$; Hermans, Defranc, Raes, Williams, & Eelen, 2005; Ottenbreit & Dobson, 2004).

Treatment Utilization. Participants were asked in a single question to report if they had a history of psychotherapy or medication utilization for depression (including current treatment).

Results

Descriptives

The sample was moderately depressed (CES-D $M = 20.02$, $SD = 9.30$), with a mean score of 20.11 ($SD = 8.54$) for the CBAS Behavioral-Social subscale and a mean score of 16.32 ($SD = 5.69$) for the CBAS Behavioral-Nonsocial subscale. On the DSSS, the General Self-Stigma subscale had a mean score of 28.60 ($SD = 0.77$), the Treatment Stigma subscale had a mean of 14.58 ($SD = 0.33$), and the Stigmatizing Experiences subscale had a mean of 23.16 ($SD = 0.57$). This suggests moderate and significant levels of stigma and stigmatizing experiences. Correlations between these measures are presented in Table 2. All correlations between the CES-D, DSSS subscales, and CBAS subscales were significant and in the expected directions, ranging in magnitude from .32 to .74.

Regarding treatment utilization, 15.0 % reported either a history of or current psychotherapy, 6.0 % reported a history of or current medication, 50.3 % reported both, and 26.3 % reported no treatment history of any kind. Those with a history of treatment for depression (combining psychotherapy, medication, and both) displayed significantly higher CES-D scores compared to those with no history (see Table 1), $t(161) = -2.56$, $p = .012$. No other significant differences were found between treatment utilization groups.

Tests of Mediation

The causal steps method (Baron & Kenny, 1986; Judd & Kenny, 1981) and normal theory (NT) approach (Frazier, Tix, & Barron, 2004; Mallinckrodt, Abraham, Wei, & Russell, 2006) were used to investigate the hypothesized mediation models. The following steps were

followed: first, test for a significant relationship between the independent variable and the dependent variable (path c), second, test for a significant relationship between the independent variable and the potential mediator (path a), and third, test for a significant relationship between the proposed mediator and the dependent variable when controlling for the independent variable (path b'; Frazier et al., 2004). These steps were tested using multiple regression analyses. The product of paths a and b' was divided by Sobel's formula for standard error (1982) in order to obtain a z statistic that can be evaluated for statistical significance on a standard normal curve. This last step is often referred to as the NT approach.

The DSSS subscales were examined as potential mediators of the relationship between depression severity on the CES-D and behavioral-social and behavioral-nonsocial avoidance on the CBAS. The results are presented in Table 3 and Table 4. All DSSS subscale scores met conditions for partial mediation of the relationship between depression and both behavioral-social and behavioral-nonsocial avoidance. Evidence of partial mediation was demonstrated by a significant z statistic according to the NT approach (described above) with depression severity remaining a significant predictor of the dependent variable (i.e., CBAS behavioral-social or behavioral-nonsocial avoidance score).

We also examined these mediational models separately for individuals with no depression treatment history and individuals with a history of treatment utilization (either antidepressant medication, therapy, or both). Results indicated that, for individuals with no treatment history ($n = 44$), General Self-Stigma partially mediated the relationship between depression severity and behavioral avoidance (both social and non-social), but Treatment Stigma and Stigmatizing Experiences did not. For individuals with a history of treatment utilization, both General Self-Stigma and Stigmatizing Experiences partially mediated the relationship

between depression severity and behavioral avoidance (both social and non-social). Treatment Stigma approached significance as a partial mediator for those with a history of treatment utilization but not for those with no history.

Discussion

In this sample of community members with elevated depressive symptoms, general self-stigma, treatment stigma, and stigmatizing experiences partially mediated the relationship between depression severity and behavioral avoidance (in both social and nonsocial realms). These results support a model in which an individual experiences depressive symptoms, which leads to an increase in the salience of stigmatizing attitudes about depression and negative consequences as a result of disclosing one's depressed status, which in turn leads to behavioral avoidance. For example, behavioral-social avoidance (e.g., not going to a social event) may result from efforts to conceal the depressive experience from others and avoid the social repercussions of stigma. Unfortunately, increased avoidance (e.g., avoidance of aversive thoughts and feelings, social withdrawal) may exacerbate or prolong depressive episodes (Joiner & Coyne, 1999; Just & Alloy, 1997; Nolen-Hoeksema, 2000; Nolen-Hoeksema, Parker, & Larson, 1994).

The salience of stigmatizing experiences, and possibly treatment stigma, may depend somewhat on receiving treatment for depression. Specifically, while general self stigma, treatment stigma and stigmatizing experiences were not higher for those who had a history of treatment utilization, stigmatizing experiences and possibly treatment stigma appear to be more influential in functioning as mediators of avoidance for these individuals. In other words, it is possible that a previous history of treatment has sensitized these individuals to treatment stigma and stigmatizing experiences (sample sizes for comparisons between medication and

psychotherapy were too small to report on meaningfully, but no apparent differences emerged). One limitation to note about these analyses is that current versus past treatment for depression were not explored.

Of note, we found evidence for a partial mediation model; in addition to these variables, other unmeasured variables are important in fully understanding the relationship between depression and avoidance. For example, some depressive symptoms, such as low energy and fatigue, may directly facilitate avoidance and passivity, as it is simply harder to act, and thus easier to avoid, when feeling fatigued. Additional cognitive factors (e.g., dysfunctional attitudes, pessimism, and low self-esteem) undoubtedly also play a role. For example, some of the negative cognitive content of depression (e.g., “I am unlovable”) may be difficult, if not impossible, to disentangle from the negative stigmatizing attitudes about depression investigated herein (Corrigan & Calabrese, 2005; Kanter et al., 2008). Although the current study did not attempt to disentangle these variables, findings support a model in which negative cognitive content (i.e., self-stigmatizing attitudes) may be a product of depression, not a cause as in the classic cognitive model (Clark, Beck, & Alford, 1999). This does not present a challenge to the cognitive model; rather, it supports elaborations of the model; the relations between depression, negative cognitive content, and avoidance are undoubtedly reciprocal and transactional.

These findings add to the literature in important ways. First, previous stigma research has largely focused on chronically mentally ill populations, often with multiple diagnoses including severe diagnoses such as schizophrenia. The current study demonstrates that depression self-stigma should be given greater attention because of its relationship to avoidance that may prevent individuals with depression from seeking treatment. In addition, these findings were based on a community sample with elevated depressive symptoms, suggesting that the ramifications of self-

stigma are not limited to severely mentally ill populations and efforts to reduce stigma should target the continuum of symptoms.

Limitations and Concluding Remarks

There were several limitations to the current study. First, a behavioral measure of avoidance was not used. Particularly relevant to the stigma literature is the issue of treatment seeking. Future research would benefit from examining depression self-stigma as a mediator between depression severity and treatment seeking. Second, this study is limited by the cross-sectional design. The model presented is sequential and longitudinal in nature, suggesting that as depression severity increases, self-stigmatizing attitudes about depression become more salient and individuals engage in increased avoidance behaviors because of this. Due to the cross-sectional nature of the current study, this was not measured. This is also complicated by the reciprocal and transactional nature of the relationship between depression and avoidance. Exploring these hypotheses longitudinally is needed in order to fully understand how these relationships unfold and interact over time. In the future if efforts to reduce depression self-stigma are effective in decreasing avoidance, specifically in regards to treatment seeking, a treatment that targets avoidance, such as BA may be particularly beneficial. Finally, because this sample was primarily Caucasian, future research investigating the relationships between self-stigma, depression, and avoidance with other ethnic groups will provide important information on the generalizability of these findings.

In conclusion, our results suggest that depression self-stigma plays an important role in exacerbating avoidance behaviors within the context of depressive symptoms. Future research on the impact of depression self-stigma on treatment seeking may augment these findings.

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Table 1

Means and Standard Deviations of Scales of Interest by Treatment History

	No Treatment		Treatment		Total	
	History		History			
	(n = 44)		(n = 119)		(N = 163)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CES-D*	24.41	10.76	28.69	8.99	27.29	9.83
DSSS-GS	30.09	12.94	32.18	13.24	31.55	13.33
DSSS-TS	14.61	5.20	15.84	5.84	15.35	5.74
DSSS-SE	23.89	9.68	25.41	9.98	25.02	9.91
CBAS-BS	19.32	9.16	20.44	8.33	20.11	8.54
CBAS-BNS	15.50	5.88	16.68	5.63	16.32	5.69

* $p < .05$

Table 2

Correlations among the Center for Epidemiologic Studies-Depression Scale, Depression Self-Stigma Scale, and Cognitive-Behavioral Avoidance Scale

	1.	2.	3.	4.	5.	6.
1. CES-D	---					
2. DSSS General Self-Stigma Subscale	.461**	---				
3. DSSS Treatment Stigma Subscale	.343**	.467**	---			
4. DSSS Stigmatizing Experiences Subscale	.384**	.727**	.426**	---		
5. CBAS Behavioral-Social Subscale	.532**	.507**	.325**	.443**	---	
6. CBAS Behavioral-Nonsocial Subscale	.470**	.508**	.319**	.442**	.741**	---

* $p < .05$; ** $p < .01$.

Table 3

Mediation Test with CBAS Behavioral-Social (B-S) Avoidance as the Dependent Variable

		General Self-Stigma		Treatment Stigma		Stigmatizing Experiences	
		β (SE)	t	β (SE)	t	β (SE)	t
Total Sample ($N = 163$)							
a	Predictor = CES-D; Predicted = Mediator	.625 (.094)	6.681**	.200 (.043)	4.697**	.387 (.072)	5.344**
b'	Predictor = Mediator; Predicted = CBAS B-S [†]	.213 (.045)	4.750**	.241 (.103)	2.331*	.241 (.059)	4.101**
c	Predictor = CES-D; Predicted = CBAS B-S	.462 (.057)	8.072**	.462 (.057)	8.072**	.462 (.057)	8.072**
z		3.856**		2.090*		4.101**	
No Treatment History ($n = 44$)							
a	Predictor = CES-D; Predicted = Mediator	.698 (.151)	4.623**	.178 (.069)	2.564*	.532 (.112)	4.749**
b'	Predictor = Mediator; Predicted = CBAS B-S [†]	.235 (.094)	2.489*	.312 (.215)	1.450	.134 (.135)	.991
c	Predictor = CES-D; Predicted = CBAS B-S	.569 (.098)	5.807**	.569 (.098)	5.807**	.569 (.098)	5.807**
z		2.199*		.206		.331	
Treatment History ($n = 119$)							
a	Predictor = CES-D; Predicted = Mediator	.573 (.125)	4.567**	.187 (.058)	3.243**	.305 (.099)	3.091**

b'	Predictor = Mediator; Predicted = CBAS B-S [†]	.206 (.053)	3.912**	.237 (.120)	1.976	.265 (.067)	3.974**
c	Predictor = CES-D; Predicted = CBAS B-S	.436 (.076)	5.761**	.436 (.076)	5.761**	.436 (.076)	5.761**
z			2.965**		1.684		2.430*

Note. * = $p < .05$; ** = $p < .01$.

[†] This regression controlled for the effect of depression by entering the CES-D score and mediator score at the same time when predicting the CBAS variable (either Behavioral-Social or Behavioral-Non-Social)

Table 4

Mediation Test with CBAS Behavioral-Non-Social (B-NS) Avoidance as the Dependent Variable

		General Self-Stigma		Treatment Stigma		Stigmatizing Experiences	
		β (SE)	t	β (SE)	t	β (SE)	t
Total Sample ($N = 163$)							
a	Predictor = CES-D; Predicted = Mediator	.625 (.094)	6.681**	.200 (.043)	4.697**	.387 (.072)	5.344**
b'	Predictor = Mediator; Predicted = CBAS B-NS [†]	.158 (.031)	5.121**	.177 (.071)	2.478*	.176 (.041)	4.344**
c	Predictor = CES-D; Predicted = CBAS B-NS	.272 (.040)	6.835**	.272 (.040)	6.835**	.272 (.040)	6.835**
z		4.045**		2.197*		3.354**	
No Treatment History ($n = 44$)							
a	Predictor = CES-D; Predicted = Mediator	.698 (.151)	4.623**	.178 (.069)	2.564*	.532 (.112)	4.749**
b'	Predictor = Mediator; Predicted = CBAS B-NS [†]	.199 (.056)	3.539*	.134 (.139)	.965	.156 (.083)	1.866
c	Predictor = CES-D; Predicted = CBAS B-NS	.369 (.062)	5.923**	.369 (.062)	5.923**	.369 (.062)	5.923**
z		2.817*		.367		.081	
Treatment History ($n = 119$)							
a	Predictor = CES-D; Predicted = Mediator	.573 (.125)	4.567**	.187 (.058)	3.243**	.305 (.099)	3.091**

b'	Predictor = Mediator; Predicted = CBAS B-NS [†]	.152 (.037)	4.091**	.190 (.085)	2.246*	.183 (.048)	3.843**
c	Predictor = CES-D; Predicted = CBAS B-NS	.234 (.054)	4.363**	.234 (.054)	4.363**	.234 (.054)	4.363**
z			3.059**		1.837		2.396*

Note. * = $p < .05$; ** = $p < .01$.

[†] This regression controlled for the effect of depression by entering the CES-D score and mediator score at the same time when predicting the CBAS variable (either Behavioral-Social or Behavioral-Non-Social)