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Group Interpersonal Psychotherapy for minoritized Head Start mothers with depressive symptoms: A mixed method study

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Abstract

This study explores minoritized mothers' experiences in group interpersonal psychotherapy (IPT-G) and relates their experiences to treatment outcomes. Quantitative and qualitative data were gathered from 26 Latinx and Black mothers who participated in IPT-G. Mothers were divided into three groups: (1) not depressed at follow-up, (2) depressed at follow-up, and (3) those with subclinical symptoms throughout the intervention, and similarities and differences across groups were examined. Results showed that mothers not depressed at follow-up reported high levels of emotional safety in IPT-G, facilitating emotional processing. Mothers depressed at follow-up referenced the impact of stigma and had greater difficulty sharing their feelings and also reported lower socioeconomic status and higher levels of trauma. It appears that high levels of environmental stressors and difficulty developing trusting therapeutic relationships were related to experiencing depression at the conclusion of treatment. Alternatively, for many mothers, IPT-G provided within head start was an effective therapeutic option.

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AUTHOR CONTRIBUTION

Conceptualization, funding acquisition, methodology, investigation, formal data analysis, writing—original draft preparation: Abigail Palmer Molina. *Methodology, supervision, writing—reviewing and editing*: Lawrence Palinkas. *Investigation, writing—reviewing and editing*: Yuliana Hernandez. *Investigation, writing—reviewing and editing*: Iliana Garcia. *Writing—reviewing and editing*: Scott Stuart. *Resources, writing—reviewing and editing*: Todd Sosna. *Resources, supervision, writing—reviewing and editing*: Ferol E. Mennen.

CONFLICT OF INTEREST STATEMENT

The authors declare that there are no conflicts of interest.

ETHICS STATEMENT

This study was approved by the Institutional Review Board at the University of Southern California. The approval numbers are UP-14-00233 and UP-14-00329.

INFORMED CONSENT

Informed consent was obtained from all individual participants.

Keywords

depression; ethnic and racial minorities; group; Hispanic or Latino; interpersonal psychotherapy; maternal-child health services; minority health; psychotherapy

INTRODUCTION

Maternal depression is a serious mental health condition that can negatively impact maternal and child well-being throughout the perinatal period and into the early childhood years (England & Sim, 2012; Goodman et al., 2011; Sutherland et al., 2021; van der Waerden et al., 2015; Woolhouse et al., 2015). If left untreated, maternal depression can impede effective parenting (Lovejoy et al., 2000) and impact children's social emotional and cognitive development (Goodman et al., 2011; Grace et al., 2003; Masarik & Conger, 2017). Rates of maternal depression in the United States differ based on a variety of environmental stressors, with low-income mothers and mothers of ethnic and racial minority backgrounds frequently experiencing higher rates (Ertel et al., 2011; Oh et al., 2018). Maternal depression can also affect mothers beyond the perinatal period. For example, a nationally representative study of head start mothers found that more than 40% met the clinical cut-off for depression (Lanzi et al., 1999). Minoritized[1] and low-income mothers also experience greater difficulties accessing high-quality mental health treatment (McDaniel & Lowenstein, 2013; Witt et al., 2011).

Several evidence-based treatments for depression have been developed. One widely used treatment is interpersonal psychotherapy (IPT; Klerman et al., 1984; Stuart & Robertson, 2012; Stuart, in press), which has a significant base of research support (Cuijpers et al., 2011, 2020), particularly for maternal depression (Moses-Kolko & Roth, 2004). However, few studies have focused on examining the utility of gold standard depression treatments like IPT with low-income mothers from minoritized racial and ethnic backgrounds, with studies showing that significant barriers remain in terms of engaging and supporting this population of mothers in treatment (Abrams & Curran, 2009; Anderson et al., 2006; Lazear et al., 2008; Levy & O'Hara, 2010). Additional research is needed to explore low-income, minoritized mothers' experiences of participating in IPT and identify change processes in the intervention to promote psychological well-being for this population.

Interpersonal psychotherapy

IPT is a brief, structured treatment program that was initially developed by Klerman and colleagues in the early 1970s to treat depression (Klerman et al., 1984; Ravitz et al., 2019; Stuart et al., in press). IPT seeks to promote healthy relationships and emotional processing by addressing interpersonal conflicts, grief and loss, and role transitions that can contribute to psychological distress (Ravitz et al., 2019; Stuart et al., 2017). IPT is an effective treatment for depression, both alone and in combination with medication (Cuijpers et al., 2011, 2016). IPT has been tested with low-income mothers in the perinatal period,

[1]The term "minoritized" was coined by Gunaratnam (2003) and highlights that individuals are actively minoritized by systems of oppression.

and has been found to be effective in reducing maternal depression (Grote et al., 2009; Toth et al., 2013). Specifically, Toth et al. (2013) found that individual IPT was effective in reducing depressive symptoms among low-income Black and Latinx mothers of infants in a community setting, and that treatment gains were maintained for 8 months after the trial ended.

In addition to individual IPT, a group model of IPT (IPT-G) for perinatal women was developed by Reay and Stuart and has been found to be effective for perinatal mothers (Deans et al., 2014; Stuart & Schultz, 2015). IPT-G also focuses on interpersonal conflicts, grief and loss, and role transitions, and utilizes the group as a source of social support (Stuart & Schultz, 2015). It is important to investigate IPT-G since group modalities may be more cost effective in community-based settings (Burlingame & Baldwin, 2011), studies show that group therapy is as effective as individual treatment for depression (Burlingame & Jenson, 2017), and group modalities can uniquely address the isolation and loneliness that people from marginalized groups frequently experience (Marmarosh, 2022).

There are four mechanisms of change that have been hypothesized to operate in IPT generally, including: (1) enhancing social support, (2) decreasing interpersonal stress, (3) facilitating emotional processing, and (4) improving interpersonal skills (Lipsitz & Markowitz, 2013). However, little research has explored participants' perceptions of the components promoting growth and change in IPT. One notable exception is a recent study by Grote et al. (2021), which examined mothers' perceptions of receiving a brief individual IPT intervention during the perinatal period. The authors used a deductive approach to examine whether IPT participants endorsed conceptually derived codes based on the four IPT change mechanisms outlined by Lipsitz and Markowitz (2013). They found support for three of the four hypothesized mechanisms, with mixed support for enhancing social support (Grote et al., 2021). However, this study utilized a majority White sample, examined an individual IPT modality, and was limited to deductively identifying the four proposed IPT change processes, rather than inductively exploring all factors that may influence treatment outcomes in IPT. For example, it is unclear whether the group IPT modality has similar mechanisms of change as those proposed by Lipsitz and Markowitz (2013) and whether there are additional change processes that may operate in treatment. Furthermore, it is important to also understand factors that may moderate treatment progress for low-income, minoritized mothers.

The current study

The current study seeks to explore low-income, minoritized mothers' experiences of participating in IPT-G in a head start setting to broadly understand their presenting concerns, perceptions of the group treatment, treatment impacts, and challenges. We also utilize a mixed methods approach to identify factors that may help explain differences in treatment outcomes between mothers who were not depressed at follow-up, mothers who were depressed at follow-up, and mothers experiencing subclinical symptoms during the intervention.

MATERIALS AND METHODS

Study design

This study utilized an explanatory sequential mixed methods intervention design in which both qualitative and quantitative data were gathered and integrated within the context of an intervention trial (Creswell & Plano Clark, 2018). First, using a methodology called "Coding Consensus, Co-occurrence, and Comparison" (Willms et al., 1990), we analyzed qualitative data to broadly explore mothers' experiences of participating in IPT-G in a head start setting. Second, we examined similarities and differences in participants' demographic characteristics and experiences based on their progress in treatment.

The Healthy Moms, Healthy Kids program

The "Healthy Moms, Healthy Kids" (HMHK) parent study was a cluster randomized controlled trial funded by the Administration for Children and Families that provided IPT-G to mothers of head start children in South Los Angeles who were experiencing depressive symptoms (Mennen et al., 2021). Mothers were recruited from 25 head start sites operated by Children's Institute, a nonprofit multiservice agency in Los Angeles from December 2014 to June 2018. IPT-G is a brief treatment that focuses on addressing interpersonal conflicts, grief and loss, and role transitions (Stuart & Schultz, 2015) that can contribute to heightened psychological distress, and it has been found to be effective in community practice settings (Reay et al., 2006). IPT-G was originally developed for women experiencing depression during the perinatal period and in this study, an adapted version of IPT-G was tested with mothers of head start children, whose ages ranged from 3 to 5 years old. Mothers with subclinical levels of depressive symptoms were also recruited for this study since research shows that even subclinical levels can impact child functioning (Conners-Burrow et al., 2014, 2016).

Adaptations for this study included that IPT-G was extended from 8 to 12 weekly sessions based on feedback from stakeholders, and food, transportation, and childcare were provided to address potential barriers to participation. The therapy progressed from introduction and cohesion building (sessions 1–2) to the three IPT interpersonal problem areas. Sessions 3–5 dealt with role transitions, sessions 6–8 with interpersonal disputes, sessions 9–11 with grief and loss, and session 12 was a graduation session. Therapy groups were offered in English and Spanish. Results show that mothers in IPT-G demonstrated a significant decrease in depression scores (β time = − 4.59, $p < 0.05$; p for time × group interaction < 0.05) and parenting stress (β time = − 6.77, $p < 0.05$; p for time × group interaction < 0.05) over the study period compared with the control group who received referral to outside mental health services (Mennen et al., 2021).

Participant selection, recruitment, and data collection

Mothers were recruited from the intervention group of the parent study, and qualitative data were collected between March and June of 2019. All previous intervention participants were invited to participate ($n = 49$), but many mothers could not be reached after several attempts. Over 50% of mothers ($n = 26$) from the intervention group participated in interviews, representing a high rate of participation given the amount of time that had elapsed since

mothers participated in the program. Overall, 24 mothers who participated identified as Hispanic or Latinx and two mothers identified as Black or African American. Two female, bilingual Latinx data collectors conducted semi-structured interviews (16 in Spanish and 10 in English). Interviews typically lasted 45 min on average and were conducted in-person at the individual's home or another location depending on the mother's preference. Interviews were recorded and then professionally transcribed and Spanish interviews were translated into English and checked for accuracy. Mothers received a $40 incentive for their participation. This study was approved by the University of Southern California Institutional Review Board and verbal informed consent was obtained from all participants.

Instrumentation

Quantitative measures

Maternal depressive symptoms.: Maternal self-report of depressive symptoms was assessed in both English and Spanish using the Center for Epidemiology Studies Depression Scale (CES-D; Radloff, 1977), a widely used 20-item scale that has been assessed for reliability, validity, and applicability across diverse populations (Radloff, 1977). Mothers completed the CES-D at intake and after the group ended. In the original psychometric testing of the CES-D, Radloff (1977) identified an alpha reliability coefficient of 0.85 in the general population. More recently, an alpha reliability coefficient of 0.90 was observed in a nationally representative study of adults in the United States, and the original factor structure of the measure was found to be valid (Cosco et al., 2017). Mothers were categorized as having (a) mild depressive symptoms (10–15 points), (b) moderate depressive symptoms (16–24 points), or (c) severe depression symptoms (≥25 points) (Moon et al., 2017). Additionally, the typical cut-off of 16 was used to determine whether mothers met criteria for moderate depression after the trial ended (Lewinsohn et al., 1997).

Maternal lifetime trauma exposure.: Maternal cumulative trauma exposure was assessed in both English and Spanish using the trauma history questionnaire (THQ), which assesses adverse experiences in several domains, including crime-related events, general disaster and trauma, and unwanted physical and sexual experiences (Hooper et al., 2011). For each of the items, the respondent indicated whether they experienced the event and then a total score was calculated for this study. Content validity for the THQ has been supported by ratings from trauma instrument developers and its high correlations with existing trauma measures (Hooper et al., 2011). Hooper et al. (2011) also found test–retest reliability of the THQ ranging from 0.51 to 0.91 depending on the trauma type. The THQ was administered at intake before mothers participated in IPT-G.

Maternal exposure to intimate partner violence.: Maternal verbal and physical intimate partner violence (IPV) exposure was assessed in both English and Spanish using the revised Conflict Tactics Scales (CTS2; Straus et al., 1996) that included other items to capture a broader range of IPV (Astin et al., 1995). Mothers completed 33 items about their partner's behavior toward themselves. All items are on a 7-point scale ranging from 0 times to more than 20 times in the past year. The CTS2 is a widely used measure among various income, racial/ethnic groups, and has well-established psychometric properties (Straus et al., 1996). For example, Straus et al. (1996) reported alpha reliability coefficients of 0.79 for the verbal

IPV subscale and 0.86 for the physical IPV subscale and showed evidence of both construct and discriminant validity. The CTS2 was administered at intake before mothers participated in IPT-G.

Background information.: Demographic information was collected at intake to IPT-G in both English and Spanish, including maternal age, maternal race/ethnicity, maternal education level, and household income. Information was also collected regarding whether the mother participated in an English or Spanish-speaking group and the number of group sessions attended.

Qualitative interview guide—A semi-structured interview guide was developed to explore mothers' experiences with the intervention, including their presenting concerns, goals for participation, perceptions of the group facilitators and intervention content, experiences participating in a group therapy modality, the impacts of treatment across several domains, and challenges they experienced during the group. Examples of questions include: *What did you hope to gain from participating in the therapy group? How did you feel about participating in therapy in a group with other mothers? What did you think of how your facilitators led the group? To what extent did participating in the group have an impact on your relationships with your children, partner, family, or friends? What, if anything, made it difficult or challenging for you to participate in the group?*

Data analysis

Quantitative data analysis—Quantitative data were analyzed using SPSS version 27.0. First, univariate statistics were calculated to capture demographic characteristics. Second, we examined whether there were differences between mothers who participated in qualitative interviews for this study ($n = 26$) and mothers from the parent RCT who did not complete interviews using independent sample t-tests and Chi-square (χ^2) tests of independence. Third, pre to post change scores for depressive symptoms on the CES-D were calculated for each participant included in this study, and if a participant was missing a score on the CES-D for the second timepoint ($n = 2$), the value from the subsequent time point completed was substituted. One participant did not have any follow-up scores and was dropped from the mixed method analysis. Fourth, mothers were categorized into three groups: (1) mothers not depressed at follow-up ($n = 10$), (2) mothers depressed at follow-up ($n = 9$), and (3) mothers with subclinical symptoms throughout the intervention ($n = 6$).

Mothers not depressed at follow-up were defined as those with at least mild levels of depressive symptoms (≥10) at the beginning of the intervention trial who then scored below the clinical cut-off of 16 at follow-up, and all mothers in this group demonstrated a decrease in their symptoms. Mothers depressed at follow-up were defined as those with any level of depressive symptoms who scored above the clinical cut-off of 16 after the intervention. Mothers who had subclinical levels of depressive symptoms were defined as being in the subclinical range at both the beginning and end of the intervention trial.

Mothers were not categorized by whether their symptoms simply increased or decreased since some mothers showed a decrease in symptoms but were still above the clinical cut-off for depression. Other mothers showed an increase in symptoms and scored above

the cut-off for depression. This choice was also made to separate the mothers with subclinical symptoms who participated. Fifth, average pre to post change scores on the CES-D were calculated for each of these three groups, and similarities and differences in participant demographics and background information were compared across the three groups. However, sample sizes were not large enough to test whether differences were statistically significant.

Qualitative data analysis—First, qualitative data were analyzed to explore mothers' presenting concerns and experiences of participating in IPT-G in head start, including their perceptions of program components and intervention impacts. Qualitative interviews with intervention participants were analyzed using Dedoose, Version 8.3.43. The PI used a methodology called "Coding Consensus, Co-occurrence, and Comparison" (Willms et al., 1990) to analyze the qualitative data. Interviews with intervention participants ($n = 26$) were analyzed using the following process. First, the PI and two other members of the research team independently coded an initial interview and engaged in open coding to record initial themes. Subsequently the PI met with the other members of the research team to discuss potential codes, and then prepared a draft codebook outlining codes, definitions, and examples of each code. Third, the PI and coding team independently coded three interviews to calculate a percent agreement on coding as an index of reliability (Boyatzis, 1998).

During this process, disagreements in assignment of codes were resolved through discussion between the members of the team and the team collaboratively developed enhanced definitions of codes, added new codes when appropriate, or merged codes. This process continued until the percent agreement of first level codes reached 80%. Based on these codes, the research team then independently coded the remaining interviews, condensing the data into segments of text ranging from a phrase to several paragraphs. Each block of text was assigned codes based either on a priori themes from the interview guide or emergent themes from the data, and the latter is called open coding (Corbin & Strauss, 2014). The PI then reviewed the final coding and codes were assigned to describe connections between categories and between categories and subcategories, which is known as axial coding (Corbin & Strauss, 2014). (6) The PI then compared categories to condense them into broader themes (Corbin & Strauss, 2014).

Mixed methods analysis—The qualitative themes and coding were exported from Dedoose and imported into MAXQDA for mixed methods analysis. A series of joint displays (Creswell & Plano Clark, 2018) was created using the "Interactive Quote Matrix" in MAXQDA to examine differences in the experiences of participants whose quantitative data indicate improvement in maternal depressive symptoms as a result of their participation in the HMHK program versus those who remained depressed or had subclinical levels of symptoms during the trial.

RESULTS

Quantitative results

Characteristics of the participants are presented in Table 1. Mothers who completed qualitative interviews for this mixed methods study completed more IPT-G sessions ($p <$

0.01) and reported lower exposure to verbal IPV ($p < 0.05$) than mothers who did not participate in interviews, but there were no differences in terms of maternal age, maternal education, maternal race/ethnicity, household income, cumulative trauma exposure, physical IPV, or whether the mother participated in an English or Spanish-speaking IPT group. On average, mothers in this study were 33.2 years of age (SD = 6.1) and most mothers identified as Hispanic/Latinx (92.3%) and participated in Spanish-speaking IPT therapy groups (80.8%). Mothers came from disadvantaged communities, with more than one-third reporting that they did not complete high school and more than half reporting annual household incomes below $35,000. Mothers reported high levels of cumulative trauma and endorsed more verbal IPV than physical IPV. Almost half of mothers attended between 9 and 12 IPT group sessions.

When categorized based on their scores on the CES-D at follow-up (1) 40% of mothers demonstrated a reduction in depressive symptoms and scored below the clinical cutoff on the CES-D at follow-up, (2) 36% of mothers with any level of depressive symptoms at intake scored above the clinical cut-off on the CES-D at follow-up, and (3) 24% reported subclinical levels of depressive symptoms on the CES-D both before and after the intervention. Characteristics of participants and the average pre to post depression change score for each of these three groups is reported in Table 1. Among mothers who were depressed at follow-up, five mothers reported some reduction in depression symptoms after intake, and four reported an increase in symptoms, but all mothers still scored above the clinical cut-off for depression.

When looking at demographic characteristics across the three groups, several potential differences emerged for mothers who were depressed at follow-up (see Table 1). First, mothers depressed at follow-up had lower levels of income and education than the other two groups. For example, over half of mothers who were depressed at follow-up reported household incomes below $20,000 and having less than a high school degree, compared with only approximately a third of mothers in the not depressed and subclinical groups. Second, mothers depressed at follow-up demonstrated higher levels of trauma exposure. For example, the average cumulative trauma score among mothers depressed at follow-up was 6.5, compared with 5.1 and 4.0 among mothers not depressed at follow-up and those in the subclinical group, respectively. In addition, mothers depressed at follow-up reported higher levels of verbal IPV compared with the other two groups (9.0 vs. 5.4 and 2.7). Among mothers who were not depressed at follow-up, a higher proportion participated in English-speaking groups, and mothers in the subclinical symptom group were older on average. There were similar patterns across the three groups in terms of maternal race/ethnicity and the total number of IPT-G sessions attended.

Qualitative results

The qualitative analyses resulted in seven broad themes that included mothers' presenting concerns at the start of treatment, reasons for participation in the HMHK program, perspectives on participating in a group therapy model, perceptions of the IPT group components and facilitators, impacts of the group across several domains, and challenges impacting participants' experiences in the program.

Presenting concerns and reasons for participation—First mothers shared their presenting concerns, or perceptions of their symptoms and needs at the start of the HMHK program. Most mothers (73%) identified as feeling depressed or described experiencing depressive symptoms at referral to treatment, including tearfulness, hopelessness, fatigue, difficulty sleeping, suicidality, and anhedonia. One mother shared:

> I felt that for me nothing had a meaning … At times I'd say and think that I no longer wanted to live, I wanted to get in a car and die. I only wanted to be home alone. I didn't want to know about anyone. I didn't want to go out. I had no urge to do anything.

Mothers also shared that they were experiencing feelings of stress, anxiety, and isolation and concerns about their relationships with their children.

In discussing their reasons for participation, most mothers shared that they were drawn to the program's group modality because of the social support it provided. For example, mothers shared that they wanted to meet other mothers and hear their perspectives, to be able to learn from one another. One mother stated:

> I needed to talk to someone. I was told it was going to help and I would deal with other parents that might possibly be going through the same thing. So that's why I decided to be in here and maybe make some lasting friendships with someone that you kind of know better than just your family.

Mothers also expressed a desire to participate to help their children, including wanting to improve their parenting and relationships with their children. Many mothers were drawn to the name of the program because they wanted to do whatever they could to help their children succeed. One mother said, "I needed techniques in dealing with depression. I needed to hear others' testimonies, how to control my anxiety and how to deal with my child."

Perceptions of participating in a group therapy intervention—Several mothers reported that the group IPT model helped them to feel less isolated and provided them with a sense of social support. Many mothers shared that they benefited just from realizing that other mothers were facing similar struggles and experiencing the same symptoms:

> It was very good because you learn about everything. You learn about other's problems, about their capacity and their ability. Like I said, we all have problems but many times you're not aware that others are suffering just as much as you.

Participants also explained that the group provided support by sharing information, giving advice, and providing emotional support and validation. One mother shared the effect of experiencing emotional support from her group members:

> At times I would think that I would be doing the wrong thing … I felt bad and they would … let me know that I did a good job. Nobody tells me, "Oh, you did a good job today," like as a mom. "Hey, you did so good today. You cleaned the house. Thank you for cooking for us." No one. And in the group, everyone would say that, and I was like, "Oh! Okay."

Mothers also shared the importance of having a safe therapeutic space within the group that allowed them to process and express their emotions.

Perceptions of IPT-G components—In addition to the importance of experiencing social support and processing and expressing feelings, mothers shared that there were several specific activities and components of the IPT-G curriculum that were helpful. First, mothers shared that the explicit focus on goal setting in the beginning of treatment helped them to develop concrete goals and provided accountability each week. Second, mothers talked about group sessions that focused on how to improve interpersonal communication with others, including spouses, children, and other family members. One mother explained:

> [The topic] was about how to ask for help and how sometimes we don't ask for help. We thought that everyone else knew that we needed help and we don't ask for it. So, what happens is, we get frustrated, but they don't help us because we never asked for help. I remember that one very well.

Another participant explained how role-play was useful to practice communication strategies for real-life problems:

> They would have us role play a confrontation amongst us, with a person whom we had a conflict with, someone would play that role and you would see the problem as you were living it. You were looking at it from someone else's perspective, not as someone going through the problem, and suddenly you realize that "I'm guilty" or if I change my attitude, she'll also change hers.

Mothers also reported that sessions focusing on exploring past difficult experiences, traumas, and significant life transitions were helpful in validating their experiences. Many mothers reported processing their immigration experiences, early childhood traumas, or other difficult experiences. One mother explained:

> They say that you sometimes keep things for years and I never thought I'd talk about these things, but I did talk about it within the group. They teach you to talk and to express your inner self and your feelings … They gave me the confidentiality and a place to express myself.

Perceptions of IPT-G therapists—When discussing their perceptions of therapists that co-facilitated IPT therapy groups, several participants shared that they trusted the therapists, which gave them the courage to speak and share with the other mothers in the group. Many shared that the first one-on-one assessment and goal-setting meeting with the therapist provided a safe space and helped them develop that rapport, and then they were able to build on that in the group setting. One participant explained:

> The type of respect that they provided … The attention. The communication. Communication was when I didn't feel well or felt something, they were there to listen. If I felt a certain way, if I was going through something, they were there to support me.

Some mothers also reported that the therapists provided assistance outside of the group setting, which they found helpful. Respondents reported that therapists helped in terms of

accessing resources and other services, providing instrumental support like offering a ride, or providing emotional support during crises, particularly since there was a lack of resources in the community. However, other participants shared that they experienced barriers to building trust with the therapists, with one mother sharing that since the therapists "didn't have children, they [didn't] really know … or … understand, so I didn't feel comfortable telling her everything."

In addition, several mothers reported feeling more comfortable and open to discussing their feelings of sadness and depression because of the therapists' professional background. Although the negative impact of stigma around mental health was noted for this community, some mothers appeared to be less impacted by stigma and instead the therapists' professional mental health background acted as a facilitator to their participation. For example:

> When we're going through various phases in life, more so, Hispanics, think that when we go see a psychologist or something like that, that it's silly, but in fact it does help us … There are times that you are going through situations and there are things that can't be trusted for example, to a family member, a friend.

IPT-G treatment impacts—Participants noted several positive impacts of IPT-G, including lowered stress and depressive symptoms, positive impacts on relationships with their partners, children, family members, and friends, increased self-awareness, and significant shifts in character. First, several mothers described feeling a reduction in sadness after the therapy groups. For example, one mothers said "My goal from there was that I was always closed. I would cry a lot and my goal was to not feel like that. At the end I was definitely a different person. I took all the sadness out."

Several mothers reported changes in their relationships with their partners, including increased communication, more support from their partner, and better problem-solving:

> My husband, I wouldn't tell him anything before. Now I tell him when I'm tired, I ask him to help with the children … If something's bothering me, I can talk to my husband … at night is when he and I talk and that has helped me out a great deal as well because I'm not keeping everything to myself.

Mothers also shared impacts on their relationships with their children, including better communication skills, spending more time with their children, and learning how to support their children's development and independence. One mother explained, "I don't scream so much … I let [my kids] do more … I learned that they are kids and I need to let them live and be children." Many mothers spoke with high levels of self-awareness during interviews, reflecting on the changes they noticed in themselves because of their participation in IPT-G. Mothers shared that they learned how to become more aware of their own thoughts, feelings, and needs, and habits or ways of thinking that were unhelpful. One mother shared: "After I began the program and I started looking at myself, I began to let more things out which made me say, 'Wow!' and to change many things as well."

Challenges—Respondents shared several different types of challenges that impacted their experiences in the HMHK program, including barriers to participation, attrition, stigma, and difficulties ending treatment. First, mothers shared a variety of barriers to participating in IPT groups, including other priorities in their personal lives (medical issues, caring for children, work, etc.), scheduling difficulties, hesitation about participating in therapy, and difficulties getting along with fellow group members. Some mothers reported significant hesitation about participating in the group, and others shared that they felt a solid commitment to attending the group sessions early on. Another significant factor that impacted mothers' experiences was the high level of attrition in therapy groups. In some cases, groups were even cancelled because of low attendance. One mother stated that "there were many [participants] when we started and suddenly, they didn't show up." Another participant explained that she would prefer a smaller, more committed group, saying it should be "for those who truly want to let their emotions out … and [have] a desire to change."

Furthermore, stigma presented a challenge for mothers in terms of sharing with others in their lives that they were experiencing depressive symptoms and attending a therapy group. One mother explained that she had to push beyond this stigma to get the family support she needed:

> I told [my kids] that I was attending a group for parents who were going through depression and who needed help emotionally … I was very direct with them about what I was doing, and I never lied to them or made up stories. I decided that if I was going to do this, I was going to be honest and not hide it because I had no reason to do so.

In terms of ending therapy, a small portion of mothers reported having significant difficulties moving through the termination phase and that they were re-experiencing symptoms of stress and depression:

> I'm going to wait for that call when they say, "Hey, we have another one." … I think I need it. It's coming back, my feelings, so maybe I could go back and try it again and feel 'clean' again. You know, kind of like when you clean yourself and you say, "Oh, I feel fine," and other times it's, "Oh, I feel down again!"

Mixed methods analysis

The mixed methods analysis sought to examine similarities and differences between participant experiences to identify factors that help explain differences in treatment outcomes. Participant responses were analyzed by group membership (e.g., mothers not depressed at follow-up, mothers depressed at follow-up, and mothers with subclinical levels of symptoms before and after the intervention). Results are presented in a series of joint displays (Tables 2–5).

The first joint display (Table 2) demonstrates similarities and differences in participants' presenting concerns and reasons for participation. One difference was that many mothers who were not depressed at follow-up clearly identified that they were depressed at the start of treatment, saying things like "I knew I had depression" or "I was under a certain

depression level." In contrast, some mothers who were depressed at follow-up reported not realizing their symptoms were abnormal. One participant explained: "When I heard others talking about [depression], I felt that I may have had it and I just never noticed," and another mother recalled her reaction when she was told she met the cut-off on the depression screener: "It made me laugh because I said, 'Well no, that's how I always feel.'" Many mothers in this group also referenced cultural and societal expectations influencing this experience, with one mother saying, "It seems as if moms keep [their feelings] to themselves because we are moms and are supposed to." In terms of reasons for participation, mothers across all three groups expressed a desire for social connection. For example, those not depressed at follow-up talked about wanting to be in community with "other moms with similar problems to [theirs]." Mothers who were depressed at follow-up reported wanting to combat "solitude" and overcome a lack of family support, and mothers in the subclinical group wanted to "make lasting friendships" and "meet different people."

The second joint display (Table 3) demonstrates differences in participants' perceptions of participating in a group modality, IPT-G components, and IPT-G therapists. Mothers not depressed at follow-up reported high levels of emotional safety and said it was helpful to be in a group to "bounce ideas off each other" or "give … advice as to how to best handle what we were going through at the moment." Mothers who were depressed at follow-up reported varying levels of emotional safety, with some mothers sharing that they were able to "vent" and others saying they felt "ashamed of talking about [their] problems."

In terms of the components of IPT-G, all mothers reflected on the positive impact of setting goals at the start; however, mothers not depressed at follow-up and those in the subclinical group reported making more progress and recalled more specific goals, whereas some mothers who were depressed at follow-up had more difficulty remembering their goals and assessing progress, saying things like "I don't remember very well" and "I think it was to get out of depression."

Mothers in all groups shared that focusing on improving interpersonal relationships was helpful, but mothers not depressed at follow-up were able to share more specific examples of ways they continue to practice these skills. All mothers discussed the importance of the IPT-G component focused on processing adversities and major life events, although mothers in the subclinical symptom group mentioned this component more often and two specifically discussed how this was helpful in processing immigration experiences. In terms of IPT-G therapists, mothers not depressed at follow-up reported high levels of trust, similar to those in the subclinical symptom group, with mothers who were depressed at follow-up demonstrating more variability.

The third joint display (Table 4) demonstrates differences in participants' perceptions of HMHK treatment impacts across several domains. Mothers not depressed at follow-up shared concrete examples of symptom relief, like "I'm not depressed anymore, lying down" and "had it not been for [the group], I would still be taking medication for depression," whereas those depressed at follow-up shared the power of sharing their feelings in group and "not holding anything in," which provided "a big release," but only a couple mothers identifying that the reduction in their symptoms persisted. Mothers in the subclinical

symptom group shared that they experienced relief after sharing their feelings, which helped them to “keep moving forward.”

All mothers reported changes in their parenting and their relationships with their partner, mostly frequently in terms of using less harsh parenting; however, mothers not depressed at follow-up reported a wider range of impacts and more specific examples of changes in their parenting, like one mother who shared: “I’m not arguing with [my children] throughout the day to pick up after themselves.” All mothers reported changes in their relationships with their partners, specifically in their ability to ask for and receive help.

Last, mothers who were not depressed at follow-up identified that the group led to greater self-awareness, with one mother stating: “I recognized many things which I couldn’t see on my own about myself.” Mothers who were depressed at follow-up and those in the subclinical group expressed a greater level awareness of their role in interpersonal conflicts and parenting, and the importance of emotional expression and self-knowledge for overall health and well-being.

Last, the fourth joint display (Table 5) demonstrates differences in perceptions of challenges in HMHK in terms of barriers to engagement, attrition over time, stigma, and termination. For mothers not depressed at follow-up, many reported no barriers to engagement or felt their depression made it difficult to attend at times, and many recalled how they overcame specific challenges to participate in the group (e.g., a disapproving spouse, medical appointments, work schedule, etc.). Mothers who were depressed at follow-up reported challenges related to getting along with therapists and other group members, as well as scheduling difficulties, and mothers in the subclinical group endorsed that they often were unable to attend due to their children’s schedules.

In terms of attrition, all mothers discussed the impact of low attendance and attrition. Mothers who were depressed at follow-up reported more difficulties expressing their feelings due to stigma than either of the other two groups, with mothers stating things like: “there are hidden things which you don’t discuss with anyone,” “I [was] embarrassed because others found out about my personal life,” and “sometimes one doesn’t want to admit [it] and says, “everything is fine.” Mothers in the subclinical group discussed the presence of stigma in the community and how their participation in the group helped them combat it, for example saying that going to therapy “doesn’t necessarily mean that you’re crazy, it simply means that you need someone to talk to.”

DISCUSSION

This study used an inductive approach to explore the experiences of minoritized head start mothers who participated in the HMHK program, which implemented an adapted IPT-G intervention for mothers experiencing depressive symptoms. This study is the first to explore the perspectives of a majority Latina low-income sample about participating in any IPT modality. Furthermore, the current study explored mothers’ experiences of participating in group IPT, which is particularly beneficial because of the cost effectiveness and social impacts of group modalities for marginalized individuals (Burlingame & Baldwin, 2011;

Marmarosh, 2022). A mixed methods approach was used to examine similarities and differences in demographic characteristics and responses between three subgroups who participated in IPT-G: (1) mothers not depressed at follow-up, (2) mothers depressed at follow-up, and (3) mothers with subclinical levels of depressive symptoms during the intervention. This analysis provides rich information about factors that may help explain differences in treatment outcomes and highlights the value of participation for those with subclinical symptoms. Also, the use of joint displays allows important meta-inferences to be drawn for each group (Fetters & Molina-Azorin, 2019).

First, for mothers who were not depressed at follow-up, the majority reported acute onset of their depression and clearly identified feeling depressed at the start of treatment. They expressed a desire for more social connection similar to the other groups (which is a proposed mechanism of IPT) but reported more specific IPT treatment goals than the other groups. Although mothers in this group also acknowledged the impact of stigma, they reported high levels of emotional safety and trust in the IPT group facilitators, which allowed them to process their emotional experiences, which is another of the hypothesized IPT mechanisms (Lipsitz & Markowitz, 2013). They also emphasized the importance of IPT-G components focused on improving communication in interpersonal relationships and decreasing interpersonal stress, which are two additional mechanisms in IPT (Lipsitz & Markowitz, 2013). As expected, mothers in this group identified specific positive impacts of the intervention across a range of areas, including depressive symptom relief, specific improvements in their relationships with their children and partners, and gains in self-awareness. Although mothers in this group reported barriers to participation, they overcame these barriers and expressed a high commitment to the group. Mothers in this group also appeared to possess greater resources that may have promoted success in treatment.

Second, mothers who were depressed at follow-up reported more generalized depressive symptoms and a desire for social connection again was a key motivator for participation in IPT-G. Mothers in this group had lower levels of income and education at intake and reported higher levels of cumulative trauma and exposure to verbal IPV than the other two groups. Mothers in this group expressed more normalization of depression in their presenting concerns and referenced the impact of societal and cultural expectation for mothers. They also expressed varying levels of emotional safety and trust in the facilitators, and while many discussed the importance of emotional catharsis in the group, few reported a persistent decrease in their symptoms. Interestingly, mothers who were depressed at follow-up also expressed greater difficulty sharing feelings in group due to stigma. Results indicate that mothers in this group may have had greater difficulty processing emotions, and possibly also accessing social support within and outside of the therapy group, which are two key mechanisms in IPT (Lipsitz & Markowitz, 2013).

Third, mothers in the subclinical symptom group shared a different perspective than the other two groups. Mothers in this group reported subclinical levels of sadness and stress at enrollment. However, they still reported benefiting several IPT mechanisms, including (1) enhancing social support, (2) decreasing interpersonal stress, (3) facilitating emotional processing, and (4) improving interpersonal skills (Lipsitz & Markowitz, 2013). In particular, participants mentioned the IPT modules focused on role-playing interpersonal

conflicts and processing role transitions (Stuart & Schultz, 2015), and for many women in this group the discussion of role transitions brought up early trauma experiences that they were able to share. Although they had subclinical levels of depressive symptoms, mothers in this group reported positive gains as a result of participating, including improved communication with partners and children, and greater self-awareness. This demonstrates the potential benefits of providing IPT-G or other therapeutic groups to mothers from a prevention perspective.

Across the three groups, there is evidence pointing to factors that help explain differences in treatment outcomes. Whereas Grote et al. (2021) found mixed support for the mechanism of enhancing social support in the individual IPT model, this appeared to be important in IPT-G for all participants, which was aided by the group format in which participants share and develop connections. Furthermore, the IPT-G mechanisms focused on improving interpersonal skills and reducing interpersonal distress (Lipsitz & Markowitz, 2013) were highly endorsed by all three groups as promoting positive change in relationships, although greater gains were seen among mothers who were not depressed at follow-up. In particular, some mothers recalled how helpful it was to problem-solve and role-play around specific interpersonal conflicts, which is one of the main foci of IPT (Stuart, in press; Stuart & Robertson, 2012). It may be that the focus on interpersonal distress and skills is helpful, but not sufficient to treat depression and reduce depressive symptoms among this group of mothers.

Results also showed that experiencing emotional safety was related to feeling comfortable processing emotions and experiencing social support within the group, which are two of the proposed IPT mechanisms (Lipsitz & Markowitz, 2013). For example, mothers who were not depressed at follow-up reported greater levels of emotional safety with both the IPT-G facilitators and with the other group members, whereas many mothers who were depressed at follow-up reported reticence and a lack of trust with the facilitators and/or group members. Therefore, it appears that establishing emotional safety is an integral part of the group IPT modality, and potentially a prerequisite to facilitate the proposed mechanisms of (1) enhancing social support, (2) decreasing interpersonal stress, (3) facilitating emotional processing, and (4) improving interpersonal skills (Lipsitz & Markowitz, 2013).

In terms of moderators influencing outcomes, results show that lower socioeconomic status, higher levels of exposure to trauma and IPV, and stigma may have limited treatment engagement and ultimately outcomes for some mothers. In this way, group therapy may have been helpful, but not sufficient for significantly under-resourced individuals and/or those who have experienced significant trauma. For example, mothers who were depressed at follow-up reported higher levels of cumulative trauma and exposure to verbal IPV at intake, which may have contributed to difficulties establishing trust and emotional safety within the group. Exposure to verbal IPV may have also made it difficult to apply IPT strategies focused on improving interpersonal communication and reducing interpersonal distress and shows that IPT-G may not be sufficient to address IPV. In addition, research shows that cultural stigma can have a negative impact on the utilization of mental health services (Bracke et al., 2019), and study findings raise important questions about the impact of cultural and societal norms and stigma on progress in IPT and other mental health

treatments. There may be links between trauma exposure in this sample, particularly verbal IPV, and the cultural norms and stigma mothers shared.

Broad prevention strategies should be implemented to reduce stigma and increase safety in community-based settings before recruiting mothers for mental health treatment, including mental health literacy programs, cultural competence training, and family engagement campaigns (Corrigan, 2004), as well as actively addressing safety, trauma, societal norms, and stigma within the IPT model itself. Results also point to the importance of providing financial assistance to meet basic needs for mothers and families with young children.

Strengths and limitations

This study has several strengths. First, this study utilized both quantitative and qualitative data in the context of a community-embedded intervention trial to understand factors influencing treatment outcomes in IPT-G for a marginalized and underserved group of mothers. Second, in-depth semi-structured interviews were conducted with all mothers from the intervention group that consented, providing rich information about their lived experiences. Third, this study utilized an innovative methodology to visualize and deeply interact with the qualitative material.

There are also limitations that should be acknowledged. First, we were unable to interview all mothers who received the intervention. Those who were interviewed attended significantly more IPT group sessions on average, and therefore conclusions likely do not represent the views and experiences of all mothers who participated. Second, this study was conducted within an intervention trial with predominantly low-income Latinx mothers in South Los Angeles, and the findings may not generalize to other low-income minoritized mothers in other settings. Third, mothers were interviewed between 1 and 5 years after completing the group intervention, which could lead to retrospective recall bias. Fourth, sample sizes for the three groups were small, precluding quantitative comparisons regarding demographic and other variables.

Implications for counseling practice

Based on these results, we encourage counselors to (a) provide psychoeducation about mental health through different modalities (handouts, group meetings, etc.) to reduce stigma and increase commitment to participation prior to IPT-G, (b) include a specific module within IPT-G discussing the social expectations of motherhood and normalization of depression, (c) utilize a trauma-informed approach in providing IPT-G due to high levels of trauma exposure over the life course, (d) embed therapeutic interventions like IPT-G into comprehensive programs that also seek to address concrete needs and provide community support, and (e) screen for IPV at intake and provide a few sessions of individual counseling prior to IPT-G to determine appropriateness for group and whether the client would also benefit from longer term individual therapy.

CONCLUSION

This study sought to explore low-income, minoritized mothers' experiences of participating in IPT-G in a head start setting to broadly understand their presenting concerns, perceptions

of the group IPT modality and treatment components, treatment impacts, and challenges, and to identify the factors that help explain differences in treatment outcomes for this population. This study adds to the existing literature by examining a group IPT modality, exploring the experiences of a minoritized sample, and utilizing an inductive qualitative approach to identify a broad range of themes. Overall, findings show that the establishment of emotional safety in IPT-G was highly endorsed by those who were not depressed at follow-up, and that this allowed participants to process their emotions and experience meaningful social support. It appears that IPT-G components focused on improving interpersonal functioning were also helpful, but not sufficient in this sample to lead to a reduction in depression, particularly for mothers who also endorsed high rates of verbal aggression in intimate relationships. Furthermore, low socioeconomic status and stigma also appeared to limit program effectiveness for some mothers.

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Table 1

Participant characteristics ($n = 26$).

	Total sample ($n = 25$) ***M* (SD), *n* *(%)***	**Not depressed at follow-up[a] ($n = 10$)** ***M* (SD), *n* (%)**	**Depressed at follow-up[b] ($n = 9$)** ***M* (SD), *n* (%)**	**Subclinical group[c] ($n = 6$)** ***M* (SD), *n* (%)**
Age (yrs)	33.5 (6.1)	32.7 (4.3)	32.9 (7.9)	35.7 (6.0)
Race/ethnicity				
Hispanic or Latinx	23 (92.0)	9 (90.0)	8 (88.9)	6 (100.0)
Black/African American	2 (8.0)	1 (10.0)	1 (11.1)	0 (0.0)
Other	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Household income				
Below $10,000	3 (12.0)	0 (0.0)	3 (33.3)	0 (0.0)
$10,000 to $19,999	7 (28.0)	3 (30.0)	2 (22.2)	2 (33.3)
$20,000 to $34,999	6 (24.0)	2 (20.0)	2 (22.2)	2 (33.3)
$35,000 to $49,999	2 (8.0)	1 (10.0)	0 (0.0)	1 (16.7)
Refused	7 (28.0)	4 (40.0)	2 (22.2)	1 (16.7)
Educational level				
Below high school	4 (16.0)	2 (20.0)	2 (22.2)	0 (0.0)
Some high school	6 (24.0)	1 (10.0)	3 (33.3)	2 (33.3)
High school diploma	7 (28.0)	4 (40.0)	1 (11.1)	2 (33.3)
Some college	7 (28.0)	3 (30.0)	3 (33.3)	1 (16.7)
Bachelor’s degree	1 (4.0)	0 (0.0)	0 (0.0)	1 (16.7)
Trauma exposure				
Cumulative trauma	5.4 (3.9)	5.1 (3.8)	6.5 (4.7)	4.0 (2.7)
IPV exposure (verbal)	6.0 (6.1)	5.4 (5.7)	9.0 (7.4)	2.7 (1.9)
IPV exposure (physical)	0.5 (1.0)	0.8 (1.3)	0.5 (1.1)	0.2 (0.4)
HMHK group language				
Spanish	20 (80.0)	7 (70.0)	8 (88.9)	5 (83.3)
English	5 (20.0)	3 (30.0)	1 (11.1)	1 (16.7)
Group sessions attended				
1–4 sessions	5 (20.0)	2 (20.0)	1 (11.1)	2 (33.3)
5–8 sessions	8 (32.0)	3 (30.0)	4 (44.4)	1 (16.7)
9–12 sessions	12 (48.0)	5 (50.0)	4 (44.4)	3 (50.0)

	Total sample (*n* = 25) *M* (SD), *n (%)*	**Not depressed at follow-up[a] (*n* = 10) *M* (SD), *n* (%)**	**Depressed at follow-up[b] (*n* = 9) *M* (SD), *n* (%)**	**Subclinical group[c] (*n* = 6) *M* (SD), *n* (%)**
Baseline depression score	18.2 (12.4)	21.4 (8.4)	25.0 (12.7)	3.3 (2.9)
Follow-up depression score	13.3 (10.3)	6.6 (2.6)	24.9 (7.1)	7.0 (5.8)
Depression change score	−5.1 (12.1)	−14.8 (9.3)	−0.1 (10.7)	3.7 (5.8)

[a] Mothers with mild, moderate, or severe depressive symptoms at intake who scored below the cutoff of 16 on the CES-D after the group ended.

[b] Mothers with any level of depressive symptoms at intake who scored above the cutoff of 16 on the CES-D after the group ended.

[c] Mothers with subclinical levels of symptoms on the CES-D during the trial.

Table 2

Joint display of participants' presenting concerns and reasons for participation by treatment progress.

Status at posttreatment[a]	Participant responses
Not depressed at follow-up (n = 10)	• Presenting concerns: Mothers clearly **identified feeling depressed at intake**, five out of 10 identified **acute experiences** that triggered their depression (e.g., car accident, cancer, separation from spouse, child diagnosed with autism, etc.), discussed feeling that depression was taboo • Reasons for participation in HMHK: To be in a group with mothers who had experienced similar problems, wanting to receive help
Depressed at follow-up (n = 9)	• Presenting concerns: Mothers report depressive symptoms, some mothers shared that they did not believe in depression or did not realize what they were feeling was abnormal **(normalization of depression)**, isolation a big factor, talking about feelings is taboo • Reasons for participation in HMHK: feeling isolated, needing others to talk to
Mothers with subclinical symptoms (n = 6)	• Presenting concerns: Mothers felt they were experiencing **low levels of sadness or stress** • Reasons for participation in HMHK: To learn new things, meet people

[a]Mothers were split into three groups based on the change in their depressive symptoms on the CES-D over the course of treatment.

Table 3

Joint display of participants' perceptions of participating in IPT by treatment progress.

Status posttreatment[a]	Participant experiences
Not depressed at follow-up (*n* = 10)	• Group modality: **High levels of emotional safety**, reported learning from others' experiences in similar situations, benefit of perspective-taking • IPT-G components: – Goals: All reported making progress towards goals chosen at beginning of treatment, many very specific (e.g., enrolling in school, filing for divorce, being more active) – Interpersonal skills: mothers recalled specific activities like role-playing a conflict to improve communication, praising others, and learning to forgive – One mother mentioned processing prior trauma and one mentioned processing deaths in the family • Therapists: Mothers reported **high levels of trust in the therapists**, reported they created a safe space for the group with confidentiality rules
Depressed at follow-up (*n* = 9)	• Group modality: **Varying levels of emotional safety**, some expressed difficulty sharing their feelings in group (one mother stated she would prefer individual therapy) • IPT-G components: – Goals: Mothers reported making some progress, some reported difficulty remembering – Interpersonal skills: Mothers recalled the importance of expressing feelings in relationships – One participant mentioned the importance of judging the gravity of a problem • Therapists: **varying levels of trusts with therapists**, most reported feeling comfortable but some had difficulty connecting or were reticent at first
Mothers with subclinical symptoms (*n* = 6)	• Group modality: Helped them reappraise severity of their problems after hearing about others' experiences, **experiencing emotional support was helpful** • IPT-G components: – Goals: All reported making progress towards goals, many were specific (e.g., returning to school, improving credit, losing weight, etc.) – Interpersonal skills: Mothers discussed how they learned to approach their children differently, how to provide mutual support in relationships – Several mothers mentioned the importance of considering early life experiences, traumas, and transitions, two specifically mentioned immigration • Therapists: mothers reported that the therapists made them feel comfortable to share in group

[a] Mothers were split into three groups based on the change in their depressive symptoms on the CES-D over the course of treatment.

Table 4

Joint display of participants' reports of treatment impacts by treatment progress.

Status at posttreatment[a]	Participant perceptions
Not depressed at follow-up (n = 10)	• Symptom relief: Participants reported **improvements in sadness and stress**, being able to get out of bed, feeling calmer, and experiencing catharsis in group sessions • Relationships: – Children: Nine out of 10 mothers reported improvements in their relationships with their children, including better communication, increased patience, more quality time – Partners: Improvements in asking for help • Self-awareness: Mothers said the group helped them develop more self-awareness, insight into themselves (concrete examples)
Depressed at follow-up (n = 9)	• Symptom relief: Participants shared that they experienced catharsis in group sessions where they vented and felt release, **fewer statements about sustained gains** • Relationships: – Children: Mothers reported less yelling, more playing with children, reflections are more general – Partner: Improvements in asking for help • Self-awareness: Mothers demonstrated self-awareness about interpersonal conflicts, parenting, and importance of self-expression
Mothers with subclinical symptoms (n = 6)	• Symptom relief: **Mothers reported experiencing relief**, being able to focus more on the future, being more communicative and open, experiencing catharsis in group sessions • Relationships: – Children: Mothers reported less yelling, one mother spoke at length about learning to support's adolescent son's independence – Partners: Improvements in asking for help • Self-awareness: Mothers demonstrated self-awareness about interpersonal conflicts, parenting, and importance of self-expression

[a] Mothers were split into three groups based on the change in their depressive symptoms on the CES-D over the course of treatment.

Table 5

Joint display of participants' perceptions of challenges by treatment progress.

Status at posttreatment[a]	Participant responses
Not depressed at follow-up (n = 10)	• Barriers to engagement: Some had no challenges, depression itself was a barrier to engagement, **mothers overcame challenges to attend** • Attrition: Mothers shared the negative impact of losing other group members • Stigma: One mother mentioned stigma regarding her son's diagnosis • Termination: Two mothers stated they wished there was another group available, or a way to check-in with previous group members
Depressed at follow-up (n = 9)	• Barriers to engagement: Mothers shared **difficulty trusting therapists/getting along with other members**, scheduling difficulties • Attrition: Mothers shared the negative impact of losing other members • Stigma: Several mothers reported **difficulty talking about mental health due to stigma**
Mothers with subclinical symptoms (n = 6)	• Barriers to engagement: Challenges related to needing to transport children to school/other activities • Attrition: Shared impact of cancelled groups • Stigma: Mothers reported presence of stigma in the community and need to overcome it

[a]Mothers were split into three groups based on the change in their depressive symptoms on the CES-D over the course of treatment.