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BRIEF REPORT

Within-Person Changes in Parenting Guilt Predict Symptom Course in Mothers With Past or Current Depression

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Mothers with depression often experience guilt related to parenting. Studies on the relation between parenting guilt and depression have been primarily cross-sectional; consequently, it is unclear whether heightened parenting guilt is a correlate, predictor, or consequence of depressive symptoms. This brief report examines longitudinal and reciprocal relations between maternal guilt and depressive symptoms over a 9-month period using methods that disentangle between- and within-person variability. Evidence that within-person changes in maternal guilt predict subsequent changes in depression symptoms, or evidence of reciprocal within-person effects, would provide more stringent evidence for the utility of addressing maternal guilt in treatment of depression among mothers. At three time points over 9 months, 225 U.S. mothers with a previous mood disorder reported on depression symptoms and parenting guilt. A random-intercept cross-lagged panel model (RI-CLPM) was used to differentiate between-person and within-person effects. Maternal guilt and depressive symptoms were significantly related at the between-person level, with moderate concurrent correlations. Significant within-person, cross-lagged effects were found from maternal guilt to later depression, but not from depression to maternal guilt. In other words, increases or decreases in parenting guilt from a mother's "norm" predicted a subsequent, corresponding change in the severity of her depressive symptoms. These findings establish temporal precedence at the within-person level, highlighting that maternal guilt may be one potentially amenable mechanism influencing the course of depressive symptoms in mothers.

Keywords: maternal depression, parenting guilt, cross-lagged model

Depression is common among mothers in the United States, with prevalence rates estimated at 10% nationwide (Ertel et al., 2011) and higher rates among more marginalized groups (Hunter et al., 2024). The widespread impacts of maternal depression are well-documented, including harsh and/or disengaged parenting, decreased marital quality, and child social and emotional difficulties (Goldfarb & Trudel, 2019; Sutherland et al., 2022). Given the prevalence and intergenerational consequences of maternal depression, it is important to develop interventions specifically for this population. One potential target in this effort is heightened guilt and self-blame related to parenting, which mothers with depression often experience (Sánchez-Rodríguez et al., 2019; Skjerdingstad et al., 2021). However, most studies on parenting guilt and depressive symptoms have been cross-sectional, making it unclear if parenting guilt plays a role in maintaining or increasing symptoms over time. The goal of this brief report was to test longitudinal relations between maternal guilt and depressive symptoms over a 9-month period using methods that can establish temporal relations at the within-person level. Evidence that within-person changes in maternal guilt precede within-person changes in depression, or that the relationship is reciprocal, would support increasing efforts to address parental guilt in treatment of women who are mothers and experiencing depression.

Outside the context of parenting, heightened guilt is one of nine core symptoms of depression (American Psychiatric Association, 2022; Zahn et al., 2015) and is a particularly common symptom among women compared to men (Vetter et al., 2021). Importantly, heightened guilt has been shown to predict the subsequent onset and severity of major depressive episodes in longitudinal studies (Kouros et al., 2016; Lythe et al., 2015). These prospective findings suggest heightened guilt may be more than just a symptom of current depression; it could also be one mechanism influencing the later course of an individual's symptoms. In addition, increased guilt may contribute to the "spread" of depression symptoms across family members. In a longitudinal network analysis, heightened guilt and

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self-blame was the specific symptom of depression most strongly related to later child and partner symptoms (Martin et al., 2023). While results from these studies highlight the potential importance of guilt in the ongoing course of depression symptoms, the focus has been on general feelings of guilt rather than guilt and self-blame specifically related to parenting. However, parenting guilt may be particularly important for maternal mental health. In a survey of over 2,000 mothers measuring multiple parenting domains, maternal guilt was the strongest predictor of mothers' overall subjective well-being and a stronger predictor of depressive symptoms than partner and friend support (Luthar & Ciciolla, 2015).

Conceptually, parental guilt involves making negative attributions about one's performance as a parent and perceiving a discrepancy between one's actual versus ideal self as a parent. Given pervasive societal messages about "good" mothering and the inherent challenges of parenting, most mothers periodically experience parental guilt (Liss et al., 2013). This may be particularly true in the United States, where many mothers endorse "intensive mothering" beliefs about how much of their time and resources should be dedicated to children (Hays, 1996; C. N. C. N. Kim & Kerr, 2024). Family factors further contribute to the frequency and intensity of parental guilt. For example, parental guilt is higher among mothers whose children have social or emotional difficulties (e.g., Shalev et al., 2023) and mothers with restrictive or demanding work settings (e.g., Borelli et al., 2017). While some parenting guilt is normative and likely unavoidable for most mothers, heightened levels may contribute to mental health problems. In longitudinal studies, heightened guilt about parenting experiences predicts depressive symptoms 1 month (Derella & Milan, 2021) and 1.5 years (Egberts et al., 2020) later, controlling for baseline depression. However, longitudinal studies on parenting guilt and depression are scarce.

Although studies have documented significant associations between maternal guilt and depression, three methodological issues limit the clinical utility of these findings. First, most studies are cross-sectional, and concurrent correlations between aspects of guilt and depression symptoms may be overestimated because most depression measures include guilt items (S. S. Kim et al., 2011). Second, both depression and guilt have strong traitlike components that can inflate prospective associations, even in longitudinal designs controlling for baseline measures (Hamaker et al., 2015). Third, most studies have conceptualized heightened maternal guilt as a correlate or cause of depression, but it could also be a consequence of other symptoms. For example, symptoms such as increased irritability may lead a parent to respond to a child's behavior in ways that they feel guilty about, withdrawal may reduce opportunities for positive parent–child interactions, and cognitive changes may increase how much a mother attends to or recollects negative parenting experiences. In this way, parenting guilt and depression symptoms may be reciprocally related and contribute to self-sustaining processes in the course of depression. While there is some evidence that maternal guilt and depressive symptoms are mutually influential over time (Derella & Milan, 2021), the directionality of relations has not been adequately tested.

From an intervention standpoint, it is most informative to know if and how within-person changes in maternal guilt and depression are related over time. That is, when feelings of maternal guilt are reduced below a mother's typical "norm," is she likely to have a subsequent decrease in depressive symptoms below her norm? Moreover, do increases in depressive symptoms forecast subsequent increases in parental guilt, which then may exacerbate depression (i.e., mutually reinforcing processes)? Evidence that within-person changes in maternal guilt precede within-person changes in depression, or that the relationship is reciprocal, would support increasing efforts to address parental guilt in treatment of depression in women who are mothers.

The goal of this brief report was to test longitudinal relations between maternal guilt and depressive symptoms over a 9-month period at the within-person level. This was done by assessing parental guilt and depressive symptoms at three time points in a sample of mothers with a previous mood disorder diagnosis and using a random-intercept cross-lagged panel model (RI-CLPM) to model data. RI-CLPM separates within- and between-person variance in testing for relations between two constructs and thus provides more stringent evidence of temporally linked change processes within the individual (Hamaker et al., 2015). By parsing out stable associations between parenting guilt and depression, longitudinal associations are also less likely to be inflated because of guilt items on depression measures. RI-CLPMs are particularly useful for evaluating mechanisms and feedback processes underlying the course of psychological symptoms (Falkenström et al., 2022).

Method

Data are from a longitudinal, online survey examining mental health and parenting vulnerabilities in mothers in the United States with a mental health history during the COVID-19 pandemic. Procedures were approved by the University of Connecticut Institutional Review Board. The study was not preregistered and was conducted for descriptive purposes as the pandemic arose, building on a cross-sectional study initially planned for measurement development. The research question addressed here was not the primary purpose of the study; thus, findings from the brief report should be viewed as preliminary. We report how we determined our sample size, all data exclusions and manipulations, and all measures in the study.

Participants

The sample includes 225 mothers (M_{age} = 36.9 years old, SD = 9.42, range = 24–60) recruited through Prolific. Eligible mothers had to (a) reside in the United States, (b) read English, (c) report being previously diagnosed with a mental health disorder, and (d) live with a "target" child between 3 and 18 years old. Recruitment was stratified for balanced numbers of target children in three developmental periods (ages 3–5, 6–12, 13–18). Recommended strategies for ensuring quality data from online platforms were utilized, including periodic attention checks, repeated confirmation of eligibility criteria, mixing survey and write-in responses, restricting duplicate IPs, and ensuring the geographic location of submission (Newman et al., 2021). Behavioral health data collected from online crowdsourcing platforms yield findings (e.g., prevalence rates, symptom correlates) consistent with other forms of data collection (Peer et al., 2022), including in longitudinal designs (Stanton et al., 2022). Among the available online platforms, Prolific consistently provides the highest quality data (Douglas et al., 2023).

Of 242 mothers enrolled in the study, 225 reported receiving a previous mood disorder diagnosis (i.e., major depression, bipolar) or were above clinical cutoffs for depression at baseline (i.e., Patient

Health Questionnaire–9 [PHQ-9] score > 10). These participants are included here given the focus on maternal depression symptom course. Of these, 70% reported receiving additional diagnoses (primarily anxiety disorders), 29% were currently in therapy, and 44% were taking psychotropic medications. Sixty-two percent of mothers were married or living with the target child's biological father, 14.1% were married or living with a new partner, and 24.2% were single. Participants self-identified as White (74.0%), Black/African American (13.2%), Hispanic/Latina (6.2%), Asian/Asian American (2.6%), Native American (3.1%), and Middle Eastern (0.9%). Educationally, 55% of mothers had a high school degree, 32.2% a bachelor's degree, and 12.8% a postbaccalaureate degree. In families with a school-age target child (70% of the sample), 46.1% qualified for free or reduced cost lunch at school. In sensitivity analysis using g*power 3.1.9.7, a sample size of 225 provides sufficient power ($1 - \beta = .90$) to detect a small cross-lagged effect ($f = .10$), using conservative estimates of within-person stability effects ($r = .5$).

Procedure

Data were collected at three time points at approximately 3.5-month intervals from September 2020 to May 2021. This time frame was chosen to cover the bulk of the academic year when COVID-19 restrictions to school and work were common across the country and impacting most families. After providing consent, participants completed a 1-hr survey including multiple measures of demographic, mental health (diagnostic history, current depression, anxiety, posttraumatic stress disorder, borderline symptoms, stress), and parenting (parenting guilt, hostility, laxness, mentalization, parent–child relationship quality) domains. Each survey also included several open-ended questions asking mothers to describe their views on several nationwide events that marked the study period (e.g., COVID-19 rates, restrictions, and vaccines; 2020 elections and protests). Participants were paid $12–15 per survey. Of baseline participants, 84% ($n = 189$) completed Time 2, and 72% ($n = 162$) completed Time 3. Women with incomplete data were more likely to be single ($r = .16$, $p < .05$) but did not differ on other baseline factors.

Measures

Demographics

Mothers provided information about age, education, race/ethnicity, finances, family structure, and diagnostic history.

Parenting Guilt

Parenting guilt was measured with the six-item parenting guilt subdomain of Luthar and Ciciolla's (2015) Parenting Experiences measure. Items assess mothers' feelings of guilt and inadequacy related to their parenting role (e.g., "I often feel guilty as I reflect on how I'm doing as a mother"; "When my child does something bad, I feel as though it is my fault"). Items are rated on a 1–5 Likert scale. Responses were summed, with higher total scores indicating more maternal guilt ($\alpha = .90$).

Maternal Depressive Symptoms

The nine-item PHQ-9 (Kroenke et al., 2001) was used to assess depression symptoms. The PHQ-9 is a widely used measure reflecting *Diagnostic and Statistical Manual,* fourth edition criteria with established psychometric properties (Kroenke et al., 2001). Items are rated on a scale from 0 (*not at all*) to 3 (*nearly every day*) based on mood in the prior 2 weeks, with a score of 10 or higher indicating clinically elevated symptoms ($\alpha = .85$).

Data Analysis

A three-wave RI-CLPM was estimated using AMOS 26 as shown in Figure 1. We first tested whether corresponding, time adjacent parameters reflecting autoregressive (e.g., depression Time 1 → depression Time 2 = depression Time 2 → depression Time 3) and cross-lag (i.e., Time 1 to Time 2 parameter = respective Time 2 to Time 3 parameter) were equivalent using nested model comparison in structural equation modeling. The model with the four equality constraints provided a good fit to the data as described below and was not significantly worse than the unconstrained model, $\Delta\chi^2(4) = 7.86$, $p = .097$. Thus, these parameters were set to be equal for the final model used to test research questions. Full information maximum likelihood was used for estimation to allow for inclusion of participants with missing data. Tests of joint multivariate normality for the model indicated no violation. Data are available by reasonable request from the lead author.

Results

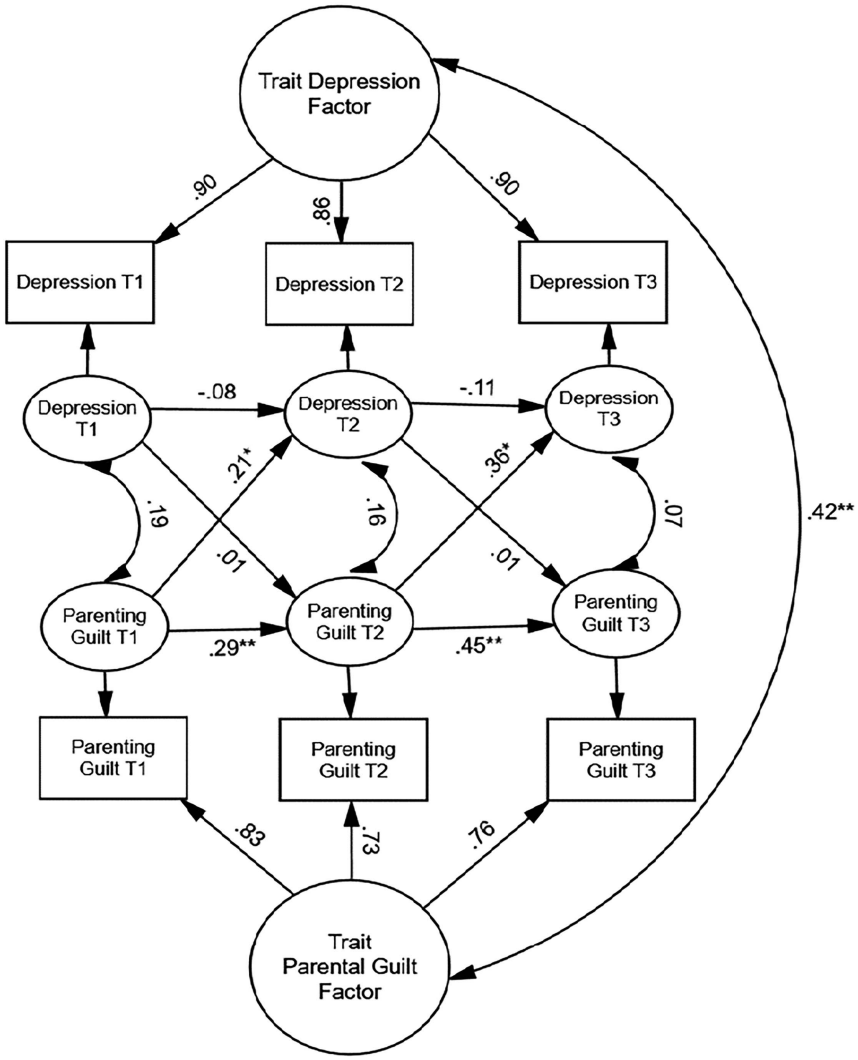
Descriptive statistics are presented in Table 1. The mean PHQ-9 score at baseline was 10.95 ($SD = 7.00$), with 53.7% above the clinical cutoff. The average parenting guilt score was 3.81 ($SD = 0.78$, range = 1–5), highlighting the normative nature of maternal guilt in this population. PHQ-9 scores were highly correlated across the three time points (rs > .74), as were parenting guilt scores (rs > .68). The repeated measures intraclass coefficient was high for depression symptoms (.88) and parenting guilt (.79), suggesting considerable traitlike stability in both. Concurrent correlations between depression and guilt were moderate (rs between .30 and .40, $p < .001$).

The RI-CLPM provided a good fit to the data, $\chi^2(5, N = 225) = 7.87$, $p = .16$; comparative fit index = .99; root-mean-square error of approximation = .05; 90% confidence interval [.00, .11]. Unstandardized and standardized estimates of effects are presented in Table 2 and Figure 1. The factor correlation between trait-level depression and maternal guilt was $r = .42$, $p < .001$, indicating stable, moderate relations at the between-person level in the two constructs. Autoregressive effects at the within-person level were significant for maternal guilt ($B = 0.41$, $SE = 0.10$, $p < .001$) but not for depression symptoms ($B = -0.09$, $SE = 0.17$, $p = .601$). There were significant cross-lagged, prospective relations from maternal guilt to depression ($B = 1.74$, $SE = 0.70$, $p = .014$) but not from depression to maternal guilt (B = 0.002, $SE = 0.02$, $p = .90$).

Results were consistent when including only participants with complete data ($n = 153$). As a post hoc analysis, we also tested whether cross-lagged paths differed significantly by target child age group (preschool, middle, adolescence) or gender (male or female) using nested model comparisons in structural equation modeling (e.g., testing the equivalence of a model with cross-lagged paths estimated separately for boys and girls to a model with paths constrained to be equal across gender). No significant moderating effects emerged, although reduced subgroup sample size limits statistical power to test moderating effects.

Figure 1

Standardized Estimates From the Random-Intercept Cross-Lagged Panel Model Testing Within-Person Relations Between Parenting Guilt and Depressive Symptoms



Note. T = time.
* $p < .05$. ** $p < .01$.

Discussion

The goal of this brief report was to further clarify the relation between maternal guilt and depression symptoms among mothers vulnerable to depression by modeling within-person and reciprocal effects. As expected, maternal guilt and depression symptoms both had strong trait-level components that were moderately correlated at the between-person level. In other words, mothers who reported more maternal guilt relative to the sample also experienced worse depression symptoms; these women tended to remain elevated on both across time. Of greater interest, we found that when increases or decreases in parenting guilt from a mother's "norm" occurred, they were also likely to experience a subsequent corresponding change in depressive symptoms. These findings establish temporal precedence at the within-person level, highlighting the possibility that parental guilt is one mechanism influencing the course of depressive symptoms in mothers who have a history of mood disorders.

Although reciprocal relations between maternal guilt and depression symptoms seem likely, heightened symptoms did not predict a subsequent increase in maternal guilt in within-person analysis. Plausibly, depressive symptoms could increase maternal guilt concurrently but not lead to sustained increases; this would be reflected in the significant trait-level correlations. Relatedly, the study assessment interval (3–4 months) may have been too long for capturing reciprocal processes. Designs that include daily diary or weekly assessments of maternal guilt may better reflect real-time changes and provide insight into the contextual factors that lead to increased guilt. For example, using ecological momentary assessment, Kerr et al. (2021) found that mothers reported experiencing relatively more guilt when they were away from their children compared to when they were with them. Thus, quantifying important within-person changes in parenting guilt may require more micro or real-time approaches.

Table 1
Descriptive Statistics for Parenting Guilt and Maternal Depression Across Time Points

Measure	*M*	*SD*	1	2	3	4	5	6
1. Depressive symptoms T1	10.91	6.95	—	.77***	.80***	.36***	.35***	.30***
2. Depressive symptoms T2	9.76	7.01		—	.75***	.36***	.37***	.30***
3. Depressive symptoms T3	9.04	6.51			—	.30***	.40***	.33***
4. Parenting guilt T1	3.89	0.78				—	.68***	.68***
5. Parenting guilt T2	3.65	0.87					—	.77***
6. Parenting guilt T3	3.62	0.90						—

Note. T = time.
*** $p < .001$.

We also found significant autoregressive effects for maternal guilt but not for depression symptoms, although this was not one of our a priori research questions. Autoregressive effects in RI-CLPM can be challenging to interpret since they are based on residuals from which stable, traitlike aspects of the variable have been removed (Falkenström et al., 2022). Conceptually, significant autoregressive effects in RI-CLPM can reflect a "fanning" of trajectories over time, meaning that the subset of women who started a downward (or upward) path between the first two time points were more likely to continue that same directional path between the next two time points. In other words, mothers who experienced increasing or decreasing parental guilt early in the study period tended to show similar changes in the later part of the study.

Overall, findings support the potential utility of assessing and addressing maternal guilt in treatment with women who are mothers and experiencing depression. While several parenting interventions target maternal emotions, these are typically offered via parenting roles (e.g., for parents of children with mental health issues). Since many mothers receive mental health services that are not directly linked to their parenting role, incorporating parental guilt in other intervention settings could be beneficial. For example, efforts to modify cognitive biases and unhelpful thoughts in individual cognitive behavioral therapy could regularly be applied to guilt-inducing parenting experiences. Acceptance and commitment therapy and self-compassion approaches that help mothers accept feelings of parenting guilt in the moment, without dwelling on these experiences as reflections of their "self," could also be useful (e.g., Sirois et al., 2019). This approach may be particularly beneficial since some degree of maternal guilt is likely unavoidable in many cultural contexts (e.g., the mix of intense parenting expectations, gendered parenting roles, and inflexible and less family-friendly work policies in the United States). Relatedly, some mothers may benefit from developing strategies to disengage from social media platforms that perpetuate perceived parenting flaws (Sun et al., 2023). Finally, print or online resources (e.g., brochures, podcasts, self-help books, and apps) that aim to reduce or normalize parenting guilt could be disseminated following parental depression screeners often done in routine pediatric or adult medical care. These efforts may benefit women with currently elevated symptoms, as well as reduce the likelihood of relapse among women who previously experienced depression.

Table 2
Cross-Lagged and Stability Effects for Maternal Depression Symptoms and Parenting Guilt

Path	*B*	*SE*	β	*p*
Depression T1 → Guilt T2	0.002	0.02	.01	.900
Guilt T1 → Depression T2	1.72	0.70	.21	.014
Depression T2 → Guilt T3	0.002	0.02	.01	.900
Guilt T2 → Depression T3	1.72	0.70	.36	.014
Depression T1 → Depression T2	−0.09	0.17	-.08	.601
Depression T2 → Depression T3	−0.09	0.17	-.11	.601
Guilt T1 → Guilt T2	0.41	0.10	.29	<.001
Guilt T2 → Guilt T3	0.41	0.10	.45	<.001

Note. *SE* = standard error; T = time.

Several study limitations should be noted. First, participants were mothers with a previous mood disorder diagnosis surveyed during the COVID-19 pandemic. This period was distinct for the convergence of multiple, simultaneous stressors that have been associated with parenting guilt in previous research (i.e., balancing work–parenting demands, increased parental responsibilities, children's heightened distress). Similarly, families potentially experienced more contextual changes between the start and end of the study period than is typically experienced in a 9-month period because of COVID-19-related events (e.g., vaccine availability), which could impact longitudinal findings. While the timing of data collection may reduce generalizability, this population (i.e., women with a mental health history experiencing current stressors) constitutes a large portion of treatment-seekers. Other characteristics of the sample, including limited racial diversity, the U.S. location, and involvement in an online research platform, may also limit generalizability given the contextual nature of parenting. Measurement issues are another limitation. Despite the ubiquity of parental guilt, there are few validated measures, and none capture the complexity of self-blaming emotions (e.g., guilt vs. shame vs. regret). More broadly, shared method variance may have inflated estimates, although RI-CLPMs attenuate some of this bias in within-person longitudinal effects.

Despite these limitations, study results further support the role of parental guilt in maternal depression by demonstrating within-person, prospective relations. Specifically, findings indicate that if mothers experience a reduction from their typical level of maternal guilt, they are more likely to have a subsequent reduction in depression symptoms. While experimental and intervention studies are needed to establish causality, these findings encourage further research on interventions in which parental guilt is a treatment target.

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