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Development and Identification of the Dimensions and Components of a Self-Efficacy Training–Based Therapeutic Intervention Package Tailored to the Characteristics of Depressed Women Aged 20–40 Years in Tehran

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A B S T R A C T

Purpose: The present study aimed to develop and identify the dimensions and components of a self-efficacy training–based therapeutic intervention package tailored to the characteristics of depressed women aged 20–40 years in Tehran.

Methods and Materials: This study employed a qualitative approach using grounded theory. The participants included 22 specialists in clinical psychology, family counseling, health psychology, psychiatry, and social work, who were selected through theoretical purposive sampling. In addition, 12 supplementary interviews were conducted with depressed women aged 20–40 years residing in Tehran to provide a deeper understanding of the context-specific characteristics of the target group. Data were collected through in-depth semi-structured interviews and analyzed using the systematic approach proposed by Strauss and Corbin (1998), comprising open, axial, and selective coding.

Findings: The findings led to the identification of five principal components of the therapeutic package: self-efficacy beliefs, emotional self-regulation, personal agency, coping skills, and perceived social support. A paradigmatic model was also developed that included causal conditions—multiple-role pressures, gender discrimination and restrictions, socioeconomic factors, traumatic experiences, and cognitive and emotional factors; the central phenomenon—low self-efficacy and depression among women; contextual conditions—individual characteristics, social support, socioeconomic status, culture and social beliefs, and access to treatment services; intervening conditions—facilitators and barriers; strategies—priority therapeutic components, cognitive, behavioral, and emotional techniques, and the structural characteristics of the package; and consequences—reduced depressive symptoms, increased self-efficacy, improved interpersonal relationships, enhanced quality of life, and reduced somatic symptoms.

Conclusion: Based on the findings, a self-efficacy-based therapeutic package was developed in the form of 16 structured sessions. The package emphasizes a self-efficacy-centered orientation, practical and assignment-based activities, a safe and nonjudgmental environment, cultural adaptation, and family involvement, particularly the involvement of the spouse.

Keywords: *self-efficacy, depression in women, therapeutic package, grounded theory, empowerment, emotional self-regulation*

1. Introduction

Depression is one of the most consequential mental health conditions worldwide and is associated with persistent emotional distress, cognitive impairment, reduced motivation, somatic complaints, interpersonal dysfunction, occupational difficulties, and substantial deterioration in quality of life. Its burden extends beyond the affected individual to families, healthcare systems, workplaces, and communities. International evidence indicates that depressive symptoms vary considerably across demographic groups, social environments, and cultural settings, suggesting that depression cannot be adequately understood solely as an individual-level disorder detached from the social conditions in which it develops (Bradshaw et al., 2026). Cross-national findings further demonstrate that many mental disorders emerge by early or middle adulthood and that their cumulative risk increases across the life course, highlighting the importance of timely, age-sensitive, and contextually appropriate preventive and therapeutic interventions (McGrath, 2025). In Middle Eastern countries, mental disorders also account for a substantial proportion of disease burden, while limitations in prevention, treatment access, and continuity of care continue to complicate effective responses to depression (Noorbala et al., 2020). Recent Iranian evidence similarly points to the continuing prevalence of mental disorders among adults and underscores the need for interventions that are responsive to the psychological and sociocultural characteristics of the Iranian population (Sharif Mirani & Heidari, 2025).

Depression is especially important in women because its prevalence is consistently higher among women than men. This gender disparity is shaped by a complex interaction of biological vulnerability, hormonal changes, stress exposure, social roles, interpersonal experiences, and gender-based inequalities (Albert, 2015). A gender-sensitive perspective therefore requires attention not only to biological processes but also to the social organization of women's lives, including restricted opportunities, caregiving expectations, economic dependency, exposure to violence, unequal employment conditions, and limited decision-making power. From a public-health perspective, gender is a structural determinant of health that influences exposure to risk, access to protective resources, healthcare utilization, and the ability to recover from psychological distress (Manandhar, 2018). Women may simultaneously occupy multiple roles as spouses, mothers, employees, caregivers, and household managers, and the cumulative demands associated with these roles may intensify emotional exhaustion and reduce perceived control. For women aged 20–40 years, these pressures may be particularly pronounced because this period commonly includes major transitions related to marriage, childbirth, parenting, employment, financial responsibility, and the negotiation of personal and familial expectations.

In the Iranian context, depression among women must also be interpreted in relation to culturally embedded expectations, family structures, social stigma, and unequal access to mental health services. Studies of Iranian girls and women have documented meaningful levels of anxiety and depressive symptoms and have linked these problems to demographic, familial, and psychosocial factors (Yaghoubi Siahgorabi et al., 2024). Research on depressed Iranian patients has also shown that depression may be accompanied by maladaptive attributional styles, impaired coherence, behavioral dysregulation, and suicidal ideation, indicating that its clinical consequences may extend well beyond low mood (Mousavi et al., 2022). Mental health systems may not always be sufficiently equipped to respond to these multidimensional needs, especially when services are fragmented, treatment is costly, specialized professionals are scarce, or governance structures do not adequately support coordinated care (Irarrazaval et al., 2025). The problem is further intensified in low-resource settings, where geographical, economic, organizational, and social barriers may restrict access to psychological services and delay treatment seeking (Reddy et al., 2026). Consequently, developing interventions that are practical, culturally adapted, acceptable, and potentially deliverable in both individual and group formats is a major clinical priority.

Contemporary accounts of depression increasingly reject single-cause explanations and instead conceptualize the disorder as the product of interacting biological, cognitive, emotional, interpersonal, behavioral, and sociocultural processes. Different explanatory frameworks may emphasize neurobiology, stress exposure, cognitive vulnerability, social disconnection, developmental experiences, or structural disadvantage, but a comprehensive understanding requires integrating these levels rather than treating them as mutually exclusive (Kurbatfinski et al., 2025). Cognitive models emphasize negative automatic thoughts, dysfunctional beliefs, self-criticism, hopelessness, and maladaptive interpretations of the self and the social world. Social-cognitive research further suggests that depression is associated with difficulties in interpreting social information and that early maladaptive schemas may

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shape negative expectations, interpersonal sensitivity, and withdrawal (Ghosh & Halder, 2024). In this regard, depression may be maintained by a cycle in which negative beliefs weaken perceived competence, reduced perceived competence discourages effective action, inactivity limits opportunities for mastery, and the resulting lack of successful experience further reinforces hopelessness.

The concepts of learned helplessness and perceived controllability are especially relevant to this cycle. Learned helplessness develops when individuals repeatedly experience adverse situations as uncontrollable, leading them to expect that their actions will not meaningfully affect outcomes. Such expectations may generate passivity, emotional distress, reduced persistence, cognitive impairment, and depressive symptoms. Conversely, experiences of controllability can strengthen adaptive expectations, goal-directed behavior, emotional regulation, and resilience (Tafet & Alonso, 2025). For women facing chronic role overload, interpersonal invalidation, financial pressure, gender-based restrictions, or repeated unsuccessful attempts to change their circumstances, the belief that personal effort is ineffective may become central to the development and persistence of depression. Therapeutic interventions that restore a sense of control and personal influence may therefore be particularly valuable.

Within this framework, self-efficacy is a key psychological construct. Self-efficacy refers to an individual's belief in their ability to organize and execute the actions required to manage situations, accomplish goals, and cope with challenges. It affects the choices people make, the effort they invest, their persistence in the face of obstacles, their emotional reactions, and their interpretation of failure. Individuals with stronger self-efficacy are more likely to approach difficult tasks as manageable challenges, use active coping strategies, persist after setbacks, and interpret temporary failure as an opportunity for adjustment. In contrast, individuals with low self-efficacy may avoid demanding situations, underestimate their capacities, disengage rapidly, and experience greater anxiety, hopelessness, and depressive affect. Research has repeatedly demonstrated an inverse relationship between self-efficacy and depression across age groups and clinical populations. Among adolescents, different dimensions of self-efficacy have been associated with depressive symptoms, suggesting that confidence in one's capacity to manage academic, social, and personal demands may protect against emotional distress (Tahmasian & Anari, 2009). Similarly, catastrophic cognitions and low self-efficacy have been implicated in adolescent depression, with academic stress contributing to this relationship (Mokhtarnia et al., 2017).

Evidence from adult and older populations also supports the relevance of self-efficacy to depression. Personality traits may influence depression partly through self-esteem and self-efficacy, indicating that perceived competence can function as a mediating psychological resource between relatively stable personal characteristics and emotional outcomes (Hosseini et al., 2019). Among older adults, self-efficacy has been associated with depression alongside personality factors, reinforcing the view that confidence in one's capacity to handle life demands remains psychologically significant across the lifespan (Hojjati et al., 2017). Among family caregivers of older chemical-warfare veterans, lower self-efficacy has likewise been related to higher depression, illustrating how chronic caregiving strain can undermine perceived competence and psychological well-being (Zanjari et al., 2019). In addition, general self-efficacy and self-focused attention may help explain the relationship between depressive symptoms and judgment bias, suggesting that low self-efficacy is linked not only to emotional distress but also to distorted evaluation and decision-making processes (Kheirmohammad et al., 2015).

Self-efficacy is also closely connected to self-regulation. Depression may disrupt the ability to set goals, initiate behavior, manage emotions, sustain attention, and monitor progress. At the same time, low self-efficacy may make individuals less likely to use effective self-regulatory strategies. Research involving mothers has shown that maternal depression and parenting self-efficacy are related to infants' self-regulation, illustrating that maternal beliefs about competence can influence both the mother's functioning and the developmental environment of the child (Bates et al., 2020). Among women, this relationship is especially important because depression may interfere with caregiving confidence, family communication, and perceived adequacy in maternal and spousal roles. When women interpret difficulty in these roles as evidence of personal failure, self-criticism and helplessness may intensify.

The relationship between self-efficacy and depression is also influenced by emotional processes. Mindfulness has been associated with lower depression, anxiety, and stress, and self-efficacy may mediate these relationships by strengthening individuals' confidence in their capacity to manage internal experiences and external demands (Sharma & Kumra, 2022). Future-oriented anxiety may similarly link low self-efficacy to depression, particularly when

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individuals doubt their ability to cope with anticipated challenges (Szota et al., 2024). These findings suggest that self-efficacy training should not be restricted to motivational statements or general encouragement. Rather, it should include structured work on emotional self-regulation, realistic appraisal, cognitive restructuring, graded task performance, coping practice, goal setting, and the development of mastery experiences.

Self-efficacy is also relevant to resilience under conditions of prolonged stress. Among nursing professionals during the COVID-19 pandemic, resilience, depression, and self-efficacy were closely interconnected, indicating that stronger efficacy beliefs may support adaptation in demanding and uncertain circumstances (Laelson et al., 2023). Such evidence is applicable to depressed women who experience repeated stressors across family, occupational, and social domains. Strengthening self-efficacy may increase willingness to engage in problem-solving, seek support, establish boundaries, and resume meaningful activities. Nevertheless, efficacy beliefs are not formed in isolation. Their development depends on actual experiences, feedback, environmental opportunity, social support, and the extent to which individuals are permitted to exercise agency.

Perceived social support is therefore a major contextual factor in the relationship between self-efficacy and depression. Supportive relationships can provide emotional validation, practical assistance, information, encouragement, and opportunities for successful coping. Evidence indicates that perceived social support may mediate the association between self-efficacy and depression or anxiety in people with chronic health conditions (Du et al., 2025). Neuropsychological and social-cognitive perspectives also suggest that perceived support may influence the regulation of anxiety and stress through processes involving the medial prefrontal cortex and related regulatory systems (Navarro-Nolasco et al., 2025). In contrast, social isolation and withdrawal are strongly associated with depressive symptoms among young adults, demonstrating that diminished interpersonal connection may both result from and contribute to depression (Kim et al., 2025). For depressed women, lack of support from spouses or family members may reinforce helplessness and increase barriers to treatment participation, whereas emotionally responsive relationships may facilitate recovery and strengthen the application of newly learned skills.

Gendered interpersonal patterns may further intensify women's vulnerability. Self-silencing refers to the suppression of personal needs, feelings, or opinions to preserve relationships or avoid conflict. Over time, chronic self-silencing may contribute to loss of agency, resentment, internalized distress, and depression. Three decades of research have linked self-silencing to depressive experiences and emphasized the need for more developmentally, culturally, and relationally informed models of this association (Jack et al., 2026). This perspective is particularly relevant to interventions for women living in settings where assertiveness may be discouraged or where family harmony is prioritized at the expense of self-expression. Accordingly, a self-efficacy-based intervention for depressed women should include assertive communication, help-seeking, boundary setting, and the ability to express needs without excessive guilt.

Women's self-efficacy may also be affected during reproductive and maternal transitions. Studies among postpartum and primiparous women have shown that self-efficacy is related to maternal confidence, mental health, and postpartum depression. A self-efficacy-based therapeutic protocol has been found to improve maternal confidence in infant care among primiparous women, indicating that structured training can enhance competence in a demanding new role (Jafarnejad et al., 2014). Intimacy with the spouse and general self-efficacy have also been associated with postpartum depression, highlighting the combined importance of personal efficacy and relational support (Vaziri Yazdi et al., 2016). Among marginalized women, postpartum depression has similarly been related to self-efficacy and mental health, suggesting that socioeconomic vulnerability may amplify these relationships (Zahmatkesh et al., 2021). These findings support the inclusion of family participation, culturally appropriate examples, and role-sensitive exercises in interventions designed for women of reproductive and working age.

The practical value of self-efficacy enhancement is also demonstrated in health-related interventions. Training designed to strengthen self-efficacy has improved clinical health status and self-management behavior among patients at high risk for diabetes-related complications (Ali, 2017). Longitudinal evidence in individuals with type 2 diabetes indicates that depression can undermine self-efficacy, illness perceptions, and self-management, producing a reciprocal cycle in which emotional symptoms reduce effective health behavior and poor self-management intensifies distress (Derese et al., 2024). Such findings show that self-efficacy is modifiable and that intervention programs can translate efficacy beliefs into observable behavioral outcomes. They also indicate that depression-related reductions in

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motivation and agency may be addressed through structured, progressive, and behaviorally anchored training.

However, the effectiveness of self-efficacy training depends on how the intervention is designed. Efficacy beliefs influence training outcomes, but other beliefs, contextual conditions, feedback processes, and opportunities for successful performance must also be considered (Laarhuis, 2020). Interventions are more likely to be effective when they provide achievable mastery experiences, model adaptive behavior, offer credible encouragement, teach emotional regulation, and allow participants to practice skills in real-life contexts. A package that is overly abstract, culturally unfamiliar, or insufficiently sensitive to barriers may fail to create meaningful changes in efficacy beliefs. For depressed women, a useful intervention should therefore move gradually from simple to more complex tasks, incorporate practical homework, offer immediate feedback, address negative automatic thoughts, and include strategies for generalizing skills to family and occupational settings.

Psychological treatments are effective for depression, but their outcomes vary across intervention types, populations, delivery formats, and contextual conditions. Meta-analytic evidence confirms the overall effectiveness of psychological interventions while also highlighting the need to clarify which treatment components are most appropriate for particular groups and settings (Cuijpers et al., 2023). General mental health reports have likewise emphasized the widespread personal and societal consequences of mental disorders and the importance of strengthening evidence-based psychological care (Edwards, 2016). Despite this body of evidence, many conventional depression interventions are developed for broad populations and may not specifically address the interaction of low self-efficacy, gendered role pressures, interpersonal constraints, emotional dysregulation, and culturally shaped barriers among women aged 20–40 years.

Accordingly, there remains a need for a context-sensitive therapeutic package that integrates self-efficacy beliefs, emotional self-regulation, personal agency, coping skills, and perceived social support within a coherent intervention model. Such a package should be grounded in the lived realities of Iranian women, address social and family barriers, include practical and assignment-based activities, and provide strategies for relapse prevention and maintenance of gains. A grounded theory approach is especially suitable for this purpose because it enables the dimensions and components of the intervention to emerge from the perspectives of both specialists and members of the target group rather than being imposed solely from preexisting theoretical models.

Therefore, the present study aimed to develop and identify the dimensions and components of a self-efficacy training–based therapeutic intervention package tailored to the individual, psychological, cultural, and social characteristics of depressed women aged 20–40 years in Tehran.

2. Methods and Materials

In terms of its purpose, the present study was applied research. The qualitative phase was conducted using an exploratory approach and the grounded theory method. This method was selected because of the nature of the research problem, namely, "developing and identifying the dimensions and components of a self-efficacy training–based therapeutic intervention package tailored to the characteristics of depressed women aged 20–40 years in Tehran." Grounded theory is a systematic and inductive method that enables researchers to identify and extract concepts and categories from qualitative data collected in the field and ultimately develop a context-specific theoretical model appropriate to the setting under investigation.

The target population in the qualitative phase consisted of specialists in clinical psychology, health psychology, and psychometrics; family counselors; therapists experienced in the treatment of depression among women; and depressed women aged 20–40 years residing in Tehran. Participants were selected through theoretical purposive sampling.

Sampling continued until theoretical saturation was achieved. Data saturation was ultimately reached after conducting 22 in-depth semi-structured interviews with specialists and 12 supplementary interviews with depressed women. The supplementary interviews were conducted to obtain a deeper understanding of the context-specific characteristics of the target group.

The primary data-collection instrument in this phase was a semi-structured interview. The interview questions were designed based on the preliminary theoretical framework of the study, including Bandura's social cognitive theory and the theoretical foundations of self-efficacy. The questions were intended to identify the dimensions and components of the self-efficacy-based intervention package and the specific characteristics of depressed women aged 20–40 years, including multiple gender-related roles, psychosocial pressures, pregnancy- and childbirth-related experiences,

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occupational and family issues, and prevailing cultural patterns in Tehran.

All interviews were audio-recorded after obtaining informed consent from the participants and were subsequently transcribed verbatim.

The qualitative data were analyzed using the systematic approach proposed by Strauss and Corbin (1998), involving open, axial, and selective coding.

During open coding, the interview transcripts were examined line by line, and preliminary concepts related to self-efficacy beliefs, barriers to treatment, sociocultural factors affecting depression among women, and coping strategies were extracted.

During axial coding, the open codes were classified into principal categories and subcategories according to their conceptual similarities and differences. The relationships among these categories were then organized within a paradigmatic model comprising causal conditions, contextual conditions, intervening conditions, self-efficacy-based strategies, and expected consequences.

During selective coding, the core category, namely, "self-efficacy empowerment adapted to the sociocultural context of women in Tehran," was identified, and the remaining categories were integrated around it.

MAXQDA software was used to manage and facilitate the coding process.

To ensure the quality and trustworthiness of the findings, Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability were assessed through procedures such as expert review, participant review, reflexivity, and continuous examination throughout the analytical process. Two clinical psychology specialists reviewed and confirmed the codes and categories. Member checking was also conducted by obtaining feedback from several interviewees regarding the researchers' interpretations.

The final output of the qualitative phase was a context-specific paradigmatic model of the dimensions and components of a self-efficacy training–based therapeutic intervention package tailored to the characteristics of depressed women aged 20–40 years in Tehran. This model formed the basis for developing the intervention package.

3. Findings and Results

Two groups of participants were involved in this phase: 22 participants who completed the in-depth interviews in the first phase and 20 participants who evaluated the validity of the package in the second phase. Because of the substantial overlap in their characteristics, their combined descriptive information is presented below.

Table 1

Frequency Distribution of Specialists by Gender and Primary Area of Expertise

Variable	Category	Frequency	Percentage
Gender	Women	14	64
	Men	8	36
	Total	22	100
Primary area of expertise	Clinical psychology	9	41
	Family counseling	5	23
	Health psychology	4	18
	Psychiatry	2	9
	Social work	2	9
	Total	22	100

Of the 22 specialists who participated in the qualitative phase, 14 (64%) were women and 8 (36%) were men. This distribution indicates relatively balanced gender representation, with a predominance of women, which was consistent with the focus of the study on depression among women.

Regarding professional specialization, clinical psychologists constituted the largest group, with 9 participants (41%), which was consistent with the study's focus on therapeutic interventions for depression. Family counselors, with 5 participants (23%), and health psychology specialists, with 4 participants (18%), constituted the next largest groups.

Psychiatrists and social workers represented the smallest groups, with 2 participants each (9%). This professional diversity indicates that multidisciplinary perspectives were incorporated into the development of the therapeutic package.

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Table 2

Descriptive Indices of Specialists' Age and Professional Experience

Index	Minimum	Maximum	Mean	Standard Deviation	Median
Age, years	42	63	51.4	5.7	51
Professional experience, years	14	32	22.6	4.8	23

The mean age of the participating specialists was 51.4 years, with an age range of 42–63 years. This finding indicates the participation of experienced, middle-aged experts.

This issue is important because the specialists' perspectives were grounded in many years of practical and clinical experience in working with depressed women and delivering psychotherapeutic interventions.

The mean duration of professional experience was 22.6 years, ranging from 14 to 32 years. Thus, all specialists had at least 14 years of direct experience in psychotherapy, counseling, or clinical work with women.

The relatively low standard deviations for age (5.7) and professional experience (4.8) indicate the relative homogeneity of the group in terms of professional career stage.

The composition of the expert panel, with a mean professional experience exceeding 20 years, enhanced the credibility of the qualitative findings and the package-validation results.

Table 3

Comprehensive Qualitative Findings: Dimensions, Components, Indicators, and Sources

Main Dimension	Components	Indicators or Concepts	Sources: Interviewee Codes
Principal components of the therapeutic package	Self-efficacy beliefs	Perceived ability to organize and execute courses of action; "I cannot" beliefs; perceived inability to change	M1, M2, M3, M4, M5, M6, M8, M9, M10, M11, M12, M13, M14, M16, M17, M18, M20, M21
Principal components of the therapeutic package	Emotional self-regulation	Ability to manage negative emotions, including sadness, anger, anxiety, and hopelessness; reduced rumination	M1, M3, M4, M6, M7, M8, M9, M10, M11, M12, M15, M16, M18, M19, M22
Principal components of the therapeutic package	Personal agency	Belief in one's ability to influence life events; responsibility for change; moving beyond the victim role	M2, M5, M6, M7, M9, M10, M12, M14, M17, M19, M20, M22
Principal components of the therapeutic package	Coping skills	Cognitive and behavioral strategies for coping with stress; problem-solving; stress management; replacing avoidant behaviors	M3, M5, M8, M11, M12, M13, M15, M16, M18, M20, M21
Principal components of the therapeutic package	Perceived social support	Perceived availability of emotional and practical support from family members, spouses, and friends	M2, M4, M7, M9, M10, M13, M14, M17, M19
Causal conditions: factors contributing to low self-efficacy and depression among women	Multiple-role pressures	Spousal, maternal, occupational, and household-management responsibilities; financial pressures	M1, M5, M8, M12, M17
Causal conditions: factors contributing to low self-efficacy and depression among women	Gender discrimination and restrictions	Workplace discrimination; social restrictions; lack of access to equal opportunities	M2, M6, M11, M19
Causal conditions: factors contributing to low self-efficacy and depression among women	Socioeconomic factors	Poverty, unemployment, limited education, and lack of access to treatment resources	M9, M10, M13, M20
Causal conditions: factors contributing to low self-efficacy and depression among women	Traumatic experiences	Domestic violence, divorce, bereavement, and sexual abuse	M1, M7, M14, M18
Causal conditions: factors contributing to low self-efficacy and depression among women	Cognitive and emotional factors	Negative automatic thoughts, rumination, dysfunctional beliefs, and perfectionism	M3, M4, M12, M16, M21
Central phenomenon: low self-efficacy and depression among women	Low self-efficacy beliefs	"I cannot" beliefs; perceived inability to change; doubts regarding personal abilities; severe self-criticism	M1, M3, M5, M7, M12, M19
Central phenomenon: low self-efficacy and depression among women	Perceived powerlessness and helplessness	Lack of control over life; learned helplessness; feelings of worthlessness	M2, M4, M6, M10, M16, M22

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Central phenomenon: low self-efficacy and depression among women	Rumination and worry	Persistent review of negative thoughts; excessive worry; extreme perfectionism	M1, M8, M12, M14, M15, M20
Central phenomenon: low self-efficacy and depression among women	Social isolation and withdrawal	Reduced social relationships; distancing from family members and friends; feeling like a burden	M2, M9, M11, M13, M17
Central phenomenon: low self-efficacy and depression among women	Somatic symptoms and chronic fatigue	Insomnia or hypersomnia; reduced energy; gastrointestinal problems; decreased libido	M1, M6, M7, M14, M19
Contextual conditions: individual and environmental characteristics of women	Individual characteristics	Age, including 20–35 versus 35–40 years; educational level; marital status; history of depression; previous treatment history	M1, M3, M8, M12, M20, M21
Contextual conditions: individual and environmental characteristics of women	Perceived social support	Support from the spouse, family of origin, and friends; presence of a supportive relationship	M2, M6, M8, M11, M15, M19
Contextual conditions: individual and environmental characteristics of women	Socioeconomic status	Household income; employment status; access to treatment resources; place of residence	M9, M10, M13, M16, M20
Contextual conditions: individual and environmental characteristics of women	Culture and social beliefs	Traditional gender beliefs; social stigma surrounding mental illness; cultural expectations of women	M2, M4, M7, M11, M14, M22
Contextual conditions: individual and environmental characteristics of women	Access to treatment services	Availability of appropriate treatment centers; treatment costs; availability of experienced specialists; insurance-related issues	M1, M5, M9, M12, M18
Intervening conditions: facilitators or barriers	Facilitators	Client motivation and cooperation; support from the spouse and family; trust in the therapist; access to appropriate services; insurance coverage; awareness of the disorder	M1, M2, M4, M7, M10, M16, M17, M20
Intervening conditions: facilitators or barriers	Barriers	Social stigma; high treatment costs; shortage of specialized therapists; fear of medication; lack of spousal support; misconceptions about depression; conflict with working hours; family restrictions	M1, M2, M3, M5, M6, M9, M10, M12, M14, M18, M22
Strategies: self-efficacy-based therapeutic interventions	Priority therapeutic components	Self-efficacy-centered orientation; emotional self-regulation; personal agency; coping skills; social support	All specialists, M1–M22
Strategies: self-efficacy-based therapeutic interventions	Cognitive techniques	Restructuring dysfunctional beliefs; identifying negative automatic thoughts; challenging cognitive distortions; positive self-talk	M1, M3, M5, M8, M12, M16, M20
Strategies: self-efficacy-based therapeutic interventions	Behavioral techniques	Role-playing; graded exposure; practical assignments; coping-skills practice; goal setting and planning	M1, M4, M6, M10, M14, M18, M21
Strategies: self-efficacy-based therapeutic interventions	Emotion-focused techniques	Mindfulness exercises; progressive muscle relaxation; deep breathing; management of negative emotions	M3, M7, M11, M15, M19, M22
Strategies: self-efficacy-based therapeutic interventions	Structural characteristics of the package	90-minute sessions; 12–16 sessions; consistent structure; combination of individual and group formats; spouse's participation in selected sessions	M1, M3, M6, M8, M12, M17, M21
Consequences: expected outcomes	Reduced depressive symptoms	Reduced rumination; improved mood; increased energy; improved appetite and sleep; reduced feelings of worthlessness	M1, M5, M7, M11, M12, M21
Consequences: expected outcomes	Increased self-efficacy	Use of empowering statements such as "I can" and "I can handle this"; taking action to initiate change; persistence in the face of failure	M1, M3, M6, M12, M14, M20
Consequences: expected outcomes	Improved interpersonal relationships	Reduced marital conflict; improved communication with children; increased social relationships; reduced isolation	M2, M8, M11, M13, M15, M19
Consequences: expected outcomes	Enhanced quality of life	Increased life satisfaction; resumption of pleasurable activities; planning for the future	M2, M4, M9, M11, M17, M22
Consequences: expected outcomes	Reduced somatic symptoms	Reduced headaches and gastrointestinal problems; improved insomnia; reduced chronic fatigue	M1, M5, M11, M14, M18

The analysis of qualitative data obtained from interviews with specialists resulted in the identification of five principal components of a self-efficacy-based therapeutic package for depressed women. These components were self-efficacy beliefs, defined as the perceived ability to cope with challenges; emotional self-regulation, defined as the management of negative emotions; personal agency, defined as the belief in one's ability to influence one's life; coping skills, defined as cognitive and behavioral strategies for managing stress; and perceived social support, defined as access to emotional and practical support from family members.

Based on the specialists' consensus, self-efficacy beliefs received the highest frequency of emphasis, as they were

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identified by 18 participants, and were therefore recognized as the core component. The components were prioritized in the following order: self-efficacy, emotional self-regulation, personal agency, coping skills, and social support.

Subsequently, based on the grounded theory approach, the paradigmatic model was organized into six principal categories.

The causal conditions, referring to factors contributing to low self-efficacy and depression among women, comprised five components: multiple-role pressures, including spousal, maternal, occupational, and household-management responsibilities; gender discrimination and restrictions, including workplace discrimination and social restrictions; socioeconomic factors, including poverty, unemployment, and limited education; traumatic experiences, including domestic violence, divorce, and bereavement; and cognitive and emotional factors, including negative automatic thoughts and rumination.

The central phenomenon of the study was labeled "low self-efficacy and depression among women." This phenomenon was manifested in five components: low self-efficacy beliefs, perceived powerlessness and helplessness, rumination and worry, social isolation and withdrawal, and somatic symptoms and chronic fatigue.

The contextual conditions comprised individual characteristics, including age, education, marital status, and history of depression; perceived social support, including support from the spouse, family, and friends; socioeconomic status, including income, occupation, and access to resources; culture and social beliefs, including traditional gender beliefs and social stigma; and access to treatment services, including treatment centers, cost, and insurance coverage.

The intervening conditions were divided into facilitators and barriers.

The facilitators included client motivation, family support, trust in the therapist, and access to services.

The barriers included social stigma, high costs, a shortage of therapists, lack of spousal support, and misconceptions about depression.

The proposed strategies or therapeutic interventions were presented at five levels: priority therapeutic components, including a self-efficacy-centered orientation, emotional self-regulation, and personal agency; cognitive techniques, including belief restructuring and identification of negative thoughts; behavioral techniques, including role-playing, practical assignments, and goal setting; emotional techniques, including mindfulness, relaxation, and deep breathing; and the structural characteristics of the package, including 90-minute sessions, 12–16 sessions, a consistent structure, a combination of individual and group formats, and the spouse's participation in selected sessions.

Finally, the expected consequences of implementing the therapeutic package were predicted across five domains: reduced depressive symptoms, including decreased rumination, improved mood, and increased energy; increased self-efficacy, including the use of empowering statements and taking action to initiate change; improved interpersonal relationships, including reduced marital conflict and increased social interaction; enhanced quality of life, including greater satisfaction and resumption of pleasurable activities; and reduced somatic symptoms, including fewer headaches, gastrointestinal problems, and sleep disturbances.

These findings provided a comprehensive framework for developing a self-efficacy-based therapeutic package tailored to the characteristics of depressed women aged 20–40 years in Tehran.

Based on the findings obtained from interviews with 22 specialists and the grounded theory analysis, the content of the self-efficacy training–based therapeutic package for depressed women aged 20–40 years in Tehran was designed as a coherent and stepwise program.

The package comprises 16 sessions, which may be condensed into 12 sessions, and is organized into seven sequential stages ranging from preparation and motivation enhancement to consolidation and relapse prevention.

Each session consists of six consistent steps: warm-up and rapport building for 10–15 minutes, presentation of the concept through a story or example for 20–25 minutes, discussion and exploration of personal beliefs for 15–20 minutes, an individual or group-based core activity for 30–40 minutes, presentation and feedback for 10–15 minutes, and summarization and assignment of homework for 5–10 minutes.

The specialists emphasized maintaining a consistent routine, changing activities every 20–25 minutes, using real-life stories of Iranian women who had recovered from depression, providing a safe and nonjudgmental environment, personalizing activities according to clients' interests and circumstances, and ensuring that the package was practical and assignment-based. The name "Self-Efficacy Club" was proposed to reflect this practical orientation.

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The specialists also emphasized cultural adaptation through the use of Iranian names, Persian proverbs, religious and national values, and immediate positive feedback.

Strategies for generalizing therapeutic gains to everyday life included involving the spouse and family, with their participation in two or three sessions; assigning practical "boomerang" or ecologically valid homework activities; using a progress and reminder booklet; employing visual reminders; participating in support groups; conducting follow-up sessions in natural settings; and developing a maintenance plan for preserving therapeutic gains.

The primary barriers to implementation included social stigma, high treatment costs, a shortage of specialized therapists, lack of spousal support, conflict with working hours, misconceptions regarding depression, and rumination. A practical solution was proposed for each barrier.

Four general objectives were ultimately defined for the package: increasing self-efficacy, reducing depressive symptoms, improving emotional self-regulation, and enhancing quality of life.

These objectives can be assessed through objective behavioral indicators such as increased use of empowering statements, reduced crying, increased smiling, fewer somatic complaints, and improved interpersonal relationships.

A summary of the principal characteristics of the package is presented in Table 4.

Table 4

Principal Characteristics of the Self-Efficacy-Based Therapeutic Package for Depressed Women Aged 20–40 Years

Dimension	Details
Number of sessions	16 sessions, which may be condensed into 12 sessions
Duration of each session	90–100 minutes
Structure of each session	1. Warm-up and rapport building, 10–15 minutes; 2. Presentation of the concept through a story or example, 20–25 minutes; 3. Discussion and exploration of personal beliefs, 15–20 minutes; 4. Core activity, 30–40 minutes; 5. Presentation and feedback, 10–15 minutes; 6. Summary and homework assignment, 5–10 minutes
Seven stages	1. Preparation and motivation enhancement, 2 sessions; 2. Identification of beliefs, 3 sessions; 3. Cognitive restructuring, 3 sessions; 4. Emotional self-regulation, 2 sessions; 5. Strengthening personal agency and coping skills, 3 sessions; 6. Improving relationships and social support, 2 sessions; 7. Consolidation and relapse prevention, 1 session
Structural characteristics	Consistent routine, beginning with a "review of the week's successes" and ending with the "self-efficacy corner"; changing activities every 20–25 minutes; at least 50% practical activities; a safe and nonjudgmental environment; personalization according to the client's interests and circumstances; use of real-life stories of Iranian women; cultural adaptation using Iranian names, Persian proverbs, and religious and national values; immediate feedback and nonmaterial rewards
Generalization strategies	Involvement of the spouse and family, including participation in Sessions 2 and 14; practical boomerang or ecologically valid assignments, such as "Try one activity you are afraid of this week"; progress and reminder booklet; visual reminders, including pocket cards and displayed positive statements; follow-up sessions in natural settings such as parks or cafés; maintenance plan for preserving therapeutic gains
General objectives	Increased self-efficacy, reduced depressive symptoms, improved emotional self-regulation, and enhanced quality of life
Objective indicators of effectiveness	Use of "I can" statements; reduced crying; increased smiling; fewer somatic complaints; improved communication with the spouse and children; increased social interactions; regular completion of assignments
Principal barriers and solutions	Social stigma: provision of scientific information and orientation sessions; high costs: referral to public centers and use of a group format; lack of spousal support: separate sessions with the spouse; conflict with working hours: evening and online sessions; misconceptions: psychoeducation; rumination: beginning with simple behavioral techniques
Key recommendations or essential requirements	Self-efficacy-centered orientation; reliance on mastery experiences; family involvement, with mandatory spouse participation in two or three sessions; practical and assignment-based activities, with at least 50% of each session devoted to practice; cultural adaptation; gradual progression from simple to complex activities; respect for the pace of recovery; attention to women's multiple roles; honest acknowledgment of difficulties; relapse-prevention planning

The content of the sessions according to the intervention stages is presented in Table 5.

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Table 5

Content of Selected Sessions According to the Intervention Stages

Stage	Session	Topic	Activities	Materials	Culturally Adapted Example
1	1	Orientation and motivation enhancement	Introducing the "Self-Efficacy Club"; discussing experiences of depression; presenting the story of an Iranian woman who recovered from depression	Picture cards, workbook, short video	"The story of Narges, a 32-year-old mother of two who overcame depression by changing her beliefs and subsequently established a home-based business."
2	4	Restructuring dysfunctional beliefs	Identifying "I cannot" beliefs; writing alternative beliefs; challenging cognitive distortions using a three-column worksheet comprising situation, thought, and alternative belief	Practice worksheet, whiteboard, cognitive cards	"Instead of writing, 'I cannot manage the household tasks,' write, 'I can manage my responsibilities more effectively through improved planning.'"
3	6	Strengthening positive self-talk	Identifying negative self-talk; replacing it with positive statements; writing five positive statements about oneself	Statement cards, workbook	"Instead of saying, 'I am a worthless person,' say, 'I am a caring mother and a supportive spouse who has the capacity for further growth.'"
4	9	Managing negative emotions	Teaching deep-breathing techniques; conducting a five-minute mindfulness exercise; identifying triggers of negative emotions	Relaxation audio file, emotion-monitoring worksheet	"When you feel sad, breathe deeply and tell yourself, 'This feeling is temporary, and I can cope with it.'"
5	12	Goal setting and planning	Teaching the SMART model; formulating one short-term and one long-term goal; designing practical steps	Goal-setting worksheet, board	"My goal is to increase my physical activity. My practical step is to walk with a friend for 20 minutes three days per week."
6	14	Effective communication and assertiveness	Teaching the use of "I" statements; role-playing asking the spouse for assistance; practicing polite refusal	Scenario sheets, role cards	"I feel very tired today. Would you please help me wash the dishes?"
7	16	Consolidation and relapse prevention	Reviewing achievements across the 16 sessions; developing a self-care plan; identifying warning signs and coping strategies; celebrating success	Planning worksheet, congratulatory card	"My self-care plan is to walk for 10 minutes every day, call a friend once per week, and regularly review my success journal."

Examples of the content of selected key sessions are provided above.

Session 1, orientation and motivation enhancement, includes the story of Narges, a 32-year-old mother of two.

Session 4, restructuring dysfunctional beliefs, includes a three-column worksheet illustrated with a culturally relevant Iranian example.

Session 6, strengthening positive self-talk, involves replacing negative statements with positive alternatives.

Session 9, managing negative emotions, includes deep-breathing and mindfulness exercises.

Session 12, goal setting, applies the SMART model to an example involving physical activity.

Session 14, effective communication and assertiveness, teaches the use of "I" statements when requesting assistance from the spouse.

Session 16, consolidation and relapse prevention, involves the development of a self-care plan.

These examples demonstrate the concrete, culturally adapted, and practical nature of the intervention content.

4. Discussion and Conclusion

The present study aimed to develop and identify the dimensions and components of a self-efficacy training–based therapeutic intervention package tailored to the characteristics of depressed women aged 20–40 years in Tehran. The qualitative findings identified five principal therapeutic components: self-efficacy beliefs, emotional self-regulation, personal agency, coping skills, and perceived social support. Self-efficacy beliefs emerged as the central and highest-priority component, followed by emotional self-regulation, personal agency, coping skills, and social support. The grounded theory analysis further yielded a paradigmatic model comprising causal conditions, the central phenomenon, contextual conditions, intervening conditions, therapeutic strategies, and expected consequences. The central phenomenon was conceptualized as low self-efficacy accompanied by depression among women, while the proposed therapeutic consequences included reduced depressive symptoms, strengthened self-efficacy, improved interpersonal relationships, enhanced quality of life, and reduced somatic complaints. Based on these findings, a structured 16-session intervention package

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was developed with an emphasis on mastery experiences, cognitive and behavioral exercises, emotional regulation, culturally adapted content, practical homework, and family involvement.

The identification of self-efficacy beliefs as the core component of the intervention is consistent with social-cognitive explanations of depression. Self-efficacy determines how individuals evaluate challenges, initiate behavior, persist in the face of difficulty, and interpret failure. Women with low self-efficacy may perceive everyday demands as unmanageable, avoid potentially corrective experiences, and interpret temporary setbacks as evidence of global personal inadequacy. This process may intensify hopelessness, inactivity, and self-criticism. Previous Iranian studies have reported inverse relationships between self-efficacy and depression across different populations. Tahmasian and Anari showed that dimensions of self-efficacy were associated with depressive symptoms among adolescents (Tahmasian & Anari, 2009), while Hosseini et al. found that self-efficacy played a mediating role in the association between personality characteristics and depression (Hosseini et al., 2019). Hojjati et al. likewise identified self-efficacy as an important correlate of depression in older adults (Hojjati et al., 2017). Although these studies examined different age groups, their findings support the present conclusion that diminished confidence in one's capacities represents a central psychological mechanism underlying depressive experiences.

The prominence of self-efficacy in the current model can also be explained through the concepts of learned helplessness and controllability. The participants described beliefs such as "I cannot," feelings of powerlessness, doubts about personal abilities, and the perception that change is beyond one's control. These experiences closely resemble learned helplessness, in which repeated exposure to uncontrollable stressors generates passivity and the expectation that personal action will not alter outcomes. Contemporary evidence indicates that perceived uncontrollability is associated with cognitive, emotional, and behavioral patterns central to depression, whereas experiences of controllability promote adaptive action and psychological recovery (Tafet & Alonso, 2025). The focus of the developed package on achievable tasks, gradual goal attainment, success monitoring, and positive feedback may therefore weaken helplessness by repeatedly demonstrating that personal actions can produce meaningful outcomes.

The finding that emotional self-regulation constituted the second major therapeutic component is also theoretically and empirically justified. Depressed individuals often experience difficulty managing sadness, anger, anxiety, hopelessness, and persistent rumination. When negative affect is interpreted as overwhelming or uncontrollable, the individual may withdraw, avoid responsibilities, or engage in repetitive negative thinking. The present intervention therefore incorporated mindfulness, deep breathing, relaxation, emotional monitoring, and strategies for identifying emotional triggers. This finding is consistent with evidence that self-efficacy may help explain how mindfulness is associated with lower depression, anxiety, and stress (Sharma & Kumra, 2022). Stronger efficacy beliefs may enable individuals to approach negative emotions as manageable internal experiences rather than as signs of incapacity. The indirect relationship between self-efficacy, future anxiety, and depression reported by Szota et al. also supports the inclusion of emotional regulation and future-oriented coping in self-efficacy interventions (Szota et al., 2024).

Rumination was repeatedly identified in the interviews as both an indicator of depression and a barrier to therapeutic progress. Rumination maintains attention on personal deficiencies, past failures, interpersonal grievances, and uncertain future outcomes. It may also reduce the likelihood of active problem-solving and exposure to mastery experiences. This finding is compatible with research showing that depression is associated with maladaptive cognitive processing, self-focused attention, and judgment biases. Kheirmohammad et al. found that general self-efficacy and self-focused attention were involved in the relationship between depression and judgment bias (Kheirmohammad et al., 2015). Ghosh and Halder further emphasized the role of social cognition and early maladaptive schemas in depression, suggesting that negative beliefs shape both self-evaluation and the interpretation of interpersonal experiences (Ghosh & Halder, 2024). Accordingly, the cognitive restructuring component of the present package, including the identification of negative automatic thoughts, challenging cognitive distortions, and generating alternative beliefs, appears appropriate for interrupting the reciprocal relationship between rumination and low self-efficacy.

Personal agency emerged as another principal component of the package. Participants described agency as the belief that one can influence life events, accept responsibility for change, and move beyond a passive victim position. This finding suggests that self-efficacy treatment should not be reduced to confidence enhancement alone; it should also

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encourage deliberate action, decision-making, boundary setting, and ownership of personally meaningful goals. This component is particularly important for women who experience chronic social restrictions, role overload, or interpersonal environments that discourage autonomy. The literature on self-silencing demonstrates that women may suppress their needs and emotions to maintain relationships, thereby increasing internalized distress and vulnerability to depression (Jack et al., 2026). The present package addresses this problem through assertiveness training, the use of "I" statements, help-seeking skills, and exercises designed to strengthen personal choice and responsibility.

The identification of coping skills as a central component is similarly consistent with previous research. Participants emphasized problem-solving, stress management, behavioral activation, goal setting, planning, and the replacement of avoidance with adaptive behavior. Depression is commonly accompanied by reduced activity and withdrawal, which limit access to rewarding experiences and reinforce perceived incompetence. Practical exercises and graded behavioral tasks can provide direct mastery experiences and generate evidence that contradicts beliefs of incapacity. Research in health-related settings has demonstrated that self-efficacy-enhancing interventions can improve behavior and clinical functioning. Ali reported that self-efficacy enhancement training improved health-related outcomes among patients at risk for diabetic complications (Ali, 2017). A systematic review also showed that depression may undermine self-efficacy and self-management among individuals with type 2 diabetes, indicating that low efficacy and behavioral disengagement may form a mutually reinforcing cycle (Derese et al., 2024). These findings support the practical, task-oriented structure of the present package.

The emphasis on mastery experiences is also consistent with research on training outcomes. Efficacy beliefs are strengthened not merely through verbal persuasion but through repeated successful performance, modeling, manageable challenge, and constructive feedback. Laarhuis emphasized that efficacy-related beliefs influence training outcomes and should be considered alongside broader learning and contextual processes (Laarhuis, 2020). Therefore, the package's use of weekly success reviews, progressive homework, realistic goals, role-playing, and immediate positive feedback may be especially useful. These elements help transform abstract encouragement into observable evidence of competence, which is likely to produce more stable changes in self-efficacy.

Perceived social support was identified as the fifth principal therapeutic component and as an important contextual and intervening condition. The specialists and women interviewed described the support of spouses, family members, and friends as facilitating treatment participation, emotional recovery, and the generalization of therapeutic gains. Conversely, lack of spousal support, family restrictions, stigma, and isolation were identified as barriers. This result is supported by evidence that perceived social support mediates the relationship between self-efficacy and symptoms of depression and anxiety (Du et al., 2025). Social support can provide emotional validation, instrumental assistance, encouragement, and opportunities for collaborative problem-solving. Neuropsychological perspectives also suggest that perceived support may facilitate the regulation of anxiety and stress through higher-order regulatory processes (Navarro-Nolasco et al., 2025). Accordingly, the inclusion of selected family sessions in the present package may strengthen both individual efficacy and the relational environment required to sustain change.

The identification of social isolation and withdrawal as manifestations of the central phenomenon also aligns with previous findings. Kim et al. reported significant associations between social isolation, withdrawal, and depressive symptoms among young adults (Kim et al., 2025). Depression may lead women to withdraw because of fatigue, shame, reduced pleasure, or the belief that they are a burden. Withdrawal then reduces access to support and rewarding interpersonal experiences, thereby intensifying depression. The intervention's emphasis on rebuilding social relationships, participating in support groups, requesting assistance, and improving communication with spouses and family members directly addresses this cycle.

Family involvement is particularly relevant for women experiencing depression during reproductive and caregiving periods. Previous Iranian research has demonstrated that general self-efficacy and spousal intimacy are associated with postpartum depression (Vaziri Yazdi et al., 2016). Zahmatkesh et al. similarly reported relationships among postpartum depression, self-efficacy, and mental health in marginalized women (Zahmatkesh et al., 2021). Jafarnejad et al. found that a self-efficacy-based protocol enhanced maternal confidence among primiparous women (Jafarnejad et al., 2014). These findings support the present package's attention to maternal roles, childbirth-related experiences, household responsibilities, and spousal participation. For women aged 20–40 years, treatment may be more effective

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when it recognizes that psychological distress is embedded within family systems and caregiving demands.

The causal conditions identified in the present study included multiple-role pressures, gender discrimination, socioeconomic adversity, traumatic experiences, and cognitive-emotional vulnerabilities. These findings reinforce multidimensional models of depression that integrate personal, relational, social, and structural influences. Kurbatfinski et al. argued that mental health conditions are best understood through multiple complementary frameworks rather than single-factor models (Kurbatfinski et al., 2025). The elevated prevalence of depression among women has likewise been attributed to interacting biological and psychosocial processes (Albert, 2015). From a gender and public-health perspective, unequal access to resources, exposure to violence, caregiving burdens, and restrictive social norms influence both vulnerability and recovery (Manandhar, 2018). The present findings therefore support the need for an intervention that addresses personal beliefs without implying that depression results solely from individual weakness or deficient thinking.

The contextual conditions identified in the model—including education, marital status, economic position, treatment history, social beliefs, and access to care—also indicate that the same intervention may not operate uniformly for all women. Depression and anxiety symptoms vary according to demographic and social conditions across populations (Bradshaw et al., 2026). Iranian research has also documented associations between demographic characteristics and depressive symptoms among girls and women (Yaghoubi Siahgorabi et al., 2024). The package was therefore designed to allow personalization based on women's interests, responsibilities, resources, and pace of recovery. This flexibility may improve treatment acceptability and prevent a standardized protocol from overlooking important contextual differences.

The barriers identified in this study, including stigma, treatment cost, limited availability of specialized therapists, working-hour conflicts, and misconceptions about depression, reflect broader challenges in mental health service delivery. The burden of mental disorders in Middle Eastern countries is substantial, yet access to appropriate services remains uneven (Noorbala et al., 2020). Difficulties in system governance, coordination, and service strengthening may further limit the responsiveness of mental healthcare systems (Irarrazaval et al., 2025). In low-resource settings, interventions must be feasible, scalable, and adaptable to limited service capacity (Reddy et al., 2026). The option of delivering the current package in group, condensed, evening, or online formats may therefore increase accessibility, although these formats require empirical evaluation.

The expected consequences of the package included lower depressive symptoms, enhanced self-efficacy, improved relationships, better quality of life, and fewer somatic complaints. These outcomes correspond to the multidimensional nature of depression. Psychological treatment research indicates that psychotherapy can meaningfully reduce depression, although the effectiveness of specific components and formats varies across settings and populations (Cuijpers et al., 2023). The current package may contribute to this field by organizing several potentially effective mechanisms—cognitive restructuring, emotional regulation, behavioral activation, social support, and agency enhancement—around self-efficacy as an integrative core. Its culturally adapted stories, Iranian examples, practical exercises, and attention to family relationships may also improve relevance for the intended population.

Overall, the findings suggest that low self-efficacy among depressed women is not merely an isolated belief but a central organizing process connected to emotional dysregulation, avoidance, social withdrawal, perceived helplessness, and reduced agency. The proposed intervention seeks to modify this system through mastery experiences, cognitive and emotional skills, interpersonal support, and culturally meaningful behavioral practice. The qualitative development of the package provides initial conceptual support for its content and structure; however, its clinical effectiveness must be established through systematic quantitative evaluation.

The study had several limitations. The participants were selected purposively from specialists and depressed women residing in Tehran, which may limit the transferability of the findings to women in rural areas, smaller cities, or culturally different regions. The qualitative nature of the research means that the identified categories were influenced by participants' experiences and the researchers' interpretations, despite the use of trustworthiness procedures. The number of women interviewed was also smaller than the expert sample, and greater involvement of service users might have produced additional perspectives regarding treatment preferences, practical barriers, and culturally sensitive content. In addition, the intervention package was developed conceptually and validated through expert review, but its effectiveness, feasibility, adherence,

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and durability were not tested in the present phase. The inclusion of a 16-session structure may also create practical challenges for women with employment, caregiving, transportation, or financial constraints.

Future studies should evaluate the effectiveness of the developed package through randomized controlled trials involving depressed women aged 20–40 years. Researchers should examine changes in depressive symptoms, general and domain-specific self-efficacy, emotional regulation, personal agency, social support, quality of life, and somatic symptoms across pretest, posttest, and long-term follow-up assessments. Comparative studies could evaluate the package against cognitive behavioral therapy, supportive counseling, behavioral activation, or treatment as usual. Future research should also test whether the 12-session condensed version produces outcomes comparable to the 16-session format. Studies involving women from different provinces, socioeconomic groups, marital statuses, and cultural backgrounds would improve the generalizability of the findings. Mixed-method research could further clarify how participants experience specific intervention components and which mechanisms account for therapeutic change. The mediating roles of emotional regulation, perceived social support, rumination, and personal agency should also be investigated.

Mental health professionals may use the developed framework to organize culturally sensitive interventions for depressed women, while adapting activities to each client's clinical severity, literacy level, family circumstances, and daily responsibilities. Therapists should prioritize achievable mastery experiences, practical homework, emotional regulation skills, and gradual behavioral engagement rather than relying solely on verbal encouragement. Where appropriate and safe, spouses or supportive family members should be included in selected sessions to improve understanding, reduce stigma, and support the client's behavioral goals. Services should consider offering group-based, evening, hybrid, or online delivery formats to reduce barriers related to cost, transportation, work, and childcare. Clinicians should also monitor suicide risk, trauma exposure, domestic violence, and severe psychiatric symptoms and arrange specialized or multidisciplinary care when required.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

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