The Power of Group-Interpersonal Therapy:

Strengthening Social and Emotional Skills to Engage in Program Activities

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Introduction

The United States Agency for International Development's Bureau for Humanitarian Assistance (BHA)-funded Graduating to Resilience Activity (the Activity) developed a robust learning agenda to drive evidence generation and facilitate Activity implementation and adaptation. This technical brief documents the Activity's integration of mental health programming, specifically the group-interpersonal therapy (G-IPT) approach, into the Activity's coaching model. The integration of G-IPT was intended to help participants address challenges that may be affecting their ability to actively participate in livelihoods activities. This technical brief highlights quantitative and qualitative data collected at different points throughout the implementation period to better understand the implementation process, outcomes, and participant experiences with G-IPT. To view other technical briefs in this series please visit: www.avsi-usa.org and www.air.org.

Key Takeaways

Participants struggled with grief, loneliness, isolation, interpersonal conflict, stress, and a lack of self-confidence, which prevented them from fully engaging in the Activity.

Impact evaluation data found no meaningful difference in mental health status between those who participated in group interpersonal therapy (G-IPT) sessions and those who did not.

Feedback from the participants highlighted that G-IPT gave them skills and tools to better manage stressors. Specifically, it helped participants:

- Develop coping strategies to manage grief,
- Build friendships to combat loneliness and social isolation,
- Strengthen problem solving skills, and
- Re-enforce skills from other Activity components such as savings and coaching.

Implementors considering integrating G-IPT into programming should:

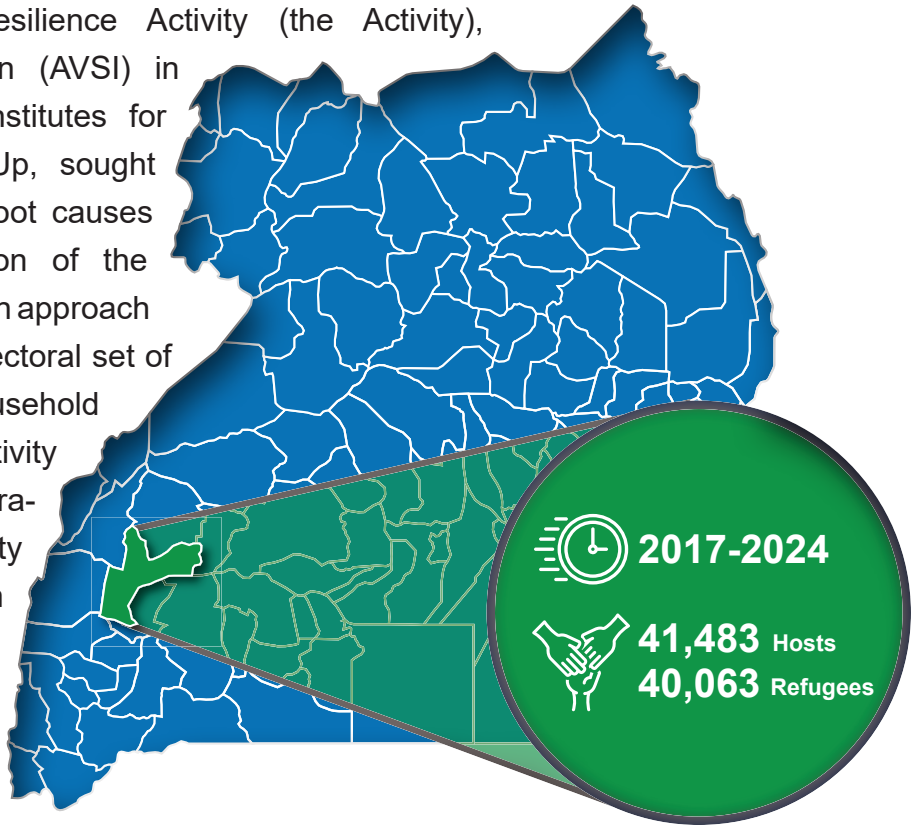
- Consider time commitment when scheduling sessions,
- Sensitize participants and household members,
- Build in time for participants to develop rapport and agree on confidentiality rules, and
- Use visual tools to facilitate sharing and discussion around sensitive topics.

Global Context

Globally, 20 percent of people living in post-conflict settings suffer from depression, anxiety disorders, and post-traumatic stress disorder.[1] In Uganda, these rates are much higher: up to 40 percent of the population reports suffering from depression, with the highest prevalence among refugees (67.6 percent).[2] Poverty and mental health are intrinsically linked. While poverty has been shown to affect individuals' mental health, the reverse is also seen, with poor mental health leading to poverty and poor economic outcomes.[3,4] Mental health challenges can affect individuals' ability to engage in economic activities, due to challenges with cognitive function, fatigue, concentration, and belief in oneself and one's abilities.[5]

Graduating to Resilience Activity

The United States Agency for International Development's Bureau for Humanitarian Assistance (BHA)-funded Graduating to Resilience Activity (the Activity), implemented by AVSI Foundation (AVSI) in partnership with the American Institutes for Research® (AIR®) and Trickle Up, sought to help households address the root causes of poverty through implementation of the graduation approach. The graduation approach is a timebound, sequenced, multisectoral set of interventions delivered at the household level. Using this approach, the Activity sought to graduate 13,200 ultra-poor refugee and host community households in Western Uganda from conditions of food insecurity and fragile livelihoods to self-reliance and resilience. These households are economically active but unable



[1] Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., Saxena, S., (2019). New WHO Prevalence estimates of Mental Health Disorders in Conflict Settings: A Systematic Review and Meta-Analysis. Lancet; 394: 240-248. Accessed at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30934-1/fulltext.

[2] Mark Mohan Kaggwa et al., "Prevalence of Depression in Uganda," American Naturalist 189, no. 5 (May 2017): 465, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9584512/pdf/pone.0276552.pdf.

[3] Vikram Patel et al., "The Lancet Commission on Global Mental Health and Sustainable Development," Lancet 392 (October 2018): 1553–98.

[4] Matthew Ridley et al., "Poverty, Depression, and Anxiety: Causal Evidence and Mechanisms," Science 11, no. 370 (December 2020): 6522. https://www.science.org/doi/10.1126/science.aay0214.

[5] Ridley et al., "Poverty, Depression, and Anxiety," 6522.

to meet their basic needs consistently without some form of assistance.

Graduating to Resilience uses the graduation approach to deliver an integrated set of interventions. Focusing on women as the entry point, the Activity seeks to engage all members of the household to improve household level resilience. Photo: AVSI.

Using a woman-plus-household graduation approach, the Activity provided an integrated mix of interventions, including but not limited to life skills coaching; core technical market skills training, including farmer field business school; enterprise selection, planning, and management; digital and financial literacy; savings and financial inclusion through village savings and loan associations (VSLA); food consumption support; asset transfer; referrals and linkages; and business coaching. To contribute to the evidence base and to help identify the most cost-effective and efficient approach to reaching ultra-poor refugees and host community populations, the Activity was implemented in two 24- to 30-month cohorts (2018–2021 and 2022–2023), with each cohort testing variations of the graduation model. Through a randomized controlled trial (RCT) conducted by Innovations for Poverty Action (IPA), the Activity tested and generated rigorous evidence around the variations.

Understanding the link between poverty and mental health, including the influence that mental health can have on individuals' and households' ability to engage in economic activities and in development programming, the Activity sought to test the integration of a mental health component. The intention was to pilot test and better understand whether the integration of mental health programming could help participants address challenges that may be affecting their ability to actively participate in livelihood activities.

This adaptation and pilot was informed by data collected at the end of Cohort 1 implementation (2021), which found that 40 percent of Activity participants (38 percent of whom were host community members and 43 percent of whom were refugees) had poor or fair mental health status. This finding aligned with similar data that was collected by AVSI Foundation in the Palabek refugee settlement in Northern Uganda, in which 35 percent of respondents indicated that they were experiencing depression at the time and in which 64 percent reported that their depression was interfering with their daily lives.

Group-Interpersonal Therapy

Against this backdrop, the Activity integrated mental health programming into the design of Cohort 2. After a review of different mental health service models, the Activity selected the G-IPT approach because of its focus on addressing stressful life events including grief, interpersonal disputes, life transitions, and social isolation.[6] Recommended by the World Health Organization (WHO) as a first line of treatment for managing moderate-to-severe depressive disorders, G-IPT can be delivered by trained, nonclinical staff like coaches or community-based trainers, and it can be easily integrated into community-based programming. Because G-IPT does not need to be delivered by a mental health professional and is delivered through a group model, it can be cost-efficient, making the approach more scalable for development programming.[7] While G-IPT can be cost-efficient and the right fit for community-based programming, it is not meant to be used to treat more severe mental health cases of depression or anxiety, which should be treated by a mental health professional.

G-IPT is a participatory, group-based therapeutic approach that aims to empower isolated and vulnerable individuals to improve relationships, develop communication and conflict resolution skills, and foster lasting support networks. This group-based approach gives participants a safe

Group Interpersonal Therapy

G-IPT has three phases, each with distinct objectives:

Initial

Help participants identify problem areas and set treatment goals, and focus on building rapport among group members to facilitate sharing of personal information.

Middle

Ensure that all members are actively engaged and helping one another by making suggestions regarding other members' problems, acquiring skills to solve problems, and understanding their depression symptoms and triggers.

Termination

Prepare group members for final sessions, remind them to continually identify triggers of depression and healthy ways to respond, and guide them in creating and reviewing individual action plans.

[6] WHO and Columbia University, Group Interpersonal Therapy (IPT) for Depression, WHO Generic Field-Trial Version 1.0). (Geneva: WHO, 2016), https://www.who.int/publications/i/item/WHO-MSD-MER-16.4.

[7] Mark Mohan Kaggwa et al., "Prevalence of Depression in Uganda," American Naturalist 189, no. 5 (May 2017): 465, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9584512/pdf/pone.0276552.pdf.

space in which to share their challenges, discuss actions taken to manage these challenges, and provide support to one another.

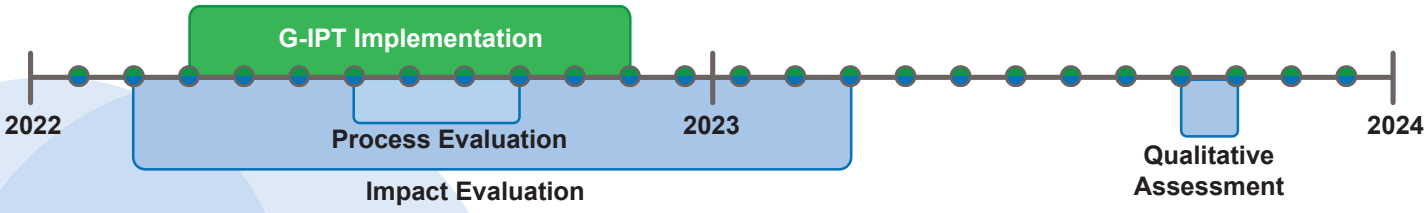
Research on G-IPT, including studies conducted in Uganda, indicate that G-IPT interventions are effective in reducing depression severity among participants, typically within 16 weeks of starting the sessions.[8] One study in Uganda found benefits such as women spending more time working in their primary occupation, better physical health, improved social networks, and women and families consuming meals more regularly.[9]

Implementation Strategy

The Activity integrated G-IPT into the Activity's group coaching model. Based on WHO guidance,[10] the Activity developed G-IPT manuals used by coaches and community based trainers (CBTs). Before starting G-IPT, the Activity conducted a mental health assessment of all Cohort 2 participants to assess their levels of depression and anxiety. The Activity found that approximately 80 percent of refugee participants and 60 percent of host community participants reported experiencing depression at some point in their lives. Based on these findings, the Activity decided that all participants could benefit from G-IPT and decided to randomly assign participants to groups.

Participants were divided into coaching groups, with half assigned to receive G-IPT sessions in addition to the Activity's normal coaching support and half assigned to receive the standard coaching support.[11] G-IPT sessions were conducted after regular coaching sessions with participants, building on the topics and skills discussed during coaching. To make the G-IPT sessions more intimate and promote higher engagement, coaching groups of 25 were divided into groups of 12 and 13 participants. Both groups received 12 IPT sessions over an eight-month period (March to November 2022), with G-IPT sessions held every other week, as recommended by WHO and StrongMinds.[12] Sessions were facilitated by coaches and CBTs, and the sessions lasted 90 minutes on average (Exhibit 2).

Exhibit 1. G-IPT Implementation and Research Timeline



[8] Paul Bolton et al., "Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial," Journal of the American Medican Association 289, no. 23 (June 2003): 3117–24. https://jamanetwork.com/journals/jama/fullarticle/196766.

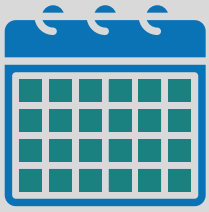
[9] StrongMinds Mental Health Africa, Impact Evaluation. End of Phase Two Impact Evaluation for the Treating Depression at Scale in Africa Program in Uganda (July 2015). https://tinyurl.com/36jc9837

[10] "Group Interpersonal Therapy (IPT) for Depression," 2016

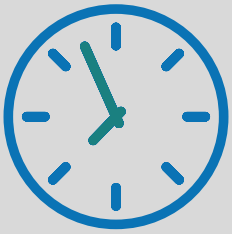
[11] After the assessment, AVSI Foundation categorized 1,611 participants as moderately depressed, 287 as moderately severely depressed, and 97 as severely depressed. AVSI used the assessment to divide coaching groups according to similar levels of depression and anxiety.

In a typical G-IPT session, participants identified and ranked their mood and perceived burden using a visual burden scale from 1 (low burden) to 5 (high burden) (Exhibit 2)[13]; shared their problems with the group, soliciting guidance and solutions from the coach and other group members; and identified action items and concrete steps to solve their problems. While the coach guided the sessions, the participants drove the discussion.

Exhibit 2. Overview of G-IPT Sessions



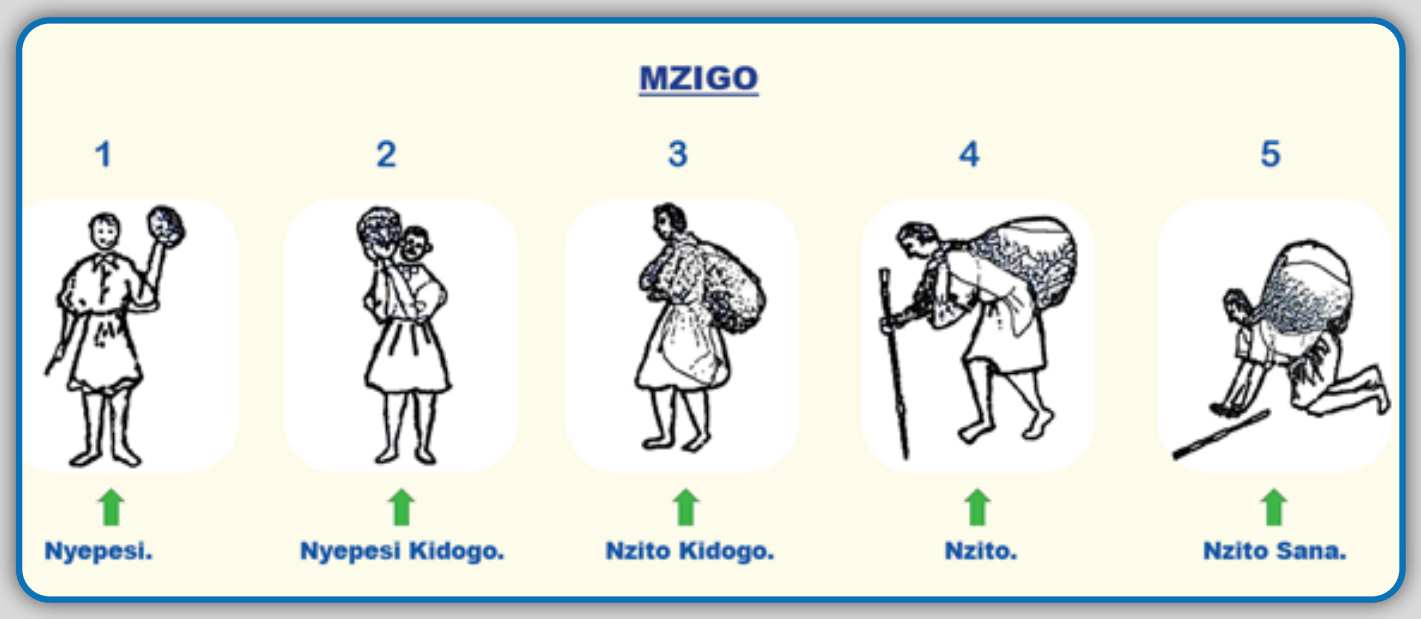
12 sessions implemented
February–July 2022



90–minute
biweekly sessions

3,442 households
(1,694 refugees, 1,748 host)
received G-IPT

At the start of each G-IPT session, participants were asked to use the burden scale to rank their mood and perceived burden that week on a level from 1 to 5.



[12] WHO and Columbia University, Group Interpersonal Therapy (IPT) for Depression.

[13] G-IPT participants used the Kagugu, or burden scale, an instrument with five images showing different levels of burden. The participants used this instrument to identify their mood and perceived burden at the start of the G-IPT session." 2016

Evaluation Methods

To understand the impacts of the G-IPT approach, the Activity and its external evaluation partner, IPA, conducted a series of studies including an impact evaluation, process evaluation, and qualitative assessment.

Impact Evaluation

As part of the Cohort 2 RCT, IPA collected quantitative data to evaluate the short-term impact of the G-IPT sessions. The midterm data were collected from January through March 2023, from two groups of participants: those who engaged in coaching and G-IPT sessions (1,605 participants sampled) and those who engaged only in coaching sessions (1,605 participants sampled), for a total of 3,210 participants. The data were collected using a quantitative survey that contained two parts. The first part, which was administered to the head of household or Activity participant, included questions about household characteristics. The second part, which was administered to the Activity participant, asked about their mental health, social network, and other things. IPA used three indices to define and measure mental health, including metrics related to psychological distress, health-related quality of life, and economic participation (Exhibit 2).[14]

Exhibit 2. Aggregated Measures Used to Measure Mental Health

G-IPT MENTAL HEALTH MEASURES

1. **Psychological distress.** IPA aggregated data on three measures of mental health: Kessler 10,[15] PHQ-9,[16] and GAD-7.[17]
2. **Health-related quality of life.** IPA aggregated information on number of healthy days, average of subjective mental and physical health rating, and days of good functioning.
3. **Economic activity.** IPA aggregated information on participant labor supply, investments, and intentions to expand economic activity.

[14] IMPEL, The Impact of a Graduation Program on Mental Health in Refugee and Host Communities in Uganda (Washington, DC: The Implementer-Led Evaluation & Learning Associate Award), 2023.

[15] The Kessler Psychological Distress Scale (Kessler 10) is a 10-item questionnaire about anxiety and depressive symptoms with a five-level response scale to measure psychological distress that has been used widely to assess psychological distress among general and clinical populations from different cultural backgrounds. The measure can also be used as a brief screen to identify levels of distress.

Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry. 2003 Feb;60(2):184-9.

[16] The Patient Health Questionnaire (PHQ-9), is a tool for assessing depression incorporating DSM-IV depression criteria and major depressive symptoms. The tool is commonly used for screening and diagnosis in a range of settings, countries, and populations.

Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. Journal of General Internal Medicine, 22(11), 1596-1602. 10.1007/s11606-007-0333-y

[17] The General Anxiety Disorder (GAD-7), is a seven-item diagnostic tool for generalized anxiety disorder and assessing its severity validated in primary care and general population settings.

Spitzer RL, Kroenke K, Williams JBW, Löwe B. A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. Arch Intern Med. 2006;166(10):1092–1097. doi:10.1001/archinte.166.10.1092

Process Evaluation

To assess the quality of implementation of the G-IPT approach, IPA conducted a process evaluation. From June to September 2022, IPA observed 27 G-IPT sessions: seven in the host community and twenty in the refugee community. In addition to observing the sessions, IPA interviewed four coaches to better understand the problems that participants were facing and the types of solutions discussed during the sessions.[18]

Qualitative Assessment

To complement the impact and process evaluations, the Activity collected qualitative data to better understand participants' experiences with G-IPT. The data included (1) the main mental health challenges faced by participants and the extent to which those challenges affected their ability to participate in the Activity interventions; (2) the positive or negative effects that participants felt the G-IPT sessions had on their life and/or relationships; (3) what skills, if any, they believed that G-IPT helped them gain; (4) what challenges, if any, they faced when engaging in the G-IPT sessions; and (5) the ways in which they believed the G-IPT could be refined or improved.

To unpack these questions, the Activity team conducted eight focus group discussions with Cohort 2 participants who engaged in G-IPT, including four groups in the refugee community and four groups in the host community. The FGDs were conducted in September and October 2023 with a total of 85 participants.

Coaches used the burden scale to help participants identify their mood and perceived burden level. Participants noted that the burden scale was a helpful tool that allowed them to more accurately describe how they were feeling. Photo: AVSI.

[18] IMPEL, Process Evaluation Report. (Washington, DC: The Implementer-Led Evaluation & Learning Associate Award), 2022.

Findings

Impact Evaluation Findings

IPA found no overall meaningful difference in mental health status between those who participated in G-IPT sessions and those who did not. All three indices showed that among refugee participants, there was no improvement in mental health scores. In the host community, although there were no differences in the health-related quality-of-life scores between those who participated in G-IPT sessions and those who did not, those who did participate in G-IPT had lower scores on psychological well-being[16] and economic activity[17] after the sessions. On the surface, these findings might suggest that the G-IPT sessions were not useful in improving participant mental health and well-being; however, measuring mental health can be complicated by limitations, such as those described below.

Evaluation Limitations:

- **Time trends.** Midway through the G-IPT intervention, the World Food Program (WFP) cut food rations to refugees following a prioritization system in July 2023[18], so overall distress may have increased among refugee participants due to external factors.[19]
- **Fidelity of implementation.** The Activity deviated from the WHO IPT model,[20] with regards to 1) group size, 2) group heterogeneity, and 3) integration with coaching. WHO recommends that groups be between six to ten people and not be mixed to include participants who are suffering from depression and those who are not. The model suggests that smaller groups allow for participants to build rapport with other group members creating a sense of trust and openness to share personal experiences. Mixed groups could facilitate feelings of stigma, specifically if those who are experiencing symptoms of depression are put into groups with those who are not experiencing symptoms. The Activity integrated therapy with other coaching sessions rather than having it as a standalone intervention.
- **Awareness of depression signs and symptoms.** After learning more about mental health, participants were better able to identify their problems, which may have contributed to a decrease in self-reported mental health status.

[16] Host community households assigned to G-IPT scored 0.11 standard deviations (SDs) higher on average than non-G IPT households, meaning higher psychological distress. Looking at the psychological distress index, we see that an increase in the aggregate index in the host community was driven by increases in Kessler 10 and PHQ-9, which were higher by 1.01 and 0.45 SDs, respectively, in the G-IPT group.

[17] Among host community participants, the economic index decreased by 0.12 SDs on average. Breakdown of the index shows the decrease for host community households was driven by a decrease in investment in income-generating activities. Among host community households, the addition of IPT decreased total investment over the previous four months by about 53,000 UGX, or about 7 percent relative to the average among non-GIPT households. This decrease was not concentrated in a particular livelihood.

[18] In July 2023 WFP food rations were cut accordingly: 1) most vulnerable receive 60% of a standard ration; 2) moderately vulnerable receive 30%; 3) least vulnerable no longer receive rations. Sources: Neiman, Sophie, and Titeca, Kristof. 15 December 2023. How a WFP food aid revamp has gone wrong for refugees in Uganda" The New Humanitarian. Accessed at: https://tinyurl.com/32smyrfz

[19] ReliefWeb, "Impacts of the Cost of Inaction on WFP Food Assistance in Uganda (2021 & 2022), April 2023," June 30, 2023. https://tinyurl.com/ycx9mzde

[20] WHO and Group Interpersonal Therapy (IPT) for Depression.

Process Evaluation Findings

The IPA process evaluation confirmed that the G-IPT approach—including the number, frequency, and duration of G-IPT sessions—was implemented according to the Activity manuals. IPA found that the coaches and CBTs who facilitated G-IPT sessions followed the process described in the coaching guide. This process included the following steps: Coaches started sessions by asking participants to rate their mood and level of perceived burden on the G-IPT burden scale, from level 1 to 5.

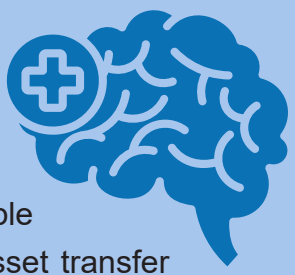
- Coaches and group members reviewed homework or progress since the previous session.
- Three to four participants shared their problems with the group.
- The coach and group members worked to generate solutions or offer support.
- The coach assigned homework to participants who had shared problems, such as incorporating suggestions from the group into specific steps for solving the problems.

Coaches used simple visual tools to help participants identify challenges and discuss sensitive topics. The burden scale was a helpful tool that allowed them to more accurately describe how they were feeling. Photo: AVSI.

According to the process evaluation, attendance rates for G-IPT sessions were around 90 percent, similar to attendance at coaching sessions given that the G-IPT sessions were held after coaching sessions.

Qualitative Assessment Findings

Mental Health Challenges



Participants confirmed that their mental health affected their ability to engage in the Activity fully due to lack of focus, stress and anxiety, and household conflicts. For example, there were conflicts between household members about time spent participating in Activity components, not being able to meet basic needs, and the best ways to use consumption support and asset transfer funds. Some participants discussed coping with grief, suffering, and life changes and not being

able to focus on activities like starting or growing a business to generate income. Others discussed experiencing isolation and not connecting with others, which affected their ability to work together—for example, in digging activities related to farming and kitchen gardens. Some participants shared that they had high levels of stress and anxiety; were unable to focus on business or income-generating activities; lacked energy; had feelings of hopelessness that prevented them from planning with their household; and had low confidence about, and low self-efficacy in, meeting basic needs and having enough savings.

Relationship and Interpersonal Dynamics

Coping strategies helped participants deal with grief. Participants discussed the skills they gained and from G-IPT and applied to cope with grief. Strategies such as positive thinking, acceptance of things beyond one's control, and seeking solace and strength through prayer were highlighted as useful tools for managing grief.

> "I liked the burden scale. At first, I did not understand it well, and I even underrated my burden level, but when our coach continued to explain it to us, I realized that I needed to admit my level, and we found out that so many people were sick and they did not know."
>
> G-IPT Participant, Host Community

Participants reported that G-IPT sessions helped them address grief triggers to cope with the feelings of loss that they had been experiencing. For example, some participants discussed grief over losing a child and finding strategies to cope with the grief, such as prayer. One participant shared that she experienced grief after losing her husband and did not know how to manage, but with the G-IPT sessions, she was able to build her self-efficacy and believe in herself. As a result, she was able to participate in her business to gain income, provide food for her children, and pay their school fees

Building friendships, social networks, and finding a trusted confidant helped participants combat loneliness and social isolation. Participants reported that they learned how to avoid keeping all their troubles bottled up by sharing problems with the G-IPT group or with friends and confidants. Through encouragement to share their thoughts and burdens with their group, participants experienced relief and clarity of thought from the advice received from fellow

> "I have made friends with whom I can share my problems. Some are my fellow participants. For example, I was not a person of sharing my problems, but when I got these G-IPT sessions, I understood that I have to go with friends, talk to them and discuss physically [in person], and find solutions."
>
> *G-IPT Participant, Refugee Settlement*

group members and from the realization that they were not alone in experiencing troubles or challenges.

Relatedly, the presence of a "confidant"—a close friend with whom to share trials and tribulations—galvanized this change. Participants explained that having a confidant helped reduce negative thoughts and stressors associated with grief. Participants reported that building these relationships helped decrease their loneliness and isolation and improved their social connection to and relationships in the community. Participants gave an example of how they built relationships to help one another: a small group went to one another's farms to dig and prepare the land, working together instead of toiling separately. Respondents from the refugee community mentioned that they could look to their current community for support instead of family and friends in the Democratic Republic of the Congo.

Developing skills in conflict resolution, problem solving, and communication improved relationships with neighbors, spouses, and other household members. Participants reported that through G-IPT sessions, they built skills and competencies in conflict management, negotiation, and problem solving. These skills included communication and generative dialogue, peaceful conflict resolution, and setting realistic expectations. Participants said they also developed patience, compassion, and politeness, as well as how to lead with respect. They explained that these skills and qualities had gradually improved their relationships with others both within and outside of the household. Participants shared how these skills helped in resolving conflicts with their husbands and with family members. Some participants reported that they even used these skills to resolve disputes between others in their communities.

Skill Building and Tools

G-IPT sessions reinforced learning and skills from other Activity components. Poverty and the struggle to meet basic needs are the root causes of stress, anxiety, conflicts, and strained household relationships among participants. The G-IPT sessions reinforced skills promoted in other Activity components, such as contributing to savings accounts with VSLA groups, planning together for the household, working with household members to spend wisely, and responsibly managing finances. These skills also improved household relationships.

According to the respondents, during the G-IPT sessions, members shared advice on managing money, working hard, planning and prioritizing as a family, and living healthfully by avoiding and abandoning habits like alcoholism, which do not solve problems but instead exacerbate stress and depression and divert spending away from covering basic needs. The advice that participants received and the skills on good financial practices and decision making that they acquired during the G-IPT sessions helped them address their challenges in meeting basic needs. Many respondents

reported that their family's well-being improved after they started planning their spending or after they increased their savings.

Simple visual tools enabled participants to visualize and identify mood and level of burden. Using the visual burden scale helped participants reflect on their mood at the start of G-IPT sessions. Many participants shared that they had minimized their moods and burdens and did not realize they had heavy burdens until they started using the G-IPT burden scale. Others mentioned that the scale let them see how their moods changed over the course of the G-IPT sessions—in some cases, moving from most severe at level 5 to lower levels. One participant said, "The burden scale photos illustrated different levels of problems and made it easy for us." Participants noted that the scale showed how the burdens affect people: At first, people are able to lift an item; then it gets heavier and they are not able to lift it.

Implementation Challenges

Time commitment to participate in G-IPT requires buy-in from and coordination with household members. Participants mentioned that because the G-IPT sessions were held after the coaching sessions, they would arrive home late, which could result in spouses being upset. Some participants, especially respondents from the host community, said that spouses complained about them returning home late. They reported that arriving home late resulted in challenges with completing household chores, attending to businesses, or preparing meals for children. Participants said they needed to coordinate with their spouse and family members to make sure these tasks were covered. Some participants mentioned that they planned these activities the night before to ensure that their children would have food the next day. Other participants said they informed other household members that they had set aside one full day engaging in the Activity, and many said that they needed support and buy-in from husbands and family members to be able to join G-IPT sessions.

Lack of self-confidence initially made participants' uncomfortable with sharing personal problems. A few participants shared that at the start of the G-IPT sessions, they were not comfortable speaking up, had low self-esteem, and feared giving wrong answers or being laughed at. Most participants said that over time, they felt more comfortable about sharing personal thoughts with a group and that doing so had built their experience and confidence.

> "I liked the burden scale. At first, I did not understand it well, and I even underrated my burden level, but when our coach continued to explain it to us, I realized that I needed to admit my level, and we found out that so many people were sick and they did not know."
>
> G-IPT Participant, Host Community

Confidentiality concerns prevented some participants from sharing openly during initial sessions. In the early weeks of G-IPT sessions,

many participants were concerned about confidentiality when sharing personal problems, especially about the risk of information that they had shared with the group getting back to their husbands. In the host community especially, some participants said they did not feel comfortable sharing personal problems if there were close neighbors in the G-IPT group. In many cases, participants developed trust in the group over time. In some groups, there initially was gossiping and sharing of information outside the groups, but the groups decided to impose fines for this practice, which made members feel more comfortable discussing personal issues.

Areas for Improvement

Other family members, including husbands and children, could benefit from engaging in G-IPT sessions to learn how to handle difficulties that affect the entire household. When asked about suggestions for how to improve G-IPT, many participants said that having separate G-IPT sessions for spouses and family members would be beneficial. Some participants shared that spouses also were facing difficulties and could benefit from the sessions, and that having husbands and wives participating together could help address causes of household conflict. Other participants emphasized that the entire household could benefit from learning how to cope with life changes and shocks.

Conclusions

G-IPT can help individuals build skills to cope with mental health concerns and to engage in development programming. The impact evaluation data paint a complex picture of mental health and quality of life; however, qualitative data from the participants about their experiences with G-IPT indicate that the interventions gave them skills and tools to better manage the stress they were experiencing. Participants shared the ways in which mental health concerns have affected their lives and participation in activity components. They described struggling with grief, loneliness and isolation, interpersonal conflict, stress related to the inability to meet their basic needs, and a lack of self-confidence. They shared that learning skills to cope with these concerns helped improve their energy, focus, and planning with household members and that their new coping skills increased their participation in Activity components. The G-IPT sessions reinforced learning and skills from other activity components, such as savings groups and coaching.

Strategies learned from G-IPT can build self-efficacy. Participants described improvement in self-perception, self-confidence, and self-efficacy as a result of the skills and strategies they had learned. For example, participants learned that everyone faces grief, that they can find ways to manage it, and that the coping strategies could help them build their self-efficacy and improve their well-being. Participants said that in times of need, they were able to turn to friends, community

members, and confidants instead of turning inward. Some participants explained that they previously felt hopeless, but because of the skills and strategies they had learned, they now could plan and jointly make household decisions with their spouse and have improved relationships with other household members.

Conflict resolution and communication skills learned from the G-IPT sessions can promote positive household dynamics and improve relationships. Participants reported that they learned strategies in the G-IPT sessions for resolving conflicts and improving relationships with spouses, household members, and neighbors. Participants said they were able to use these skills to manage conflicts with neighbors and have better relationships with family members.

Building rapport and ensuring confidentiality are critical to making participants feel comfortable sharing personal problems in G-IPT sessions. WHO guidance recommends groups of between six and ten participants to allow sufficient time for participants to discuss their challenges. While the Activity made an effort to make the G-IPT groups small by dividing coaching groups of 25 participants into two G-IPT groups of 12 and 13 participants each, participants explained that it took time for them to build rapport with the other group members and the self-

Coaches and participants both commented on the benefits of having primary participants and household members engage in coaching sessions. The intentional integration of male household members into coaching helped ensure that the information learned during coaching was applied. Photo: AVSI.

confidence to share their problems with the group. The initial lack of self-confidence could have been due to having a slightly larger group, 12 to 13 people, as opposed to the recommended six to ten.

G-IPT groups that are mixed regarding levels of depression could lead to stigma and discomfort in sharing personal problems. Having G-IPT groups with a mix of participants, including some with symptoms of depression and some without, could lead to stigma and difficulty relating to other participants and discomfort about sharing information during sessions. Including only participants who have been screened for depression at the current time would follow WHO guidelines and could result in more comfort and openness for participants to share experiences during sessions. While it was necessary for individuals to be randomly assigned to G-IPT groups for the RCT, this may have impacted the effectiveness of the intervention as participants who had symptoms of depression were mixed with those who did not. As noted earlier, WHO guidance recommends that all participants in the group exhibit signs of depression as a way to limit the potential for stigma. Given that the groups were mixed, it could have taken longer for participants to build rapport because they felt uncomfortable openly speaking about their problems to members whom they perceived as not exhibiting signs of depression.

The time commitment required to participate in G-IPT can be a challenge for participants. While there was a high level of participation in the G-IPT sessions (90 percent), the sessions were conducted immediately after coaching normal sessions. This made for long days for participants and often led to conflicts within the household, as participants arrived home late and had to balance sessions with other household responsibilities. Providing more information on G-IPT sessions, the benefits of participation, and the time commitment would help participants understand the program as well as promote buy-in from family members, especially regarding any coverage needed for household tasks or businesses.

Some mental health concerns may affect an entire household, so other family members, such as husbands and children, could benefit from participating in G-IPT sessions. This would enable everyone in a household to learn about the same topics and ensure that the household has learned the same skills and coping strategies. For example, a household may be facing a life change or coping with grief, so the strategies would be relevant for multiple household members.

Both quantitative and qualitative data are needed to evaluate G-IPT programming to fully capture nuances on mental health and participant experiences. The impact evaluation found no meaningful difference in mental health status between those who participated in G-IPT sessions and those who did not. There was no improvement in mental health scores among refugees, and scores for some indices were lower for host community members. However, including qualitative data for evaluation would allow for more nuance and context in addition to measuring changes in mental health scores.

Recommendations

Sensitize participants and household members on the importance and benefits of G-IPT.

Given the time commitment and the novel experience of sharing personal concerns in a group setting, providing more information about G-IPT would help gain buy-in from participants and household members. This information would be a key element to integrate from the beginning to ensure clear understanding of the time commitment required of participants.

Consider the time commitment of G-IPT sessions when designing the intervention.

Planning for the time commitment of G-IPT sessions from the beginning would help determine when to hold G-IPT sessions that work best for participant engagement. For example, programs may consider scheduling G-IPT sessions as a stand-alone activity rather than as a follow-on to another activity, such as coaching. Programs should include clear communication about the time commitment and consider the time of day for holding sessions, taking into account participants' other responsibilities, such as cooking meals for children and responsibilities for households and businesses. For example, other household members may need to help cover responsibilities for businesses or to care for children or prepare meals if the primary participant will be arriving home late.

Screen participants before starting the intervention.

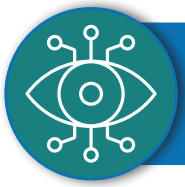
For G-IPT to be useful, participants must be willing to participate and engage in the intervention. This will help ensure that only people who have been screened for depression and anxiety participate and that people with similar levels of depression and anxiety are placed in groups together, to help avoid stigma. This approach aligns with WHO guidelines. Although participants were asked whether they had ever experienced depression in their lives, they were not screened for having recently experienced symptoms of depression. Additionally, it would be helpful to place close neighbors in different groups to promote open sharing during G-IPT sessions.

Agree on confidentiality rules and penalties for breaking confidentiality from the beginning to ensure that participants feel comfortable about openly sharing at G-IPT sessions.

Providing sufficient time to build rapport and establishing clear guidance on rules for confidentiality, as well as fines or penalties for breaking these rules, would help participants feel more comfortable about sharing personal problems and expressing concerns about group members sharing information outside of the group. For example, some group members were uncomfortable until they saw that members who shared confidential information outside of the group would be fined or removed from the group.

Consider expanding G-IPT sessions to include husbands and other family members.

Designing separate sessions for the primary participant, spouse, and family members would help members of the same household feel free to speak about personal problems in the G-IPT context, and it would give them opportunities to learn coping skills and strategies.



Continue using simple visual tools, such as the G-IPT burden scale, to let participants visualize and identify mood and level of burden.

Using the burden scale at the start of G-IPT sessions can help participants determine their level of burden and then compare this level across sessions. This tool was also helpful due to the varying levels of literacy among participants.

Align measurement and evaluation tools with key mental health skills and competencies.

Although IPA data found no difference in mental health status among refugee participants and lower scores among host community members, respondents discussed gaining skills for coping with grief, building friendships, resolving conflicts, and reinforcing learnings from the Activity to meet basic needs. In addition to the mental health and well-being indices used, measurement and evaluation tools should be refined to ensure that they are capturing information on key competencies and skills that participants may gain from participation in G-IPT sessions.

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