

# GROUP INTERPERSONAL THERAPY (IPT) FOR DEPRESSION

WHO generic field-trial version 1.0, 2016  
Series on Low-Intensity Psychological Interventions – 3

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**Contact for feedback and communication:** Department of Mental Health and Substance Abuse at WHO ([mhgap-info@who.int](mailto:mhgap-info@who.int)), Dr Myrna Weissman at the College of Physicians and Surgeons and the Mailman School of Public Health, Columbia University ([weissman@nyspi.columbia.edu](mailto:weissman@nyspi.columbia.edu)) or Dr Lena Verdeli at Teachers College, Columbia University ([verdeli@tc.edu](mailto:verdeli@tc.edu)).

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# Acknowledgements

Interpersonal Psychotherapy (IPT) was developed by **Gerald L Klerman** and **Myrna M Weissman** (see Annex 1 for key resources and references on the origins of IPT and its application in groups, including a book on group IPT primarily for eating disorders).

The current guide uses the term Interpersonal Therapy (IPT) to clarify that IPT may be used by a range of specialists and non-specialists, including in countries where “psychotherapy” is a regulated term. WHO considers Interpersonal Psychotherapy and Interpersonal Therapy as interchangeable terms - both have the same acronym (IPT).

The current guide has been prepared for World Health Organization (WHO) by **Lena Verdeli**, **Kathleen Clougherty** and **Myrna M Weissman**, Teachers College, Columbia University and Columbia College of Physicians and Surgeons and the Mailman School of Public Health, United States of America (USA). This guide covers an 8-session protocol that is similar to *Interpersonal Psychotherapy Adapted for a Group in Uganda (IPT-G-U)*, a 16-session protocol devised by **Kathleen Clougherty**, **Lena Verdeli** and **Myrna M Weissman**. The 16-session version of IPT-G-U was successfully tested among adults in a randomized controlled trial through World Vision Uganda programmes (Bolton et al., 2003).

The current guide has been edited by **Mark van Ommeren** and **Kenneth Carswell**, under the direction of **Shekhar Saxena** (Department of Mental Health and Substance Abuse, WHO).

The guide has been reviewed by **Neerja Chowdhary** (Mumbai, India), **Katie Dawson** (University of New South Wales, Australia), **Capucine de Fouchier** (WHO, Guinea), **Devora Kestel** (WHO Regional Office of the Americas and Pan American Health Organization, USA), **John Markowitz** (Columbia University, USA), **Sean Mayberry** (Strongminds, USA), **Lincoln Ndogoni** (Openspace, Nairobi, Kenya), **Paula Ravitz** (University of Toronto, Canada), **Cassie Redlich** (WHO, Ukraine), **Khalid Saeed** (WHO Regional Office of the Eastern Mediterranean, Egypt), **Alison Schafer** (World Vision International, Australia), **Yutaro Setoya** (WHO, Fiji), **Holly Swartz** (University of Pittsburgh, USA), **Martin Vandendyck** (WHO, Bangladesh), **Nana Wiedemann** (International Federation of Red Cross and Red Crescent Societies, Denmark) and **Inka Weissbecker** (International Medical Corps, USA).

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Annexes 5–9 have been adapted from existing tools with permission of the tools’ original authors. Annexes 5, 6, 8 and 9 are based on work by Lena Verdeli, Teachers College, Columbia University, 2014. Annex 7 (Group IPT Task Checklists for Supervisors and Facilitators) is based on the IPT-A Consultation Checklist developed by Laura Mufson, Kathleen Clougherty, Jami Young and Lena Verdeli, New York State Psychiatric Institute, Columbia College of Physicians and Surgeons, 2004.

# Preface

Depression is an important health condition. It is the leading cause of disability worldwide, and it can be a cause of suicide. For these reasons, treatment coverage of depression, along with other severe mental disorders, is an indicator to monitor implementation of the World Health Organization (WHO)'s Comprehensive Mental Health Action Plan 2013–2020 endorsed by the 66<sup>th</sup> World Health Assembly, consisting of Ministers of Health of 194 WHO Member States. Depression will be the theme of WHO's World Health Day 2017.

Interpersonal Psychotherapy (IPT) was developed by Dr Gerald L Klerman and Dr Myrna M Weissman in the 1970s for the treatment of depression by mental health specialists. It has been adapted for different disorders and age groups and for diverse community and medical settings around the world. Its effectiveness has been demonstrated in numerous clinical trials in high-, middle- and low-income countries using both group and individual approaches.<sup>1</sup>

This manual modifies IPT for depression for use in 8-session groups and involves a simplified format for facilitators who may not have received previous training in mental health. The current guide uses the term Group Interpersonal Therapy (Group IPT) to aid dissemination and to clarify that IPT may be used by supervised non-specialists, including in countries where “psychotherapy” is a regulated term. Indeed for WHO, Interpersonal Psychotherapy and Interpersonal Therapy are interchangeable terms that link to one and the same scientific literature. The acronym of both is IPT; they are the same intervention.

The objective of WHO's mental health Gap Action Programme (mhGAP) is scaling up services for mental, neurological and substance use disorders, especially in low- and middle-income countries. mhGAP focuses on a limited number of conditions, one of which is depression. The *mhGAP Intervention Guide* includes both pharmacological and non-pharmacological first-line treatment options for depression, including IPT. IPT may be provided at health-care centres by supervised non-specialized staff with dedicated time to deliver the intervention. Where such staff are not available at the centre, non-specialized health-care providers may refer for IPT delivered in community settings, within social services or through specialized mental health care.

We are pleased to release this guide and call upon all relevant agencies to make IPT available to ensure that people with depression around the world have access to this evidence-based treatment.

Dr Shekhar Saxena

Director, Department of Mental Health  
and Substance Abuse

World Health Organization

Dr Myrna M Weissman

Diane Goldman Kemper Family  
Professor of Epidemiology and Psychiatry

Columbia University College of Physicians and  
Surgeons and the Mailman School of Public Health

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<sup>1</sup> See meta-analyses by Cuijpers and colleagues (2011, 2016) for a synthesis of the evidence on IPT.

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# Chapter 1

## INTRODUCTION

### 1.1 mhGAP and Interpersonal Therapy (IPT)

This Group Interpersonal Therapy (Group IPT) for depression manual complements the *mental health Gap Action Programme Intervention Guide (mhGAP-IG)* (WHO, 2016). This mhGAP guide includes guidance on evidence-based interventions to manage a number of priority mental, neurological and substance use conditions, as part of WHO's mental health Gap Action Programme (mhGAP), which aims to make care for these conditions more widely available.

One of the mhGAP priority conditions is moderate-severe depressive disorder. The *mhGAP Intervention Guide* recommends psychological interventions for this disorder but does not describe in sufficient detail what these are or how to implement them. The purpose of this manual is to provide detailed instructions on Group IPT, which is one of the first-line mhGAP psychological treatments for this disorder.

In 2015 an independent WHO Guidelines Development Committee agreed on the following recommendation for management of moderate-severe depressive disorder:

As first-line therapy, health-care providers may select psychological treatments (such as behavioural activation, cognitive-behavioural therapy [CBT], and interpersonal psychotherapy [IPT]) or antidepressant medication (such as selective serotonin reuptake inhibitors [SSRIs] and tricyclic antidepressants [TCAs]). They should keep in the mind the possible adverse effects associated with antidepressant medication, the ability to deliver either intervention (in terms of expertise, and/or treatment availability), and individual preferences ... Different [psychological] treatment formats for consideration include individual and/or group face-to-face psychological treatments delivered by professionals and supervised lay therapists (WHO, 2015).

Also, WHO (2015) recommends that evidence-based psychological interventions such as IPT and CBT should be the first-line treatment for pregnant and breastfeeding women with moderate-severe depressive disorder and for adults with mild depressive disorder. Antidepressant medication should be avoided where possible for these two groups. It is thus essential that either IPT or CBT is accessible everywhere in the world.

This manual provides guidance on the use of IPT in a group format, which in many contexts may be more feasible than providing IPT on an individual basis. This Group IPT manual also aims to use simple language. In line with this goal, it uses – from here on – the term *depression* for moderate-severe depressive disorder. The manual describes practical group and individual exercises to help people understand the problems that contribute to their depression and to find ways to manage them more effectively.



## 1.2 Depression and Group IPT

### 1.2.1 What is depression?

Depression is a common mental disorder, involving persistent sadness or loss of interest or pleasure accompanied by several of the following symptoms: disturbed sleep or appetite, feelings of guilt or low self-worth, feelings of tiredness, poor concentration, difficulties making decisions, agitation or physical restlessness, talking or moving more slowly than normal, hopelessness, and suicidal thoughts or acts. A person with depression has considerable difficulty with daily functioning (e.g. at home, school or work). Periods of depression can be long-lasting or can come and go for different periods of time.

Depression is different from usual mood changes and short-lived emotional reactions to challenges in everyday life. Especially when long-lasting, it may become a serious health condition when the affected person continues to suffer greatly and function poorly at work or at school and in the family and community. Depression can lead to suicide. However, it is very important to keep this in mind: *depression is treatable*.

### 1.2.2 Why is depression an important problem?

Depression is a common problem worldwide, with an estimated 350 million people affected. It is a condition that affects the mind and the body. It affects functioning, i.e. how people take care of themselves, their families and how they function in their communities. Depression makes usual work and family life very difficult, and has an impact on both the affected person and those around them. Since depression can often start when people are young, it can affect them at the peak of their most productive years. As depression is common, recurring and highly impairing, it is essential to increase awareness and provide ways to manage it effectively.

### 1.2.3 Implementing Group IPT within health and social services to care for depression

Group IPT may be implemented through diverse health services, such as:

- in the community. For example, supervised community health workers may offer it in community centres or areas;
- within non-specialized health-care services. For example, it may be implemented alongside the *mhGAP Intervention Guide* in primary health care settings, where people with depression may be given a choice between antidepressants, joining Group IPT or a combined treatment. Group IPT may be delivered by supervised nurses or dedicated psychosocial staff at the centre;
- within specialized mental health services. For example, Group IPT may be offered at community mental health centres, mental health units in general hospitals and tertiary mental health care services;
- as a stand-alone service by a specialized non-governmental organization (NGO). For example, an NGO specialized in psychological treatment may receive referrals for Group IPT from primary health services that implement the mhGAP programme.

Group IPT may also be offered outside health services – for example, by social services. No matter where it is implemented, the following points are important:

- There should be a functioning system to identify people with depression who may want to join a group and to exclude people for whom Group IPT is not suitable (e.g. people with psychosis, people with plans to end their life in the near future – see Annexes 2 and 3).
- There should be referral possibilities for people for whom Group IPT is not suitable as well as for those for whom Group IPT is not enough (e.g. people with depression who have not improved after Group IPT).
- Group IPT facilitators should not only be trained but should also be supervised after training is completed.
- Confidentiality should be maintained. For example, records related to group members' identities and scores on depression rating scales should be kept confidential and secure (e.g. in a locked drawer).

## 1.2.4 Who is this Group IPT manual for?

This manual is designed for use by non-specialist providers. Group IPT may be applied by a wide range of trained and supervised people, ranging from community workers with as little as 10 years of education to people with diverse university degrees (e.g. nurses, graduates with social or behavioural science degrees) but without formal counselling or mental health training. Use of the manual requires no previous knowledge or experience of mental health care, but does require training and supervision, as well as an understanding of depression.

Although this manual has been prepared for non-specialist providers, specialists in mental health care (e.g. psychiatrists, psychologists, counsellors, social workers, mental health nurses) will also benefit from receiving training and supervision in Group IPT.

## 1.3 Elements and structure of Group IPT

### 1.3.1 The 4 IPT problem areas

The basic idea of IPT is that there is a relationship (connection) between a person's mood and their interpersonal relationships. Triggers for periods of depression are often interpersonal difficulties. IPT recognizes 4 categories of interpersonal difficulties associated with the onset and persistence of depression as IPT problem areas: grief, disputes, life changes and loneliness/social isolation. Not everyone who struggles with problems will definitely develop depression. However, years of studies on the impact of life events on health show that these problem areas significantly increase a person's chances of developing depression.

#### 1. Grief

**Death of someone significant to the person (e.g. death of a child, spouse, parent or another family member).**

Depressive symptoms may start around the time or shortly after the death of a loved one or of someone who has

played an important role in the person's life. In some cases the person may have had a complicated or difficult relationship with the person who has died. In normal grief, grief reactions that may look like depressive symptoms usually go away within a few months.<sup>2</sup> Although the person needs support from family and/or community members, Group IPT may not be needed in normal grief. However, when symptoms persist and affect the person's ability to function, then the person may have depression and, if so, could benefit from Group IPT.

*In the case of grief, the goals of therapy are to help the person mourn the loss of the loved one and to find other activities, social roles and people who will help to make life better.*

## 2. Disputes<sup>3</sup>

### Disagreement with someone in the person's life.

The people involved can be fighting openly, or they may never acknowledge the conflict, however significant. For example, a husband wants more children but his wife does not, a neighbour is stealing but the victim cannot prove it, a person's boss gives a better job to someone else who has only recently been hired and the person believes that this is unfair.

Depressive symptoms can be connected to an ongoing disagreement with someone important in the person's life. The disagreement usually has to do with different expectations and communication problems between the person and the other party. The person has doubts that the disagreement can be resolved. Disputes can be obvious – when people argue openly – but also hidden, when they do not argue openly about the issue but are very distant and cold.

*In the case of disputes, the goals of therapy are to help the person figure out what they and the other party want and expect, to develop new skills for communicating effectively with the other party, to practise those skills and to mobilize people who can help bring about a resolution of the conflict.*

## 3. Life changes

### Changes in a person's life or expectation of changes, negative or even positive, which influence personal relationships.

Examples of life changes include: a woman getting married and moving to a new home, a spouse who wants to separate, a person learning that they have a serious illness, caring for someone who is dying, moving away from the family, retiring, marriage, childbirth, poverty after the death of a household earner, separation or rejection by a lover, or becoming a refugee. Life changes may include chronic situations such as poverty, either when the person's situation has become worse because of circumstances or it is not improving despite the person's hopes.

<sup>2</sup> The length of time for which mourning is expected to last varies from culture to culture, but in most cultures this period is at least 6 months. During that time the person may not need Group IPT. However, in some cases a person may have severe symptoms of depression (e.g. thoughts of suicide, feeling worthless or guilty, slowed speech and movement) soon after the bereavement. In such cases, consult your supervisor to decide whether the person has depression and may benefit from Group IPT.

<sup>3</sup> The terms "dispute" and "disagreement" are used interchangeably in this manual.

In this problem area, depressive symptoms occur around the time of a life change that affects the person's roles and interpersonal life. The person is having difficulty managing the situation and does not feel prepared for what has happened or is going to happen.

*In the case of life changes, the goals of therapy are to help the person recognize that they are experiencing feelings such as sadness and anger, confusion or powerlessness about the change; examine what is positive about the change or its potential for growth and meaning; learn the skills necessary to manage the change; and find support to make the change easier.*

#### **4. Loneliness/social isolation**

##### **Longstanding feelings of loneliness, boredom and/or emotional distance from others.**

The person has a history of problems in beginning or maintaining relationships with friends, relatives or others. The person talks about feeling lonely and separate from others. Although these feelings are longstanding, they may become worse after one of the other problems surfaces (such as a move to a different town for a new job, or the death of a friend or relative who used to be central in bringing people together socially).

*In the case of loneliness/social isolation, the goals are to help the person find out what contributes to their loneliness and guide them to make friends by learning how to begin and maintain friendships.*

### **1.3.2 The IPT problem areas and Group IPT**

One or more of these 4 problems areas are usually connected with what triggered the depression and what has kept the depression going. Since Group IPT, as described in this manual, is a short intervention (8 sessions), there is only time to focus on 1 or 2 of the IPT problem areas that has triggered the person's current depression, even if more than 2 problem areas are present. However, focusing on just a limited number of problem areas can still be very helpful to the person.

In Group IPT, facilitators help group members to find links between depression and current life problems, and to build communication and other interpersonal skills to manage their problems more effectively. The interpersonal nature of the group and the conversations within the group are helpful parts of this process, because this is where group members learn and where they get ideas on how to address their problems. Once the person has an idea about how to address the problem, they are encouraged to try it out and then discuss the results in the following session. This may help the person and other group members come up with more helpful ideas.

In summary, Group IPT focuses on:

- the current depression;
- the links between the person's depression and current problems that influence relationships; and
- finding new ways to deal with these problems.

### 1.3.3 Delivery structure of Group IPT

In Group IPT, there are usually 6–10 members per group and each session lasts 90 minutes. If there are more than 10 people, the group session may last 2 hours to allow sufficient time for different group members to speak. In most settings, it is appropriate to separate men and women into separate groups. Depending on the context, other characteristics (e.g. age, ethnicity) may need to be considered as well. The group facilitator and all group members should speak the same language.

All members who enrol in Group IPT should have depression. The depression may have been identified by a health-care provider or by a knowledgeable person in the community, using an appropriate depression rating scale (see section 2.1 for suggestions). Group IPT is not appropriate for people who have plans to end their lives in the near future: these persons immediately need more specific help. On the other hand, if participants have thoughts of ending their lives but have made no plans or recent attempts, then they may participate in Group IPT. See Annex 2 on how to identify and help someone who has plans to end their life in the near future. Similarly, people who have severe impairments related to other mental, neurological or substance use disorders (e.g. psychosis, harmful use of alcohol or drugs, severe intellectual disability, dementia) should not be enrolled in Group IPT for depression.

## 1.4 Phases of Group IPT

Phases	Sessions	Ideal frequency and length
<b>Pre-group phase</b>	An individual session with each prospective group member	Once, 90 minutes
<b>Initial group phase</b>	Session 1 (first group session)	Weekly sessions, 90 minutes each
<b>Middle group phase</b>	Sessions 2–7 (6 group sessions)	
<b>Termination group phase</b>	Session 8 (final session)	

For each session, tasks and steps are outlined in the manual for the facilitator to complete. See Annex 7 for an overview of the group sessions.

### Pre-group phase

The facilitator starts with one individual session for each prospective group member to assess the person's depression, learn about their life problems and how these may link to their depression, inform them about how Group IPT may help, and invite them to join a group. The facilitator explains to the person what depression is (using relevant local concepts), how it can affect functioning and how interpersonal problems may be linked to depression. If the person wants to attend the group, the facilitator helps them set goals for the therapy and aims to

instil hope and motivation. During this phase, facilitators should keep in regular contact (e.g. weekly) with people who agree to attend the group to inform them of next steps and monitor their depression.

### The group phases of Group IPT

The 3 group phases (initial, middle and termination group phases) of Group IPT are conducted over eight 90-minute weekly group sessions led by the Group IPT facilitator. If weekly meetings are problematic for logistical reasons, an effort should still be made for the first 3 group sessions to take place weekly, followed by the remaining sessions every 2 weeks. Should it be necessary to complete Group IPT in under 8 weeks, the group can meet twice a week for the first 2 weeks (4 sessions) and then once a week for the remainder. As members get to know each other, the group becomes a place to learn and practise interpersonal skills that help them to cope more effectively with life problems. During meetings, the group members will be encouraged to:

- talk about their depressive symptoms;
- talk about problems that contribute to their depression;
- support each other;
- give suggestions; and
- practise new ways of handling problems.

Members have the opportunity to practise new ways of handling problems first in the group, then to try out what they have learned in their daily lives, and then to report back to the group on how this went.

## 1.5 Key requirements for Group IPT facilitators, training and supervision

### 1.5.1 Key requirements for Group IPT facilitators

- **High motivation to help others:** This is perhaps the most critical requirement. The facilitator has to be genuinely interested in helping others who are distressed, scared or very sad. Often, people prefer to confide in facilitators from their own community.
- **Good communication skills:** Listening attentively, being respectful and showing understanding of a person's feelings and experiences is important. This helps make people feel comfortable in the facilitator's presence and reassures them that they can trust and confide in him or her. Once they know that the facilitator cares, they will start paying attention to what the facilitator says, and his or her words will have an effect. Listening to depressed people in this manner is crucial in helping them to deal with their difficulties. Good communication skills are essential for successful Group IPT delivery. See section 6.1 for additional suggestions on good communication.
- **Good organizational skills:** These are important to help track the attendance and review the progress of each individual in a group. It is advised that the facilitator brings a folder to each session with the materials listed in Annexes 5–8. Some of the materials are specific to each phase of the process as indicated in the manual.

## 1.5.2 Trainers and supervisors

Group IPT trainers and supervisors should have received Group IPT training and have practised it by completing at least 3 groups under supervision.

IPT trainers should be mental health professionals and, if possible, should gain experience in co-training on Group IPT with an IPT master trainer.

IPT supervisors are not required to have a mental health background, but such a background is strongly recommended. Often IPT trainers are also IPT supervisors.

## 1.5.3 Training workshops

For trainers, a generic training schedule and curriculum with participatory training exercises is available upon request. Training workshops for facilitators should be tailored according to the setting in which Group IPT is to be implemented. The following advice should be observed when designing training:

- The training should be carried out in groups not exceeding 15 participants.
- The training should be carried out by a pair of trainers working in tandem.

The training workshop should include:

- brief lectures introducing the key concepts outlined in this chapter;
- group discussions of the key concepts;
- role-plays – this is a very important component of training. Role-plays should be conducted by trainers to demonstrate new skills as well as by facilitators to learn these skills. Facilitators undergoing training should work in pairs to practise tasks associated with each session. Lectures should take up less time compared with group discussions and role-play.

A knowledge test may be conducted at the end of the training (see Annex 9).

## 1.5.4 Supervision

Supervision is the most important aspect of learning IPT. It is crucial to organize sufficient supervision. Supervision may be provided to multiple facilitators together at the same time.

- Each new facilitator should receive supervision of a minimum of 3 complete IPT groups (each having 8 sessions and covering all phases of Group IPT).
- Supervision of these 3 groups should be conducted weekly or at least twice a month in small groups of 4–5 new facilitators, and each supervision session should be at least 2 hours long.
- The supervisor should also meet with each new facilitator individually to discuss the sessions.
- Supervisors should attend Group IPT sessions to understand how new facilitators are performing.

Supervision should continue after the completion of the 3 groups but it may be less frequent (this depends on resources). For example, all (new and old) IPT facilitators should seek advice from supervisors when a group member is not improving, as shown by the weekly depression assessment.

Advice for Group IPT supervisors:

- Seek to ensure that Group IPT is delivered as it was designed to be delivered. Facilitators should continue to review the key principles and skills during supervision. A checklist can be used by the supervisor to provide constructive feedback to facilitators (see Annex 7). Facilitators usually like to use this checklist themselves as a reminder of the tasks they need to complete in the session and as a way of self-rating their skills and addressing ways to improve them.
- Spend the most time on group discussions and role-play scenarios.
- Allow facilitators to share difficulties and recognize success.
- Brainstorm to enable facilitators to generate local solutions to difficult problems and share experiences and observations.
- Organize brief role-plays in which supervisors ask facilitators to enact various scenarios from their day-to-day practice of Group IPT, followed by a discussion that allows new facilitators to reflect on their knowledge and skills.

## 1.6 Adapting Group IPT to the local context

This version of the manual is designed for global use with a focus on settings typical of low- and middle-income countries (LMICs). Most of the principles employed are universal and can be adapted to the local context. For permission to translate or adapt this Group IPT manual, please contact WHO Press (see inside cover page for contact details).

WHO is in the process of developing guidance for systematically adapting psychological interventions to the local context. A key step within this process is to share the manual with key stakeholders (including facilitators, persons with depression, local experts) and to solicit their opinions about it in terms of relevance, acceptability and comprehensibility of the text. Local terms for mental health problems and illustrations and activities may



require adaptation. Words that are not easily understood or that carry a negative connotation in the local culture can be replaced by alternative words with similar meaning.

For terms used in this manual, the most easily understood and simplest local term should be used. For example, "group member" could be replaced with the local equivalent of "client" and "session" with the local term for "meeting". Similarly the terms "dispute" and "disagreement" are widely used in this manual, though in many languages one word may cover both these terms.

Adaptations may also be required to integrate Group IPT into local systems of care. Group IPT was developed and evaluated in the context of a community-based programme. In its original form, it was conducted over 1–2 individual and 16 group sessions. For this generic WHO version, it has been reduced to 8 sessions, which is sufficient to bring about a satisfactory degree of recovery from depression (Swartz et al., 2014) while increasing the efficiency and reach of the intervention. If resources allow, Group IPT may be, for example, implemented as a 12-session protocol by extending the middle phase by 3 sessions (making this phase 9 sessions overall) and extending the termination phase by 1 session (making this phase 2 sessions overall). It is expected that with a longer protocol, on average, outcomes would be even better than with an 8-session protocol.

#### Notes for adaptation

The manual uses text boxes shaded light grey to indicate key points that are likely to require local adaptation when used in different settings.

## 1.7 An overview of this manual

The manual has 7 chapters. Chapter 2 addresses the pre-group phase. Chapters 3 and 4 cover activities during Group IPT sessions. Chapter 5 gives an overview of how to address the 4 core IPT problem areas. Chapter 6 provides suggestions for facilitators on dealing with specific challenges in delivering Group IPT. Chapter 7 gives case examples. Example scripts and dialogue are provided throughout the manual. These do not need to be repeated exactly (verbatim), but may be adapted by the facilitator to their own style.

In this manual the following important terms are used:

- *Facilitator* refers to the person running the group.
- *Group members* or *clients* refer to people attending Group IPT sessions.
- *IPT problem areas* refers to the interpersonal problem areas covered by Group IPT. There are 4 problem areas: grief, disputes, life changes and loneliness/social isolation.
- *Techniques* used in IPT refers to the techniques used in Group IPT that are used across the 4 IPT problem areas (see Chapter 4).
- *IPT strategies* refers to the specific strategies used in Group IPT for addressing specific IPT problem areas (see Chapter 5).

- *IPT phases*: There are 4 phases to Group IPT – pre-group, initial, middle and termination (see Chapters 2, 3 and 4).
- *Interpersonal inventory* refers to the method for obtaining information on the important people in the client's life, including who provides support and who may contribute to difficulties.
- *Session(s)* refers to the 8 Group IPT meetings and the pre-group meeting during the 4 phases of Group IPT. Each session has several tasks and steps.
- *Tasks* refers to the activities the facilitator has to complete in each session. For example, Task 1 of each session is to welcome the group and complete measurements of depression.
- *Steps* refers to the steps within each task to be completed.

Annexes 1–9 provide supporting materials and sheets to be used during the therapy. Annexes 1–4 cover key resources and references, assessment and a session-by-session protocol. The following annexes are necessary for learning about and implementing Group IPT:

- Timeline of depression and interpersonal events (Annex 5);
- Guide for facilitator's weekly notes (Annex 6);
- Task checklist for supervisors and facilitators (Annex 7);
- Reminder note (termination phase) (Annex 8);
- Group IPT knowledge test (Annex 9).

## Chapter 2

# MEETING THE GROUP MEMBERS INDIVIDUALLY (PRE-GROUP PHASE)

For the pre-group session with each person, the facilitator needs to bring a folder with the following materials:

- An appropriate depression rating scale for rating symptoms (see below);
- Timeline of depression and interpersonal events (Annex 5) to help link depression to IPT problem areas;
- Guide for facilitator's weekly notes (Annex 6) to fill out immediately after the session, so that you can remember what happened when you meet the person again and when you meet with your supervisor;
- Task checklist for supervisors and facilitators (Annex 7) as a reminder during the session of all the tasks you need to complete for each phase. The checklist can also help you to rate yourself after the session and find out what you need to improve.

This session is critical because the prospective group member forms the first impression about you (the facilitator), your organization and the nature of the work that will follow.

In the pre-group session you meet the person who may potentially join the group. The pre-group session can take place at the person's home, at a health or community centre or anywhere else, as long as it is conducted in a sufficiently safe and confidential environment.

Pre-group sessions usually take place within 3 weeks before the start of the group. Facilitators should keep in regular contact (e.g. weekly if possible) with people who agree to attend the group to inform them of next steps and to monitor their depression. This is particularly important for people with more severe depression.

### Tasks of the pre-group phase

**Task 1:** Help the person recognize and start dealing with current depression.

**Task 2:** Help the person understand links between current depression and IPT problem areas; conduct an interpersonal inventory.

**Task 3:** Decide with the person on the interpersonal problems that are linked to the current depression, invite the person to join the IPT group and discuss goals and rules.

By the end of the pre-group session you will have an understanding of the person's depressive symptoms, IPT problem area(s) and specific goals, and you will be able to complete the weekly notes in Annex 6. You will need to bring these notes to each Group IPT session to remind yourself and, if necessary, group members of their problems and specific goals.

## 2.1 Pre-group phase task 1: Help the person recognize and start dealing with current depression

This task contains 7 steps. There is a lot to remember, but you will see a logic in the order of steps.

**Step 1:** Introduce yourself to the person and describe who you work for.

**Step 2:** Explain that what is discussed in the meetings will be kept confidential.

**Step 3:** Ask the person about their symptoms of depression and how they affect the person's everyday functioning.

**Step 4:** If the person meets the criteria, tell them they have depression.

**Step 5:** Explain that depression is a treatable condition.

**Step 6:** Discuss with the person how to create an environment that will help recovery from depression.

**Step 7:** Mobilize resources.

**Step 1: Introduce yourself to the person and describe who you work for.** In the case of community-based programmes, describe why you came to visit the person at home or at the community centre.

**Note for adaptation**

In many communities it is customary to be greeted when entering a home. It is possible that because of depression the person may not greet you properly. Do not see this as rudeness. Rather, understand that this can be part of depression.

**Note for adaptation**

You may have to explain clearly to the person that you will not be offering material goods now or in the future, especially if you represent an agency that usually does this.

*FACILITATOR: Hello, my name is ..... I am from (organization name), and I understand that you are having some difficulties that I might be able to help you with. I'd like to tell you more about a group programme that is being run soon and you can decide if this is something that might be helpful for you.*

*Some people experience depression that may affect their ability to carry out day-to-day tasks. A programme has been developed that helps people cope with these difficulties better. This programme will take 8 weeks and I will be running it.*

*What we hope you will get out of the programme are ways to deal with these problems. So the programme is not about providing direct material support or money, but helping you learn how to cope.*

*If you are interested in this programme, I'd like to interview you now about how you are feeling and doing to see whether it is suitable for you. Would you like to continue?*

**Step 2: Explain that what is discussed in the meetings will be kept confidential.** The only exception to this can be if there is a risk of harm to self or to others.<sup>4</sup>

*FACILITATOR: Before we start, it is important for you to know that everything you tell me during this interview and during the group programme is kept confidential. This means I cannot share this information with anyone other than my supervisor, or if you tell me it is okay to share it with someone, like a doctor or a nurse. However, I will have to write down your responses to the interview. The responses are then stored under lock and key in the office of (name of organization).*

*The only time I am allowed to break this confidentiality is if I believe you are at high risk of ending your life or hurting someone else. This is because it is my job to keep you safe. If I need to break*

<sup>4</sup> National legislation and policies on breaking confidentiality vary from country to country.

*confidentiality, I will try to talk to you about it first and then contact my supervisor. My supervisor is someone who is specifically trained to help people who are at risk of ending their life. Would you like to continue?*

**Step 3: Ask the person about symptoms of depression and how they affect the person's everyday functioning** (for example, using the *mhGAP-IG* or an appropriate depression scale that is used in the region<sup>5</sup>) and assess the impact of depression on functioning (the person's ability to carry out daily tasks and fulfil major roles in their lives, e.g. as a breadwinner, raising children, attending gatherings, etc.). The following dialogue shows a simple way to find out how symptoms of depression affect functioning.

*FACILITATOR: Alice, you mentioned feeling bad, having a heavy heart; not sleeping, eating, getting out of bed, and not laughing any more or wanting to see friends. Sometimes these symptoms affect how people take care of themselves, their families and work. Have you noticed how these symptoms have affected your life?*

*ALICE: Yes, I wake up early in the morning, but I don't want to get out of bed, even when the baby cries. My husband says that I have become lazy, and that makes me feel even more sad.*

Check if the person has (a) a plan to end their life in the near future (see Annex 2) or (b) severe impairment that may not be related to depression but to other mental, neurological or substance use disorders (e.g. psychosis, harmful use of alcohol or drugs, severe intellectual disability, dementia) (see Annex 3); people with these problems need care other than Group IPT. These questions can be very sensitive, and this evaluation needs to be done in a way that is respectful, appropriate and not stigmatizing within the local culture. Discuss with your supervisor how to ensure appropriate referrals for people requiring additional or other care.

#### Note for adaptation

Depending on the context, you may already know that the person has depression. For example, this may have been identified by a health-care provider, who referred the person to you. However, it is often useful to ask these questions again as part of building a relationship with the person and to confirm that they meet the criteria to join the group.

<sup>5</sup> It is best to use a locally validated depression rating scale. The Patient Health Questionnaire-9 (PHQ-9) has been validated for many countries and is available in numerous languages from <http://www.phqscreeners.com/select-screener>. Email [mhGAP-info@who.int](mailto:mhGAP-info@who.int) for advice on scales if needed.

**Note for adaptation**

Depending on the context, functioning may be assessed either through interview or by questionnaire.<sup>6</sup>

**Step 4: If the person meets the criteria, tell them they have depression.**

*FACILITATOR: Based on your answers to the questions I've asked – how you're feeling and about what's happening in your life – I believe you have depression. This is not your fault or failure. You are not alone, depression is a common problem, but it affects people's lives greatly and makes everything even more difficult.*

Note: Where possible use a local, non-judgemental term for depression. Doing so reduces guilt and shame. It is important that the prospective client knows you are not judging or condemning them. You may choose to directly say this or convey this message by communicating an accepting and supportive attitude towards them in the pre-group session.

**Step 5: Explain that depression is a treatable condition.** It is important to give hope, but do not make false promises, such as *Everything will be fine after these sessions.*

*FACILITATOR: We have many techniques to help you feel better from depression. It may take a bit of time to find out what works for you, but I'll be helping you to build on your skills to cope with depression.*

**Step 6: Discuss with the person how to create an environment that will help recovery from depression.**

Help them to reduce expectations of functioning the way they used to as long as the depression is there: this is called "giving the sick role".

*FACILITATOR: Until you recover from depression, you may not be able to do the tasks you want and need to do. As you get better, you will be able to do them again. In the meantime, let's try to make things as easy as possible for you so you can start feeling better.*

Other ways to reduce expectations of functioning include:

- Use the example of a broken leg (*You wouldn't be able to continue running if your leg was broken, you would try to stay off of it and get some help, otherwise it will get worse.*)
- Find ways to explain the need for reduced expectations about usual functioning to other people (*Let's discuss how you can explain to your spouse that the reason you stay in bed is not laziness but depression [use local term].*)

<sup>6</sup> It is recommended to use the 12-item interviewer version of the WHO Disability Assessment Schedule (WHODAS) 2.0 (available at <http://www.who.int/classifications/icf/whodasii/en/>)

- If possible, encourage the person with depression to suspend major life decisions as far as possible until they are able to discuss them later with the group. *(Try not to leave your job (or community, education, family, etc.), even though you feel that you are not as good as you used to be. Let's try to think about this when you feel better. When you have [local term for depression] it is harder to see good options for your problem.)*
- Try to improve sleep by making sure the person is sleeping enough but does not stay in bed excessively. *(Good sleep is important for your recovery and will help you feel more rested. Although fatigue is part of depression, sleeping too much can make you feel worse. Do you have any thoughts on how to get up on time? Can your family help you?)*

**Step 7: Mobilize resources:** When people stop taking care of themselves and their family because of depression they may become hungrier, their children may not be brought to health posts to receive vaccinations, they may lose jobs, stop medical treatment, etc. As part of the “sick role” you can ask the person to think about ways to get help while they try to recover. For example, what material and emotional support do they need *right now* to start improving functioning? Which people, agencies, community resources can assist, especially with urgent problems (e.g. health, nutrition, child care, housing)? If the person cannot think of any support immediately, suggest that they think about this in the coming week.

*FACILITATOR: Alice, to be able to get your everyday work done and take care of yourself and family, you may need more help. You mentioned that you are too tired to take your daughter to the clinic. We discussed before that this is not your fault, it is due to your depression, and will get better. This is the time to find support and help to get your daughter to the clinic.*

Depending on the situation and the locally available resources, you may ask:

*FACILITATOR: What have you done in the past that helped with your daughter's health problems? Have you talked to the community health worker? Do you know others with similar problems? Do you know, or could you find out what helped them?*

After allowing some time for this (e.g. 5–10 minutes) you may say:

*FACILITATOR: Next we will discuss what is happening in your life and relationships [the interpersonal inventory], so let's start now by thinking of who amongst your family, friends and community can help you with getting your daughter to the clinic?*

Remember to share information about other organizations or sources of help and support in the community.



## 2.2 Pre-group phase task 2: Help the person understand links between current depression and IPT problem areas; conduct an interpersonal inventory

You do this task in two steps:

**Step 1:** Find out what was happening in the person's important relationships and social roles when the current depression started.

**Step 2:** Discuss the important people in the person's life (interpersonal inventory).

**Step 1: Find out what was happening in the person's important relationships and social roles when the current depression started.**

**FACILITATOR:** *Think about the time when you started feeling very sad, crying, and did not want to eat. When was that?*

**ALICE:** *At the beginning of the rainy season, 5 months ago.*

**FACILITATOR:** *What was happening in your life at that time?*

Note: If it is not clear when the depression started, you may ask: *When was the last time you felt well, your normal self? What happened afterwards?*

Use the timeline (Annex 5) to fill in information about the person's symptoms and life events, to help make the connections.

### Questions to find out about the IPT problem areas

This section contains a sample list of questions that you can use to determine what problem (death of someone significant, disputes, life changes, loneliness) may be related to the person's depression. Please keep in mind that these questions are meant to guide, and are not meant to be asked one after the other. The aim is to ask questions in a way that makes the person feel comfortable, which may mean asking open as well as closed questions and making sure that it does not feel like a formal interview. In order to build a relationship, you should add supportive comments between questions such as *That must be difficult* or *I'm sorry you are having such a hard time*. Make sure that you cover all four IPT problem areas.

### Is the problem related to the death of someone significant to the person?

*I'd like to ask you some questions about deaths of people close to you around the time you started to feel depressed. Is that OK?*

- *Did someone close to you die around that time? Tell me about him/her.*

- *Have you been able to talk about the deceased person with anyone?*
- *What illness did your husband/wife die of? Do you have fears that you have the same illness?*
- *Were there people to support you when the person died?*
- *Did you attend the funeral? Was the funeral the way you wanted it to be? Were the expected rituals performed?*

**Is the problem a dispute?**

*Now I'd like to ask you some questions about any disagreements that you may have been having.*

- *Are you and someone else in your life having a disagreement? If yes, tell me about it. (Give me an example of a recent dispute.)*
- *Are you and the other person still talking about the issue or have you given up talking?*
- *How have you resolved problems with that person in the past?*
- *Are there people who make this disagreement worse? Better? How?*
- *Have you tried to get someone to help you solve this problem?*
- *What would you like to change in the relationship, or the situation?*

**Is the problem related to a life change?**

*Now I'd like to ask you some questions to see if you've had any important changes in your life recently. Has there been any big change in your life lately? Tell me about it.*

- *Has anyone moved into or out of your home? Tell me about it.*
- *Has a friend/relative moved away recently? Tell me about it.*
- *Has there been a change in your relationship with your husband/wife? Children? Relatives? Friends? Tell me about it.*
- *How about changes in your income (or land, or livestock)?*
- *Any other big change in job, family life or community?*
- *Have you or someone you care about become ill recently?*
- *Are you having problems with the local authorities?*
- *Have you had any other change that I have not asked about?*

**Is the problem loneliness/social isolation?**

*Now I'd like to know if you have been feeling lonely or isolated.*

- *Do you feel that you have supportive friends and family members around you? (If the person says that this is true, go on to ask the following questions. Use your judgement; if you find that the person is satisfied with their relationships and is not lonely, then there is no need to continue with this line of questioning.)*
- *Do you have trouble starting friendships or other relationships? Tell me about that.*
- *Do you have trouble keeping friendships or other relationships? Tell me about that.*

At the end of the questions, you should have some idea of what has been happening in the person's life and when the depression began.

**Step 2: Discuss the important people in the person's life (interpersonal inventory).** Briefly identify the important people in the person's life and what role they play in contributing to the current depression, or whether they are in a position to support the person. This is called the *interpersonal inventory*.

Questions you might consider asking or areas to explore include:

- *Who are the important people in your life right now?* (Find out names, who the person lives with, sees frequently, etc.)
- Ask a few questions about each person, and if they are a source of stress or support: *What effect does the person have on your life? How do you feel when you are with them? Has the relationship changed over time and if so, how?*
- For the relationships that contribute to depression, use questions that contain the idea of "change". This is a way to mobilize the person: *What would you like to change in the relationship? What would the relationship look like for you to be happy?*
- It is crucial for the person to also identify the positive and sustaining aspects of the relationship. The following important question can help with this: *What would you like to stay the same in the relationship?*

**FACILITATOR:** *I'd like to learn about you and the people in your life. Let's start with you telling me about the people who have an impact on your life.*

**ALICE:** *Well, there's my husband, my children, my mother and my two friends, Jasmine and Anette.*

If the person is not sure where to begin, you can make a suggestion such as:

**FACILITATOR:** *Why don't we start with your husband? Tell me about your life with him around the time when you started to feel depressed.*

As the person begins to talk about people in their life, ask questions that will elicit as much detail as possible.

**ALICE:** *My husband is having an affair with another woman and he spends money on her. I don't want this. We are poor and we don't have enough money even for our own children.*

**FACILITATOR:** *When did this affair start?*

**ALICE:** *About 5 months ago.*

**FACILITATOR:** *When did you start getting depressed?*

**ALICE:** *Around that time.*

**FACILITATOR:** *Have you tried telling him how you feel about this?*

**ALICE:** *Yes, but nothing has changed.*

FACILITATOR: *What did you tell him and how did you say it?*

ALICE: *When I tried to talk to him he told me not to talk to him and then he left. I am not able to talk to him about this.*

FACILITATOR: *Is there anyone else who can help you with this?*

ALICE: *No.*

FACILITATOR: *Tell me what it's like at home now.*

ALICE: *My children are hungry and my little girl needs to see the nurse at the clinic every week because she is sick. My husband is not helping me with this now because he is away from home a lot, so we argue. I'm afraid he will leave me and things will get even worse. I love my husband, but this is so hard.*

FACILITATOR: *You have a lot going on. How do you feel about all this, Alice?*

ALICE: *I feel sad. I don't want to do anything any more. I don't want to cook or take care of my children.*

FACILITATOR: *I'd like to know what else is going on in your life and about the other important people in your life.*

Questioning continues until you have a good idea of how the important people that the person has mentioned help them, or make their problems worse. Move from person to person by saying something like: *So now we've spoken about your husband, who would you like to talk about next?* or if they are unsure, you could suggest who they talk about next e.g. *Why don't you tell me about your daughter who needs to go to the clinic every week?*

The facilitator then ends this step and moves on to the next:

FACILITATOR: *Thank you. You mentioned a number of important people in your life, some who are offering you lots of support, like your sister, and some who may be causing you stress or to feel sad.*

## 2.3 Pre-group phase task 3: Decide with the person on the interpersonal problems that are linked to the current depression, invite the person to join the IPT group and discuss goals and rules

You do this task in 4 steps:

**Step 1:** Explain the connection between depression and problem areas.

**Step 2:** Decide with the person on 1 or 2 goals that they can work on.

**Step 3:** Ask the person if they would like to join the group.

**Step 4:** Provide information on the group and end the session.

Choose 1 or 2 IPT problem areas that seem to be contributing most to the person's depression and poor functioning. Even if the person seems currently to have problems related to all 4 areas, try to identify the ones that are a priority. This will help you to focus the treatment.

**Step 1: Explain the connection between depression and problem areas.** After talking with the person about what has been happening and who the important people are in their life, you need to explain the connection between their depression and 1 or 2 problem areas. For example:

*FACILITATOR: As we discussed earlier, you have depression. Your depression seems to be connected to the disagreements you are having with your husband. You've been feeling sad, having trouble sleeping, not doing your work at home ever since your husband started having an affair with another woman. Though you've tried telling him how you feel, things don't seem to be getting better. So now you and he argue a lot and don't have good times with each other or with the children.*

**Step 2: Decide with the person on 1 or 2 goals that they can work on.** Do this by helping the person to identify goals and ideas that might help with their problems. If the person has significant problems with functioning, include a goal related to identifying people and places that can help (mobilizing resources). For example:

*FACILITATOR: Now we've learned that you have been depressed, I'd like us to see if we can come up with some goals to manage these problems. Can you think of some ideas that would help things to change? What do you think would make you feel better in this situation?*

*ALICE: I want him to understand that I need him to stay home. And I want him to give me money to support our family.*

*FACILITATOR: So one goal is to let him know that you want him at home. The other is that you want to let him know that you need more money to support your family.*

*I'm going to write these down. You also mentioned before that you have trouble getting your daughter to the clinic for treatment. You mentioned that your sister used to help you get her there but now her back hurts and she cannot help. Do you think you could discuss with her other ways to get help? She seems to have some helpful ideas for you.*

**Common challenges:** Sometimes people find it difficult to identify what problems they want to work on, especially if they have too many of them. In these situations you can try to focus on 1 or 2 problems. For example: *It seems that conflict with your husband, the recent loss of your child and feeling unable to pay for your children's education are all contributing to your depression. It may help if we choose 1 or 2 problems to focus on. Which ones do you think we should focus on for now?*

If the person responds by saying something like *I don't know* or *It's all too much to choose*, help them to identify an answer. Start by asking what problem they think is most important. If they say *I don't know* or something similar, then ask: *You mentioned [list the problems]. If taking care of one of them could make you feel better, which one would that be?* If they still cannot answer, consider suggesting 1 or 2 problems that from your interaction with the person seem to be having the biggest impact.

**Step 3: Ask the person if they would like to join the group.** It is important not to force a prospective member to participate in a group. If the person is not interested at the moment, explain the benefits again and tell them if a new group is planned to start in the future.

You need to mention the number of people in the group (typically 6–10) and its gender composition and make it clear that all the people in the group will have depression (you can use the accepted term for depression here).

*FACILITATOR: Alice, in many parts of the world one way that we have found to help with people's depression is to join a group of people who also have problems with depression and who all help each other find ways to manage the problems that are linked to it, like your arguments with your husband about his affair and money for your family. You could speak about this problem with the other members of the group. They might have gone through a similar problem and might have ideas on how you can manage, and others who haven't gone through this problem themselves might also have some ideas about how to make things better. You will also help them with their problems that make them depressed.*

*After you get ideas about ways to cope with your problems during the group meeting, you will try them out during the week and will discuss in the next meeting how things went. This way we can all find out what helps you and what does not and get some more ideas that may help the other people in the group.*

*Everyone in the group has depression just like you. And like you, some members have disagreements with important people in their lives. Some other members are depressed because of changes in their lives or because someone they loved has died. We will spend the time figuring out how to make things in all your lives better so that you won't feel so depressed any more.*

*Are you interested? Do you think you would like to join? (Wait to get agreement. If not, try to understand and address the person's reservations. Is confidentiality a problem? The hopelessness of depression?)*

**Step 4: Provide information on the group and end the session.** This step involves describing what is required to participate in the intervention and asking the person to agree to take part. The facilitator describes the number of sessions (8), length of sessions (90 minutes) and rules, such as confidentiality and coming on time, and transportation to sessions.

*FACILITATOR: We'll meet once a week for 8 weeks. Every session will be about 90 minutes long. Sometimes we may have to change our meeting time if there is a funeral to go to or for some other very important reason. It's important that you come on time. Everything that happens in the group is private and should only be talked about within the group. It is important for everybody to feel safe in the group: therefore I am asking every group member not to repeat to others what has been discussed in the group. Is this all OK with you?*

*ALICE Yes, I agree with this.*

*FACILITATOR: Our meeting has come to an end. You told me many important things about yourself today – you've worked hard! I am very hopeful that you will feel better soon in the group sessions. The group will begin meeting once I have finished meeting with all the other group members. If this is fine with you, I will contact you again next week to find out how you are doing and let you know when we are starting. (Then say goodbye.)*

#### **After the pre-group session**

At the end of the meeting with the prospective group member, write up notes on how it went using the weekly notes form (Annex 6). Remember to keep everything confidential. When writing down sensitive information or anything that may get the person in trouble, make sure that you will do no harm. This means that your notes need to be kept locked and secure so the person's confidentiality is protected.

## Chapter 3

# GROUP IPT SESSION 1 (INITIAL GROUP PHASE)

Bring a folder with the following materials:

- A rating scale for depression;
- Guide for facilitator's weekly notes (Annex 6). It's best to fill this out right after the session, so you can remember what happened when you talk to your supervisor and to each person in the following session. Annex 6 will also give you the information from the previous sessions (depression scores, what happened, etc., to help evaluate progress);
- Task checklist for facilitators and supervisors (Annex 7). Use this during the session as a reminder of all the tasks you need to complete for each phase. The checklist can also help you to rate yourself after the session and find out what you need to improve.

### Tasks of initial phase – Session 1

**Task 1:** Introduce the group members and talk about depression (30 minutes).

**Task 2:** Discuss depression and the IPT problem areas that the group members are facing (45 minutes).

**Task 3:** Discuss how the group will work (15 minutes).

## 3.1 Initial phase task 1: Introduce the group members and talk about depression

*Duration: approximately 30 minutes*

The aim is to have group members get to know each other. It is possible that some group members may ask you questions (e.g. whether you had depression at any point, or about unrelated issues). How you respond depends on the culture of the community, the setting or the rules of the agency you work for. It is usually preferable to be frank and open about your experiences but also to direct the discussion back to the group. It is important to help members feel comfortable within the group so that they can talk about how they feel and what is happening in their lives.



Task 1 has 4 steps:

**Step 1:** You and the group members introduce yourselves to each other.

**Step 2:** Remind the group about confidentiality.

**Step 3:** Talk about depression in general.

**Step 4:** Give hope.

**Step 1: You and the group members introduce yourselves to each other.**

*FACILITATOR: Hello. I'd like to welcome all of you to our first group session and thank you for taking this big step by coming along to the group today. By doing this, you have taken a positive first step towards recovery. I've already had a chance to meet with each of you, and while most of you may already know others in the group, I'd like each of you to say hello to your neighbour, and later you will introduce each other to the group. Following this we'll do a fun group activity.*

**Note for adaptation**

It is important that the facilitator helps group members to feel comfortable with each other. You could do a group activity such as the “common ground” exercise, in which participants are divided into pairs or small groups to discuss the traits/principles/life circumstances that they may have in common e.g. jobs, recreational activities, family status, etc.). After 5 minutes, the pairs/small groups are invited to share with everyone what they have found out. You can also ask everyone to talk about a place that makes them feel peaceful or happy.

**Step 2: Remind the group about confidentiality.**

*FACILITATOR: As we discussed in my individual meetings with you, it is important that none of us repeats what we say to each other here to people outside the group. Here in the group, we will be trying new ideas and ways of talking and behaving, so it is important for everybody to feel safe. Knowing that people will not share outside the group will help people to feel safe.*

**Step 3: Talk about depression in general.**

You should discuss in non-stigmatizing terms the fact that everyone is attending the group because they feel depressed and need support to help them recover. Remind the group that depression is very common, and describe its symptoms.

*FACILITATOR: As you've all heard when I met each one of you separately, you are all here because you want to feel better from your depression. Many people have depression at some point in their lives.*

Use the depression rating scale and start going over the symptoms:

*When you have depression, you might be sad and feel empty, or feel like you don't enjoy what you liked to do in the past, your energy often isn't as good as it was, you may cry a lot, you don't feel that things will get better and you may even believe that life isn't worth living.*

It is important that, as you describe these symptoms, you look around the group to see if members are nodding their heads or in some other way acknowledging that they recognize these symptoms. If these signs are visible, you should point them out to the group to help group members bond.

*FACILITATOR: As I was talking about problems with sleeping, I saw people nodding. Who has trouble with sleeping? (Wait for members to respond). This is a common problem. How about lack of energy? (And so on, covering all the symptoms of depression.) As you start feeling better, you'll see a lot of improvement in your symptoms.*

If there are group members who did not previously indicate any thoughts of suicide in the pre-group individual session but who nod when suicide is mentioned, then you will need to be approach them at the end of the session to further evaluate their risk of self-harm.

**Step 4: Give hope.**

*FACILITATOR: We know that people with depression get better with support and that this type of group therapy has been shown to help people all over the world. It might feel almost impossible at the moment for you to consider, but I am hopeful that each and every one of you here today will slowly start to feel better with every session. You have already taken this important first and very brave step of coming along today and so have started on your road to recovery.*

## 3.2 Initial phase task 2: Discuss depression and the IPT problem areas that the group members are facing

*Duration: approximately 45 minutes*

You do this in 3 steps:

**Step 1:** Discuss in general links between depression and IPT problem areas.

**Step 2:** Review each person's problems and goals.

**Step 3:** Ask group members to talk about their lives.

### **Step 1: Discuss in general links between depression and IPT problem areas.**

*FACILITATOR: Each of you has talked with me about some problem in your life that you are having, and it is understandably having a negative impact on your mood. It might be that you've recently been told that you have a serious illness, or that someone special to you has died, or that you find that you're always arguing with someone who is important to you. We're going to try to help you understand these problems, and make changes in your life that will make you feel better. We may not address every problem you may have, but helping with a couple of major ones will make a big difference in your life. Many of you have probably already started doing this work after our first individual meeting.*

**Step 2: Review each person's problems and goals.** Take out the list of each person's specific problems and goals for solving the problem that were made in the pre-group sessions. You can say:

*FACILITATOR: I've made a list of the problem areas and the goals that each of you want to work on. Does anyone remember from the pre-group session what we discussed that was making you feel depressed?*

### **Step 3: Ask group members to talk about their lives.**

The facilitator tries to build a feeling of closeness between members of the group. You should keep in mind two important facts about the group: everyone has depression and everyone needs to support each other within the group. You should show understanding and help to build this closeness using body language such as nodding and showing interest while group members are talking.

In this step, the aim is to have the group talk about their lives. As facilitator, your role is to ask questions in order to stimulate discussion. Examples of how you might facilitate discussion are outlined below.

*FACILITATOR: Each one of you in this group has depression, but now I'd like each of you, if you feel ready, to describe your reasons for joining the group and the problems in your life that seem to have triggered your depression.*

If no one volunteers, you might add:

*It's often difficult to begin talking in a group, but I think you will find that as the weeks go on this will become a lot easier. At this point, is there anyone who could tell us something about how you've been feeling and why?*

Usually someone will try to help the facilitator by saying something. It is important to accept whatever they say and to try to make a link between how the person is feeling and the problem in their life that seems to be related to depression.

*JASMINE: I feel sad all the time and I can't take care of my children. I don't know why I can't take care of them, but you told me that it might be because my husband died. I don't know what to do.*

From this, acknowledge the contribution by thanking the person or nodding and move to the group to see if anyone would like to add something. For example:

*FACILITATOR: Now that we've heard from Jasmine, is there anyone else who has felt the same way, or who is having trouble taking care of their children?*

If no one volunteers, you might prompt someone; for example:

*FACILITATOR: What Jasmine said reminds me of the struggle that many people have. Barbara, what do you think?*

Then wait for the person to begin.

Remember that you should not force anyone to speak. However, gentle prompting can be fine, as long as you do not tell the group or suggest what a person's problem might be; instead, wait until the person feels ready to share. You might also at any point ask a group member how they are feeling when talking to the group about problems and ask others if they are having similar feelings. This is a way to show the important link between people's feelings about what has happened in their lives and their depression. For example:

*FACILITATOR: Jasmine, I saw you crying as you talked about how hard it is for you to take care of your children. How were you feeling as you talked?*

If a group member is having trouble talking about him or herself, the facilitator should step in to assist. For example, if the group member begins talking about symptoms, you might ask when they first noticed these

symptoms. Then you might ask what was happening in their life at that time. Following this, you can share your opinion on the connection between depression and the problem in the person's life.

*FACILITATOR: Josephine, you said that since the start of the year you've had no energy, have cried a lot, have not wanted to talk to others and have wanted to sleep all the time. This depression gets in the way of working on the farm. You also shared with us that around that time you found out that your husband had taken money from the family bank account and gambled with it. Understandably, you felt angry and sad. You also felt trapped because he started beating you up and not letting you talk to your family about it. Your depression seems to be closely linked to this big change in your life and the arguments with your husband. What do you think?*

After she responds you may ask: *What does the group think?*

### 3.3 Initial phase task 3: Discuss how the group will work

*Duration: approximately 15 minutes*

After everyone has had a chance to join in, the facilitator ends the session by describing how the group will work. You do this in 3 steps:

**Step 1:** Describe how Group IPT works.

**Step 2:** Cover group rules.

**Step 3:** End the session.

**Step 1: Describe how Group IPT works** (duration, length and structure of the sessions).

*FACILITATOR: We will meet for the next 7 weeks, and each session will last about 90 minutes. We'll begin every session by checking to see how each of you has been feeling since we last met. This will take about 15 minutes. We'll use the last 15 minutes of each session to talk about your plans for working on your goals during the coming week. Today we're aiming to get to know each other and to understand each other's problems and goals. In the next 6 meetings, that is until (specify the approximate date of termination, e.g. the end of May), you will start working on your goals and make changes in your lives. You'll probably notice that your depression symptoms are going away and that you're feeling better. You will also notice that you're changing the ways that you're talking with people in the group and at home. In the 8th meeting, the last meeting, we will talk about how it feels to end the group and look at the changes you've made in how you're feeling and interacting with others. We will also talk about what might be possible problems in the future and how you*

*can deal with them. At this point, most of you will be feeling well and your depression, if not gone, will be much less. While all of this may seem like a lot to do in 7 weeks, I think you'll be able to do it.*

**Step 2: Cover group rules.** During the first group session, the facilitator should discuss not giving material goods, attendance and dropping out of the group.

***Not giving material goods***

Where relevant, remind the group that you will not be giving them any material goods. The support you are offering is to help people find new ways to solve the problems that appear to relate to their depression.

*FACILITATOR: As I told you when I met with each one of you separately, we will not be giving you goods now or in the future. We are trying to help you feel better and find solutions to your problems.*

***Attendance***

*FACILITATOR: It is important to attend each meeting of the group. I realize that sometimes you won't be able to, but I'd like you to try. In each meeting we will learn new things about each other and about new solutions, so it is important not to miss sessions.*

***Dropping out of the group***

*FACILITATOR: If you feel like you want to stop coming to the group, please bring it up with the group for discussion, because others may feel that way too. Also, it may help to find out what makes you uncomfortable. However, if you prefer, you can talk to me privately.*

**Step 3: End the session.** At the end of the session, ensure that you confirm the time of the next meeting, provide a space for group members to ask any questions and remind them that they may or may not notice any differences in how they feel and how they manage their problems after this session, but that they still have a number of sessions to go. Write up notes after the session, ensuring that confidentiality is preserved.

# Chapter 4

## GROUP IPT SESSIONS 2–8 (MIDDLE AND TERMINATION PHASES)

Bring with you a folder with the same materials as in the initial phase:

- A rating scale to assess depression;
- Guide for facilitator's weekly notes (Annex 6);
- Task checklist for facilitators and supervisors (Annex 7).

During the middle phase of Group IPT, group members work actively to find ways to deal with the IPT problem areas that relate to their current depression. These are the problem areas that the facilitator and the person decided to focus on during the pre-group session.

During the middle phase sessions:

- Continue to make group members feel comfortable in the group and try to have all members describe their symptoms of depression and how they are trying to overcome them.
- Help members to listen to each other and offer ideas for dealing with problems.
- Encourage members to try out new ideas.
- Help members to act in a caring way towards one another.
- Continue to show that there is hope and that each person can make changes in their life and feel better.

### 4.1 Techniques used in Group IPT

The following 7 techniques are used in Group IPT to address the 4 IPT problem areas throughout the middle phase.

#### ***Technique 1: Rating of depression***

Always start the group session by asking how each member has been since they last saw you. Go over depression symptoms for each group member, using the depression rating scale. To speed this up, just ask about the symptoms that the group member has mentioned so far (see Section 4.2.1 below).

**Note for adaptation**

In settings where all participants are literate, ask each group member to fill out their own form before the session begins.

Keep a written record of previous symptom ratings (in the facilitator's weekly notes) and bring this with you to each session to remind group members of changes in symptoms from previous weeks. Comment on the differences (*Your symptoms are improving – you are still fighting depression but you seem to be getting better.*)

**Technique 2: Linking mood to event and event to mood**

For example, when a group member says *I feel sad*, the facilitator asks *What happened?*, or if a group member says *I had a terrible fight with my wife*, the facilitator might respond by asking *How did this make you feel?*

Linking moods and events is an essential technique in Group IPT, relevant for every group member. It helps to demystify depression by clarifying how a person's mood is linked to life events. You should pay attention to both negative and positive events and moods, pointing out improvements. For example:

ALICE :            *I feel better this week.*

FACILITATOR: *I'm very glad to hear this. What do you think has made you feel better?*

**Technique 3: Communication analysis**

A detailed description of a recent interaction with another person is used to help group members understand the verbal and non-verbal messages they give, and to understand how the content and manner of communication affect others and how the others, in turn, affect them. Do at least one communication analysis with each group member during the course of the Group IPT meetings.

If a group member talks about many incidents that happened the week before, ask them to pick the one that affected their mood the most and describe it in detail: *If I had been there, what would I have seen? What did you say? What did she say back? How did you feel when she said this?* This analysis will give information that can later help to improve these interactions and the person's mood.

**Technique 4: Decision analysis**

This technique helps group members to come up with options and ways of managing life problems. Use it with every person in the group. Ask group members to focus on a problem that affects them; ask one person and the group to come up with as many options as possible. (*What are you thinking of doing about the situation – what are your options?*) During this "brainstorming" step, it is important not to judge whether these options are actually useful or not. After the group has finished brainstorming, discuss positives and negatives about these options, and select one option or a combination of options to try during the week. Finding options to fight depression strengthens a person's ability to deal with the feelings of hopelessness and helplessness that often come with it.



**Technique 5: Role-play**

This involves acting out a recent or planned conversation to help the group member better understand their own feelings and behaviours, as well as those of others. The group member can sometimes play both roles (theirs and the other person's).

**Technique 6: Interpersonal skills building**

This involves teaching group members interpersonal communication skills, in a culturally appropriate way, including how to:

- find a good time to have an important conversation;
- focus on a specific situation instead of mentioning everything that has gone wrong;
- clarify expectations;
- understand (though not necessarily accept) the other person's point of view;
- negotiate with the other person ("give to get");
- show appreciation when interactions go the way the group member wanted.

Although some group members need to learn how to use this technique, depending on their problem or their existing skills, you may find that others may not need to learn this as much or at all.

**Note for adaptation**

This technique almost always needs cultural adaptation to be used appropriately. For example, in many cultures it may not be acceptable to confront someone directly; instead, a less direct way is preferred for people to get their message across.

**Technique 7: Work at home/setting practice exercises**

From session to session, group members are encouraged to practise what they have learned during the group sessions in their daily lives. They then report back to the group on how the situation went and what they learned. At the end of the session, ensure that all group members understand their home practice and encourage them to come back and report on what worked and what did not.

## 4.2 Middle phase tasks

### Tasks of middle phase – Sessions 2–7

**Task 1:** Start each group session by reviewing group members' depression (15–20 minutes).

**Task 2:** Link depression to events from the previous week (10–15 minutes).

**Task 3:** Use strategies specific to each IPT problem area (45 minutes).

**Task 4:** Assign practice exercises and end the session (15 minutes).

### 4.2.1 Middle phase task 1: Start each group session by reviewing group members' depression

*Duration: approximately 15–20 minutes*

You do this in 2 steps:

**Step 1:** Start the group.

**Step 2:** Review depression symptoms.

**Step 1: Start the group.** Make sure to start the session on time. Welcome each group member. If needed, review group rules.

**Step 2: Review depression symptoms.** Go around the group asking about and rating each group member's depression symptoms.

There are different ways to complete this step: for example, (a) group members complete a rating scale before the session (if literate); (b) group members complete their own scale while the facilitator reads out the questions; (c) the facilitator reviews each person's scale in turn by asking about changes in symptoms they mentioned in the previous session; (d) the facilitator completes the scale when each person volunteers to talk about the previous week. It is important to modify the approach to the context and needs of the group (e.g. literacy, confidence etc.), as there is no "right" single way.

An example of doing this involves asking the following important question:

*FACILITATOR: How have you been since we last saw each other?*

When a group member has said how they have felt, complete the rating scale (Technique 1: Rating of depression). Comment on whether the group member's depression has improved, stayed the same or worsened compared with the previous week.

## 4.2.2 Middle phase task 2: Link depression to events from the previous week

*Duration: approximately 10–15 minutes*

Make decisions about which group members you will focus on during the session (usually 3–4 people per session). Try to include members who have experienced both negative and positive events since the previous session.

You do this in 2 steps:

**Step 1:** Discuss events from the previous week.

**Step 2:** Link these events to the group member's problem areas.

**Step 1: Discuss events from the previous week.** Invite group members to talk about what happened the previous week (or since the last session if longer than a week) that relates to either an improvement or lack of improvement in their depression.

**Step 2: Link these events to the group member's problem areas.** Use Technique 2: Linking mood to event and event to mood. Throughout the sessions, you should make the important connections between how mood affects interpersonal events and how interpersonal events affect mood. For example, if the group member says *I felt really down over the weekend*, find out what happened and how the interpersonal events linked to their problem areas. If the group member says *I had a lot of fights with my relative*, find out how this affected their depression symptoms before exploring what happened. You might ask: *How did you feel after the fight? What happened to your depression symptoms?*

Make sure that everyone gets a chance to describe what is happening in their lives at least *every other* session if there is not time to do this each session.

### 4.2.3 Middle phase task 3: Use strategies specific to each IPT problem area

*Duration: approximately 45 minutes*

For this task you will use the strategies for dealing with each problem area described in Chapter 5. You will see that as you implement the strategies you will be using the 7 techniques described above.

### 4.2.4 Middle phase task 4: Assign practice exercises and end the session

*Duration: approximately 15 minutes*

Remind each group member to keep working on their specific goals before the next session. Take, for example, a woman who has been depressed since her husband's family stopped visiting them. Her goal has been to try to get her husband's help to resolve this issue. Having worked with her in the session using strategies for dealing with disputes (see section 5.2 for these strategies), you highlight one particular recommendation that has come up. For instance, for a particular week her general goal is to find a good time to tell her husband how the behaviour of his family makes her feel.

End the session by confirming the date of the next meeting, provide a space for group members to ask any questions and remind the group that they may or may not notice any differences after this session, but that they still have a number of sessions to go.

## 4.3 Case example of a middle phase session

The following is an example of a middle phase session. As you may remember, sessions begin with the facilitator welcoming the group members and asking who in the group would like to talk about how they have been feeling during the past week. This will let you assess their mood and how comfortable they are in the group. Try to get everyone to talk about their symptoms. It should take about 15–20 minutes for everyone to briefly describe their symptoms since the last session (Task 1).

Once the review of symptoms is completed, you ask who in the group would like to talk about what has happened during the the past week (Task 2).

**FACILITATOR:** *Welcome back. (Facilitator reminds the group how many sessions are left.) This is our 4th meeting, we have 4 more meetings left after this one. I'd like to hear from each of you how you've been feeling this week: were you feeling sad or depressed? (use appropriate local term for depression) How was your mood, sleeping, eating, your energy? (Facilitator looks around the room and waits for someone to say something. Usually someone will begin, but if not you may choose someone by asking). James, what about you? Last week you were feeling sad and crying a lot. How about this week?*

JAMES: *I still feel sad.*

FACILITATOR: *Can you tell us a little more?*

JAMES: *Nothing is right. I just cry and want to stay sitting in my chair. I don't even want to be with my children.*

FACILITATOR: *Yes, that's the way you felt last week, I remember. It's hard to feel that way, and not to want to be with your children. (Facilitator completes the depression rating scale with James.) Your depression score is a little lower this week, which means that you are a little better but still feeling depressed. We have 4 sessions left, so together we will continue to work on ways for you to improve. How about somebody else?*

ANEIL: *Mostly I felt the same, but one day I was a little happier.*

FACILITATOR: *That's great that on one day you felt a little happier. Later in this session I want you to tell everyone in the group what was happening on the day you felt a little happier. Let's complete your depression scale for this week: (facilitator completes depression rating scale.) Your depression is better than last week, Aneil. How about someone else letting us know how your week went?*

Continue like this until everyone has had a chance to describe their mood for the week. No one should be forced to speak. As time goes on, and as the group members become more comfortable, more of them will find it easier to talk in the group.

At this point, you can begin asking who in the group would like to talk about what has happened during the week. It is important to link the events to symptoms of depression (Task 2). The following is a further example from a middle phase session.

FACILITATOR: *Now that you've all had a chance to talk about how you felt this week, I'd like to see if we can figure out why you felt the way you did. Aneil, you said that you felt a bit better one day this week. What happened that made you feel that way?*

ANEIL: *My brother came over and helped me. He knows I haven't been doing so well. He talked with me for a while and helped me to fix my bicycle. I think that's why I felt better. I like having my brother around.*

FACILITATOR: *Aneil, what you just said is very important. You recognized something in your life that made you feel better. During the next weeks it will be important for all of you to notice what is happening in your life that is making you feel less depressed, and what is making you feel worse. Did anyone else notice that something made you feel better this week?*

CARLO: *Some of the women in the village helped my wife with the children. She didn't want to accept their help, but she really couldn't do it herself. She's too sick.*

*FACILITATOR: Thank you, Carlo, for sharing. Who else would like to talk? (By this point, most of the group members will be comfortable talking about what has been going on and how they have been feeling.)*

*TOM: I know I'm doing better because all this week I farmed the fields. Remember I couldn't even get my work done one day last month?*

*FACILITATOR: Do any of you remember? (This is a way for you to encourage other members to join in what's happening in the group.)*

*GEORGE: I do. You felt terrible and you didn't like getting help from anyone to get your work done. You sound so different now. That's really great. I feel better too. I never thought I'd feel better. Is that how you felt? (Tom nods, but does not say anything. The facilitator asks him to use words to explain how he's feeling.)*

*FACILITATOR: That's what everyone feels when they're depressed, that things will never improve and you'll never feel better. But both Tom and George now know that when things in your life go better, you can feel better too. You both also know that you put a lot of effort into making this change in your life.*

*DAVID: Well, I don't feel better. Nothing is better for me. I don't think I will ever feel better. My wife and sister died last year and I still miss them. I'm just not happy any more. I am all alone.*

*TOM: You are not doing enough to help yourself feel better. (As this response could be interpreted as being unsupportive, the facilitator needs to check to see how David is feeling about what Tom has said. Is he hurt? A supportive statement can be added here.)*

*FACILITATOR: For some people in certain situations it takes longer to feel better. It's so difficult to get over the deaths of two such important people in your life. Does anyone else feel the way David does? (The facilitator waits to see if anyone responds.)*

*Tom suggested something that's come up before in the group. You can feel better by making small changes in how you spend your days. David, you were going to spend more time with your friends so that you wouldn't be so lonely, how's that been going?*

*DAVID: It went much better. I decided to pay Jed a visit. I showed up and told him why I had not been in touch. He was very happy to see me. (This is a good moment to do a communication analysis - Technique 3 to get information on the actual conversation. What did each person say? This may help to understand what made David and Jed feel good).*

The group continues in this way until about 15 minutes before the end. As the session comes to a close, remind the group members to keep working at solving their particular problem.

## 4.4 Termination group phase – Session 8

Bring with you a folder with the following materials:

- Guide for facilitator's weekly notes (Annex 6);
- Task checklist for supervisors and facilitators (Annex 7);
- Reminder note (termination phase). This will be completed by the facilitator and each group member during the session; the members may also contribute to each other's reminder note by drawing or writing about one of their memories of the member during the group (Annex 8).

Termination should be discussed over the course of the sessions. Mention termination in the pre-group session, Session 1, a couple of times through Sessions 2–6 and during Session 7. Termination gives the opportunity to review what has happened during treatment, and for group members to say goodbye to each other and the facilitator and to make plans about how to address problems that might keep coming up or new problems that emerge. This is a special time, one of ending but also of celebration, rather like completing education or choosing to move away from friends and family for an exciting opportunity.

Before the session, review the latest depression scores of all group members and plan for follow-up actions for those who have not sufficiently improved e.g. referral for additional support.

These are some termination strategies:

- Welcome the members and remind them that this is the last group session. Check on each group member's symptoms and mood the same way you have done in previous sessions.
- Review with each group member changes in symptoms, mood and IPT problem areas. (Have the goals been met? What remains to be done?) Be specific.
- Ask group members how they are feeling about termination – fear, excitement, pride, sadness? You should express your own feelings about termination too.
- Discuss possible sources of problems in the near future, and skills that group members might use to prevent depression recurring. (Ask about specific problems that might arise for each group member and what skills they have learned to prevent depression from happening.)
- Ask group members to describe how they would know if their depression was coming back, i.e. what symptoms they would notice first. Make an action plan for each person according to their symptoms. For

example: *When you start noticing that you have trouble sleeping and find yourself thinking too much all the time for more than a week, contact me or [name the agency or clinic].*

- Support group members who have not improved or who have only partially improved. Make sure that they have an opportunity to express their feelings about this and – if it is an option – seek to continue speaking with them individually after the session. For those who still have symptoms of depression, you may want to discuss options for continuing the work if possible (the options depend on the resources available<sup>7</sup>). The message you want to give to those who have not responded is that they have not “failed” at Group IPT, but that Group IPT has “failed” them, and they might be better suited to a different type of treatment.

#### Notes for adaptation

Optional activity in groups with literate participants (if you do this, the final termination session needs to be twice as long): Prepare during the final session with each group member a little notebook that includes their IPT problem areas and goals; strategies that have worked for them; their depression symptoms at the beginning and end of Group IPT; a short description of symptoms that should alert them if their depression is coming back and a short plan on what to do; and a note or a drawing of something that will remind them of the group (see Annex 8).

A culturally appropriate termination ritual chosen by the group can sometimes be helpful.

The following is a sample text summarizing the most important aspects of this session. It is not a full case example dialogue.

**FACILITATOR:** *I want to remind you that this is our last session. Today we will discuss one more time how you are managing the problems in your lives that seem to be making you depressed. But we’re also going to talk about the changes you’ve made since we started that have made you feel better, what you still need to work on even after we stop meeting, and how you are feeling about not coming to the group any more.*

**ALICE:** *I am getting along better with my husband. We don’t fight as much and I feel better, but I’m afraid that I won’t know what to do next week when we aren’t meeting. Everyone helps me here. I am afraid that I’ll get depressed again.*

**FACILITATOR:** *Does anyone else feel like Alice?*

**MARY:** *I do. I was feeling very sad and worried this week when I began thinking about this.*

<sup>7</sup> Ensure that you are aware of other sources of support and referral before you start the final session, so that you have a good idea about options for more help when needed.



*FACILITATOR: Let's discuss how each one of you will be able to recognize if depression is coming back. Alice, what symptoms will tell you that you are getting depressed again?*

*FACILITATOR: (Ask each person in the group this question. After everybody who wants to respond has said something, continue.) If you notice these symptoms coming back, then you need to come and visit me at the clinic and ask to speak to me, or to my colleague if I am not there. Let's now discuss what type of things you learned in the group that have helped you to deal with your life problems.*

*(When the discussion is finished, continue.) In the next year, do any of you expect any big changes in your life? What are these? Try to think how what you have learned here can help you to deal with these problems.*

*(After the discussion has finished and near the end of the session, remind the group that negative feelings – like Mary's – are common when a group ends.)*

*Some of you here today have said that you feel sad about this group ending. I, too, feel sad to be saying goodbye to you, but I am also very proud of all the work and caring you have put into the sessions, your sessions. I am honoured to have met you and to have helped you support each other in this group.*

## Chapter 5

# STRATEGIES FOR DEALING WITH THE 4 IPT PROBLEM AREAS

This chapter provides examples of overall strategies for dealing with the 4 IPT problem areas. Within these strategies, the 7 techniques used in Group IPT (See Chapter 4) may be applied.

### 5.1 Strategies for grief

When the problem area is grief over the death of someone significant to the group member, help them to accept and mourn their loss. Help them to find meaning in life without their loved one.

The following are some strategies for achieving this:

- Educate the client about the grieving process. For example, sometimes the painful feelings of grief appear to have ended, but they resurface again at unexpected moments. Discuss how symptoms worsen around the time of anniversaries, holidays, etc.
- At times people do not want to give up their grief. They may feel afraid that they will lose their connection with their deceased loved one if they do. It can help to explain that you will not take their grief away; they will live with the grief. (*You'll carry it on your shoulders for the rest of your life.*) You can only help them to become stronger so that they can carry the grief as they continue their life. (*We'll help make these shoulders stronger to carry the grief.*)
- Encourage group members to describe the circumstances of the loved one's death, how they learned about it, what they witnessed and who was around to support them. This may include how they took care of the person during sickness, how the person died or how the group member and the community participated in burial/cremation rituals. Ask about the last time the person saw their loved one alive – what happened? Throughout these discussions, the client is gently encouraged to talk about their feelings and reactions. It is important not to put pressure on them to go into details about this. The point is to find out how all these events have affected them.

#### Note for adaptation

Following burial rituals is an important practice for most people. If a body is not recovered or able to be buried in a traditional way, relatives may feel even more pain. In such situations, explore options for alternative rituals to support the mourning process.

- Encourage people to tell the story of their relationship with the deceased. This includes how they met, how their relationship evolved, the positive aspects of the relationship and, if relevant and the person seems willing, the disappointing aspects of the relationship. Recent and past memories can be discussed. You may ask the person to bring along a picture or a gift from the deceased.
- While the group member is mourning, encourage them to discuss their feelings about the future, including unrealized plans and changes in their social or family status. Encourage them to find other people or activities to help fill the void. Support them to interact more with caring friends and family and to learn ways to distract themselves if they are feeling overwhelmed. What are some interests that could be reintroduced? New roles that they could take on? Encourage the group member to break their social isolation if this has been their way of coping up to this point.
- Set aside some time during the day to mourn: *You said that thinking about your son does not let you work in the fields. Would it be helpful to set time aside during the day to connect with him in your thoughts? Then you could remind yourself that you have put this time aside for you and him, and get back to your work?* (This strategy may be used if the group member has a lot of trouble functioning.)

The following is an example of how you might approach a group member in an early and then a later session of the middle phase when the problem is the death of someone significant to them. This dialogue demonstrates techniques and strategies that you can use.

*FACILITATOR: Aria, we know from what you told us in our first meeting that you have felt sad ever since your husband and daughter died. Do you think you could tell us today about your husband?*

*ARIA: I don't know what to say. (This is a common response. You can help at this time by giving some guidance.)*

*FACILITATOR: Well, could you start by telling us about his illness and death. What happened to him when you started to feel sad?*

*ARIA: This is so hard. I get sad whenever I think about it.*

*FACILITATOR: Why don't you try? We'll all listen and help you if we can. I think you'll begin feeling better after you've talked about your deceased loved ones. Sharing your feelings about the deaths of your husband and daughter may help you to cope with your grief.*

*ARIA: I'll try. My husband died first. He was living with TB and was sick for about a year. I didn't know what was wrong with him until just before his death.*

*FACILITATOR: How long has it been since your husband died?*

*ARIA: He died last year during the rainy season. He was so sick for the whole year. He couldn't even farm. So we didn't have enough money last year. I took care of him. The healer gave him some herbs, but nothing helped. He was so weak. (She is crying as she describes the last year of her husband's life.)*

*FACILITATOR: I'm so sorry, Aria. You look so sad as you talk about him. (This helps to build connection and trust.)*

*ARIA: I cry every day. Nothing makes me happy. I always think about him. I was his wife. He treated me well. He always gave me money for food when we had visitors.*

*FACILITATOR: He was a good husband and you miss him a lot. (The facilitator uses Technique 2: Linking mood to event and event to mood.)*

*ARIA: Yes.*

*FACILITATOR: How are you feeling right now?*

*ARIA: Terrible. I don't know what to do... (Aria is crying.)*

*FACILITATOR: I look around and see in the eyes of the group members their pain and concern for you. Who would like to tell Aria how they feel about her husband's death? (The facilitator uses Technique 6: Interpersonal skills building.)*

*JOSEPHINE: I feel your pain, my sister, I know what it feels like to lose people you love...*

*FACILITATOR: Aria, how does it feel to hear Josephine's words?*

*ARIA: I feel that I am not alone. But I also miss my husband even more.*

The facilitator allows Aria to continue talking about her husband and his illness. At some point, if there is someone else in the group who is grieving, you might try to ask for their response to what Aria is saying.

This is an example of a later session in which Aria is further along in her mourning.

*FACILITATOR: Aria, I noticed that when you were describing your depression symptoms, you had fewer than last week. Why do you think that is?*

*ARIA: Yes, I am feeling better. I'm not crying so much and I'm taking care of my home and I've started going to the market with my neighbours. I'm just not as sad. I'm not sure why.*

**FACILITATOR:** (The facilitator asks if anyone else has any ideas. If not, explain what you think has happened.)  
*I think part of the reason you're feeling better is that you've been mourning the deaths of your husband and daughter and that you've been doing things with others in your village.*

**ARIA:** *Yes, some of the young women in the village have been coming to me for advice. I like helping the young women. I want to keep doing this.*

**FACILITATOR:** *I'm so happy to hear this. Would anyone else in the group like to say anything to Aria?*

## 5.2 Strategies for disputes

When the interpersonal problem area is a dispute, help the group member to:

- clearly define what the problem is between the two sides;
- identify the phase of the disagreement (see below: still negotiating, being stuck or ending the relationship); and
- explore options for a plan of action to resolve the problem.

After the group member has defined each side's conflicting view of the situation, help them – with the assistance of the group – to find out what they wish to do and find new ways of getting this message across to the other party, or negotiating about it. Encourage the group member to think about what has worked in the past with similar conflicts, and identify people who can help with this conflict.

### Note for adaptation

When helping with disputes, keep in mind the group member's culture and values, and try to understand what are helpful communication options within their environment.

Disagreements may have three stages:

**Still negotiating:** The parties are still trying to resolve the disagreement. The facilitator and the group help the group member to find different ways of talking to the other person to manage the problem. A person at this stage of the process still wants to work things out, but needs help with how to do this.

**Being stuck:** It feels like nothing will work, and the group member feels stuck. Talking has stopped and there is a lot of anger in the air. The group member thinks that nothing can be done to make things better. The facilitator and group members try to get them to “try one more time”, and to find new ways of handling the problem.

**Ending the relationship:** One person or both may want to end the relationship. The facilitator explores if there are any positive reasons for the relationship continuing. If the relationship cannot continue and if it is safe and appropriate, the facilitator and the group help the person to end it, mourn and move on.

Note: The facilitator tries to do 2 things: either move the “being stuck” stage to the level of “still negotiating”, so that the two people can start interacting and negotiating, or help the person to end the relationship in its current form (unless this puts the person in danger of violence).

#### Note for adaptation

People may be in situations where formally ending a relationship is not an option, for cultural or financial reasons. Still, the relationship may change, and there may be an end of what it used to be. People sometimes continue to live or interact with each other but have a different type of relationship from what they had before. This may be useful if it helps the person to find ways not to be depressed.

The following are some strategies for achieving this:

Ask the group member to describe in detail their view of the problem and what they would like to change. Also ask what they want to stay the same in the relationship.

Next, ask the group member to describe the problem from the other person’s point of view, and the other person’s reactions and feelings. Help the group member to understand (but not necessarily to accept) what the other person wants or expects (Technique 3: Communication analysis and Technique 5: Role-play can help here).

Find out what the group member has tried to change about the problem and encourage them to think about what they want to do and what options there are, including perhaps identifying somebody who has more power and can help with the conflict (Technique 4: Decision analysis).

Throughout this process, the group member is encouraged to give specific examples of recent exchanges with the other person. This is a time when group members might role-play the disagreement to clarify each person’s position. Role-play can also be used to help the group member come up with new ways of interacting with the other person. Keep in mind that changes in communication need to be in keeping with the local culture.

Here is an example of how you might approach a group member in a middle and then a later session when the problem is a disagreement:

*FACILITATOR: Jasmine, during our first group session you told us that you are very unhappy with your husband and that you have been arguing with him for almost a year.*

*JASMINE: Yes.*

If the group member does not add any more detail, you may encourage them to do so by asking the following:

*FACILITATOR: Would you tell us about the disagreements that you’ve been having?*

**JASMINE:** *I need to go to the next village to stay with my mother, who is sick. Whenever I do, I come home to find that my husband has bought expensive presents for another woman. I tell him not to do this. I tell him that I am a good wife and that he should not do this. He tells me that I am at my mother's all the time, that I pay him no attention and that he will do what he wants.*

**ANNET:** *I have the same problem with my husband. He's always looking for other women. There's nothing we can do.*

**SARAH:** *That's not true. I let my husband know that I'm unhappy by cooking bad meals. He gets the message.*

**JASMINE:** *That hasn't worked for me. I don't know what to do. Maybe I'll leave him.*

**FACILITATOR:** *So, Jasmine, let's discuss what you'd like to do with the situation.*

**JASMINE:** *I don't know, I don't really want to leave him but he's not being a good husband to me or a good father to my children.*

**FACILITATOR:** *This must be very upsetting for you, but perhaps you have some options that you haven't thought of. One thing you mentioned and we need to understand more is that your husband started seeing the woman after he felt that you do not pay attention to him and spend a lot of time with your sick mother.*

**JASMINE:** *But what can I do? My sister does not go often and there is nobody to take care of our mother.*

**FACILITATOR:** *You are right, this is not an easy situation for you. But let's think now about what he said to you. I don't mean that he is right. We are simply trying to understand why he behaves this way, and help you find ways to communicate better with him. What do the others think? (Here the facilitator is using Technique 6: Interpersonal skills building, especially the point about understanding (though not necessarily accepting) the other person's point of view.)*

**MIRIAM:** *I think your husband is jealous because you pay a lot of attention to your mother and don't take care of him as much as you did. He may be angry about that.*

**JASMINE:** *Well, this may be true but I can't do anything about this. He is with the other woman now. I don't have any hope for us.*

This is a good opportunity for the facilitator to educate group members about the symptoms of depression, in this case hopelessness.

*FACILITATOR: Jasmine, I'm glad to hear that you are listening to the others here. I think you may get some ideas to try with your husband that might work. I also want to point out that feeling hopeless is often part of depression. Do others feel hopeless about their situation?*

Continue the example by involving the group and practising interpersonal skills. This gives you a chance to include others and to move on to some of the problems that other members of the group are dealing with.

The following is an example of a later session in which Jasmine talks about her progress with her husband.

*FACILITATOR: I'd like to remind everyone that this is Session 4 and we're halfway through all of our sessions. I'm interested in hearing from everyone how you've been progressing in improving the situations that seem to be contributing to your depression. Would anyone like to start?*

*JASMINE: I will. Things are a bit better at home. I tried many of the suggestions that my friends in the group made to me. Before I came here I tried cooking bad meals, locking my husband out of the house, and even moving back with my family. None of this worked. But hearing all of your ideas gave me one of my own. I decided to tell my husband that because of all the presents he was buying for other women I was so down that I wasn't taking good enough care of our children and our home. This made sense to him. And while he doesn't like me saying it, he loves his children and his home. So he has stopped buying presents for that woman, and I'm much happier, and now we just fight about everyday things. Also, after I listened to Miriam I've stopped going to my sick mother's as often as I did. I have asked my sister to go more often. I feel better. Thank you to all of you.*

*FACILITATOR: Thank you, Jasmine, for working so hard. It's good to hear that you are feeling better, and there have been some positive changes in your life. Who else would like to tell us about how they're doing?*



## 5.3 Strategies for life changes

When the problem is life changes, people's relationships and roles have usually changed too. For example, a person who has lost their ability to work may no longer be fulfilling the role of "family earner". But there are new roles, such as being a carer of extended family, a supportive friend or member of a community. Strategies to use here generally involve helping the group member to identify new roles they can take on. Help the group member to:

- identify the old role and mourn its loss;
- think about positive and negative aspects of the new role or potential opportunities for growth and meaning; and
- develop skills to manage the new role, break any social isolation and find supportive people who can help.

The following are some strategies to achieve this:

- Help the group member to describe in detail the changes that are occurring (*How were you before [change]... How are you after [change]; where would you like to be in the future?*)
- Help the group member to explore the positive and negative aspects of the old role and mourn its loss.
- Assist the group member to explore the positive and negative aspects of the new role. If there are no positive aspects to the new role, e.g. terminal illness, then the group member needs to work on another strategy (see below) and see if there are opportunities for growth or meaning.
- Encourage group members to identify skills and people in their lives that will make the new role easier.

Here is an example of how you might approach a group member in an early session and then a later session when the problem is a life change:

**FACILITATOR:** *Hass, we know that you've been depressed ever since you found out you had HIV.*

**HASS:** *I knew I had HIV. I've been sick for a long time. Last year I got so sick that I couldn't work, and I couldn't even get out of bed. I went to the clinic and they told me that I have HIV. Now I don't care what happens to me. I know I will die soon.*

**FACILITATOR:** *HIV is a very serious illness, but some of the hopelessness that you feel is because you're depressed. People with depression usually feel hopeless.*

**HASS:** *I am going to die, and nothing will change that. The nurse tells me things to do but I don't listen.*

**FACILITATOR:** *What does the nurse say?*

**HASS:** *I have to be careful with my health, and always use a condom. But I don't do that.*

*OTHER GROUP MEMBER: You mean you that you are giving HIV to your wife? You're awful. Don't you care about your family and our village? Too many people are dying.*

*ANOTHER GROUP MEMBER: I agree.*

*FACILITATOR: It sounds like many of you are angry. It's important that Hass feel comfortable talking about how he feels. Hass, how does it feel for you when people tell you how they feel about your behaviour?*

*HASS: They don't know what it's like to be dying. They'd do the same thing.*

*OTHER GROUP MEMBER: I'd never do what Hass does. I think he should stop.*

*FACILITATOR: How are you feeling right now?*

It is often difficult to get members to talk about their feelings in a group. Keep trying to get them to talk about feelings by first asking questions about their behaviour.

*FACILITATOR: In the group, we need to express our feelings, but we also need to respect what others say. Let's try to have Hass talk more about what he's going through and why he's behaving the way he is. Hass, can you continue?*

*HASS: I don't care any more. Why would God do this to me and not to others?*

*FACILITATOR: You sound angry, Hass. While we can't change the fact that you have HIV, we can help to get rid of your depression. That may make you feel a bit more hopeful about living a life with HIV. And we might also help you to plan for the time that you are alive.*

*HASS: I don't want to talk any more today. This is too much.*

*FACILITATOR: OK, Hass. That's fine for today. There will still be much opportunity to talk during later meetings.*

This is a section of a later middle phase session with Hass:

*FACILITATOR: Hass, how have you been doing?*

*HASS: I've been arguing a lot with some of the other group members when we're not at the meetings. They keep telling me to think about the community and my family. They want me to use condoms. Aiden said something that made sense. He asked me to think about how I'd feel if a man who had HIV was with my daughter and didn't use a condom. That made me very angry. I don't want my daughter to have this terrible illness. So I think I am going to be careful. I still think it's unfair that I'm sick, but I can see that I don't want to hurt others.*

*FACILITATOR: That's so good to hear. And have you thought any more about what you can still do now even though you have HIV?*

*HASS: It is hard. Sometimes I feel I can do nothing, but Aiden also told me that I can still be a good father and teach my children what they need to be healthy and good in their lives. He is right, I can do that even though I may not be healthy for long.*

*FACILITATOR: And how does all this make you feel?*

*HASS: I feel a bit better. And I'd like to thank Aiden for the suggestion. Maybe he has others for me. Maybe he can help me with my life.*

*AIDEN: I will try.*

*FACILITATOR: Aiden, thank you for being so helpful. Maybe others will have ideas also.*

## 5.4 Strategies for Loneliness/social isolation

Commonly, 2 types of social isolation are related to depression:

- First, social isolation can be the result of big changes in the group member's social circle resulting from the other 3 problem areas (grief, disputes, life changes). Bear in mind that, for this type of isolation, at some point the group member usually had a solid social circle before depression set in.
- The second type of isolation is a more longstanding one, where the person has profound difficulty in starting and maintaining friendships and other relationships. If the person wants to change this and is looking to make friends, Group IPT can be very helpful.

Strategies for both types of social isolation aim to help people to be less lonely and take steps to form ties with members of their community. However, in the case of the longstanding type of isolation, much more building of interpersonal skills is needed to show the group member practical new ways to interact. The other group members can be very helpful supporters and guides in this process.

Strategies used to help with loneliness include:

- Help the group member to understand links between depression and social isolation – how one makes the other worse.
- Find out if the group member wants to have more people around them.
- Assist the group member in finding opportunities to change their habits and end their social isolation by increasing activities with other people and joining in the community, workplace or places of religious worship.
- Guide the group to support the group member and use extensive role-play and feedback in preparing and reviewing their interactions and activities with others.
- Explain that, when depressed, you may not feel like going out and doing activities, but in fact if you go out you have a greater chance of feeling better.

FACILITATOR: *Barbara, how was your week?*

BARBARA: *The same. I did not feel like going out and stayed at home.*

FACILITATOR: *Your eyes seem sad as you are saying this. Do you feel sad?*

BARBARA: *Well, yes, I wish somebody would come and visit me during the week. Since my mother died, nobody comes by any more.*

FATIMA: *Barbara, you said last time that all your relatives tried to visit but you would not even open the door.*

BARBARA: *I did not want to see anybody when my mother died...*

FACILITATOR: *We just talked about two important things. Barbara, you now want to have people in your life, which is a good sign: it tells us that you are feeling better from your depression. I believe that if you start seeing more people, your depression will improve even more. Also, as Fatima said, other people want to be in your life. This is really good news. So, let's think of ways for you to start seeing more people. Do you have any ideas? (The facilitator starts doing a decision analysis (Technique 4) that involves the exploration of options.)*

BARBARA (to facilitator): *Maybe you can give me an idea?*

FACILITATOR: *Why don't you ask the fellow group members their opinion?*

- BARBARA:* Do you have any ideas on how I can start seeing more people? My mother is not around any more. She used to invite my cousins and her friends. I was not lonely then.
- SONIA:* You are a good person, you don't gossip or create trouble, and people would like to have you in their home. Do you like to cook?
- BARBARA (laughing):* I do, but why are you asking?
- SONIA:* There is a group of young girls like you who meet on Wednesdays and cook for the orphans at the community centre. Why don't you go?
- FATIMA:* My cousin goes and likes it. They also teach each other knitting.
- BARBARA:* Maybe I can try.
- FACILITATOR:* This was a very good moment for the group. Barbara asked the group for help, the group responded, and Barbara will consider following their suggestion. How do you feel, Barbara?
- BARBARA (smiling):* I feel better. Thank you all for your help.

In this case, the facilitator links Barbara's mood to the positive interaction that has happened in the group. This is an effective way to show this link. You may need to discuss specific interpersonal skills that could help Barbara approach the knitting group and tell them that she would like to join. To do this, you might use Technique 5 and carry out a role-play to help Barbara do this.

## Chapter 6

# SUGGESTIONS FOR FACILITATORS

### 6.1 General suggestions

#### Suggestions for setting up and running groups

- Start all the groups with the usual greetings.
- Remind group members at the start of each session (and if needed during a session) that their conversations will remain confidential and that they have a right to privacy.
- Try to be mindful of seating arrangements. It's best for everyone in the group, including the facilitator, to sit at the same level if possible.

#### Suggestions for good communication

- Always speak in a friendly tone.
- Try to encourage group members to talk openly about what they think and feel, by asking open-ended questions. For example: *How do you feel? How have you been feeling since we last met?*
- After listening to the group member, you can summarize what you have understood about their problems. In this way, the group member will know that you have heard and tried to understand their problems. The group member will also have the opportunity to correct you if you have not understood the problem correctly.
- You should show that you are listening by using non-verbal cues such as looking at the person when they are talking, nodding, saying *Uh-huh*.

#### Suggestions for working with group members in Group IPT

- Encourage group members to express their feelings about problems, even when those feelings are painful.
  - For example: *It can be very hard expressing difficult feelings, but it usually helps. Try to tell us how you are feeling. You are safe here in the group.*
- Get information from group members that will help understand the problems they are having in their lives. Do this by asking the following kinds of questions.
  1. Ask *direct* questions, such as:
    - *Could you tell me about your children?*
    - *Who are the important people in your life?*
    - *Who did you see this week?*
  2. Ask *open-ended* questions, such as:
    - *Tell me about your depression and when you think it began.*
    - *What is the reason you felt so sad this week?*

- Encourage people to express their feelings, including anger, sadness, guilt and shame. Normalize these emotions (e.g. say: *It's OK to feel anger at this situation, many people do*).
- Make links between a person's thoughts and feelings as well as between symptoms and what is going on in their life. For example:
  - *So it sounds like since you lost your land, you've been thinking it's hopeless and there is nothing you can do. This worry makes you unable to sleep and makes you feel like you are failing your family.*
- Point out similarities in feelings and problems among group members, but only if the problems have already been disclosed by the group member. For example:
  - *I see here how both Rita and Jessica are feeling sad because of problems with their relationships at home.*
- Observe and ask how members are affected by another person's discussion of their problems.
- Point out how one person has helped another.
- If group members do not want to talk or join the discussion, you may not know why and you may feel uncomfortable. It is important to talk about this in supervision.
- Encourage group members to practise in the group new ways of dealing with problems.

## Other suggestions for interacting with group members

- Try to avoid giving advice as much as possible and always listen first, before offering any advice.
- It is more helpful to explore if group members have had a similar problem in the past and how they resolved it, rather than offer your personal advice.
- Ask the group to make suggestions and encourage the group member to consider these or to come up with their own options. If there is another member of the group with a similar problem, explore whether there are any options for that person that might work for the other group member.
- If you do have an idea to suggest, express it as though you have heard it from others, not by telling the person what you think they should do. For example:
  - *I have heard that it has helped some people to speak to their spouse about how they feel.*
- The facilitator is not a friend. However, you are someone who listens without scolding or criticizing, and who supports what each group member is saying.
- Group members may sometimes approach you for advice about problems outside of the group sessions. It is important to try and limit this and not try to solve all of their problems, as this is likely to lead to you feeling overburdened with work or stressed. Try to limit any support you offer group members to the group sessions. For example, you can say something like:
  - *I'm sorry to hear that this has happened to you this week. Can I ask that you bring this to our next group session, so that the whole group can support you. In the meantime, maybe you can think of something or someone who can help you with this?*
- Make notes on each group member at the end of each session. Review these notes just before the next session so that you are familiar with exactly what each member is working on during the week. This will help you to keep track of what is happening for each group member and will make you feel more confident in your role.

- Bring the focus back to the group when group members talk about something that does not seem to be connected with their depression or to what group members are working on. For example:
  - *This is an interesting discussion, but let's first talk about things that are connected to our member's depression so we can help each other.*

## 6.2 Common challenges

### 6.2.1 A group member does not want to talk

This is a common problem, especially in early Group IPT sessions. Many people who do not talk in early sessions will begin to talk when they become more comfortable in the group. This is especially common if the person's problem is loneliness and social isolation.

If by Session 3 or 4 the person still does not talk, you might meet with them after the session to find out why. Some people may feel too shy or embarrassed about their problems, or perhaps too depressed to share. Normalize these feelings and encourage the person to engage more with the group. During the private meeting, you might plan with the group member what they might talk about in the next session and practise what they might say (Technique 5: Role-play).

At all times, look for opportunities to bring silent members into group discussions. When someone else is talking about a problem similar to theirs, you might draw them into the group by inviting them to comment on what has been said. It is important to ask open questions that cannot be answered simply "yes" or "no". It is also important that you "invite" the person to say something and never make them feel forced. This is especially important in early sessions. For example:

*FACILITATOR: Mary, I recall you mentioned to the group that you have a problem similar to Jasmine's. She just told us that she has tried everything to make things better. Would you like to tell us a little about your struggle and what you've tried? If not, that is OK too.*

### 6.2.2 A group member does not let others talk

This may be a problem for the first few sessions, but once other members are more comfortable talking in the group, the over-talkative person may not get as many chances to talk.

You may need to interrupt a very talkative member of the group. You need to do so when someone is talking too much about a situation and other group members seem to be losing interest, or when the person begins repeating themselves. For example:

*FACILITATOR: Robert, what you are saying is important and I'd really like to hear more about it. Unfortunately,*



*though, I'm going to need to interrupt you at this point so that others get a chance to talk about what went well and what their problems have been since we last met. You might like to listen to what everyone else is saying and see if you have any suggestions for them.*

At the beginning of the next session, you might mention the importance of giving everyone a chance to talk.

### 6.2.3 A group member has thoughts of suicide

This is a very serious problem, and one that you must watch for when working with people who have depression.

Listen for any mention of thoughts of suicide during the opening part of each group session when group members describe their mood during the past week. If a group member says that they are feeling worse, ask detailed questions. Don't be afraid to ask about suicide. It is a symptom of depression that, because of its seriousness, must be checked out. A common belief is that asking about suicide may make it more likely that the person will try to kill themselves – but this is untrue. Rather, asking about the subject can help the person to get the support they need.

#### Note for adaptation

It is important to ask the group not to make judgements, such as considering suicide to be illegal or immoral, instead reminding them that it is a common symptom of depression and that the person is asking for support by sharing how they feel.

For example:

**GEORGE:** *I had a terrible week. Nothing was good. I just stayed in bed and I couldn't eat.*

**FACILITATOR:** *George, you seem to feel worse this week. Do you feel like you'd rather not be alive?*

**GEORGE:** *Yes. (If he says no more, you need to ask more questions.)*

**FACILITATOR:** *Have you thought about hurting yourself? (If the answer is yes, continue by asking for more details.) Do you have a plan for how you would hurt yourself?*

**GEORGE:** *Yes. I may take poison.*

**FACILITATOR:** *George, thank you for opening up and trusting us with this information. I'm glad you did that because now we can all try to find ways to help you. I will also speak with you after the group to see if there is anything else you might need to help you.*

If the group member has thoughts or plans to hurt him or herself, you need to meet with them immediately after the group session. You need to follow the guidance in Annex 2 to find out if they have plans to end their life in the near future.

If the group member does have plans to end their life in the near future, then you or someone else must stay with them. Do not leave that person alone. Contact your supervisor and organize help so that the person does not hurt or kill him or herself.

Family members can often be helpful in making sure that the person stays safe. All possible means of self-harm (including pesticides, medicines, knives or any locally relevant means of suicide) should be removed so that the person cannot use them. The person needs to be watched carefully at all times (i.e. 24 hours per day) until they no longer have imminent plans of suicide

It is important to mobilize carers, friends, other trusted individuals and community resources to monitor and support the person if they have plans to end their life in the near future. Explain to them the need for 24-hour-per-day monitoring. Ensure that they come up with a concrete and feasible plan (e.g. who is monitoring the person at what time of the day).

You also need to offer extra support to any group member who has thoughts of suicide, even if they do not have plans to end their life in the near future. It is preferable to have this discussion one-on-one.

- Do not start by offering potential solutions to the person's problems. Instead, try to instil hope. For example: *Many people who have been in similar situations – feeling hopeless, wishing they were dead – have then discovered that there is hope, and their feelings have improved with time.*
- Help the person to identify reasons to stay alive, and ask them who and what has helped them in the past. Search together for solutions to the problems.

## 6.2.4 Group members come to the group under the influence of alcohol or drugs

This can be a common problem, especially in men's groups. Encourage group members to avoid drinking or using substances before the session, so they can get the most out of what the group and its members have to offer, and also so that they are in a good state of mind to help other group members. When people use alcohol or drugs most of the time, it is unlikely that they will change their behaviour in order to attend Group IPT sessions. If someone regularly attends the group when intoxicated, continue to encourage them, in a non-judgemental way, not to drink or use drugs before the sessions. If someone's behaviour is disruptive or their comments are particularly unhelpful or harmful to other group members, try to get the other members to talk directly about the effect of the disruption on the group and their own wish that the individual should not attend sessions while under the influence of alcohol or drugs.

## 6.2.5 There are rumours in the community about the group

Sometimes, people in the community might have incorrect ideas that something dangerous is going on in the group. For example, a rumour might start that the women's group is encouraging women to leave their husbands or that the men's group has a secret political agenda; or that group members are getting special gifts that others in the community are not receiving. Encourage group members to explain the purpose of the group to others and tell them what goes on at meetings – but without discussing specific details about group members.

## 6.2.6 Members want to bring their children or friends

Group members may want to bring relatives or friends to the group because they find the group helpful and want others to get the same help. Sometimes they may want to bring younger children, as they do not have alternative care arrangements for them.. However, bringing children or friends often makes other group members feel uncomfortable about sharing and about the risk of their confidentiality being broken. For this reason, no other people should attend the group, except babies and young children under 2 years of age.

The facilitator should aim to support the group in a discussion about inviting others to attend the group, with the hope that the group itself will identify this as a problem. This is more powerful than just telling the group that this is not allowed. When someone asks if others can come, speak with the group about this directly, giving members a chance to offer opinions. For example:

*FACILITATOR: Annet has raised the idea of bringing family members into the group. Is there anyone else who agrees with this?*

*JASMINE: I think it's a good idea.*

*FACILITATOR: Why would you like this to happen?*

*JASMINE: If my husband was here, he could see that I'm not the only person who's depressed.*

*ANNET: That's what I think too.*

*FACILITATOR: Is there anyone who doesn't want non-group members to attend the group?*

*ALICE: I don't want my family here. I wouldn't like talking in front of them.*

*FACILITATOR: It's common for some members to want to bring important people with them to the group. But having new people would cause a few problems. The group would become very big and give each of you even less time to talk. As Alice said, many of you would not be comfortable talking about your problems in front of non-group members. This group is here to help you learn new*

*ways of solving your problems, and then practise these outside the group. Jasmine, I want you to keep talking with the group about what you could do to help show your husband that you really are depressed and not just lazy.*

This is an important discussion and it can continue for as long as the group needs to talk about it.

## 6.2.7 A group member wants to drop out

It is quite common for group members to wish to stop attending the group. This is more likely at the beginning of group sessions, when people realize that there is no material support, or members are uncomfortable being together, talking about their lives and feelings, especially if from the same community or if living close to each other. If a group member comes to you outside the group to discuss this, ask them about the problem at the next group meeting. Let the group member know that there are probably others in the group who are thinking about stopping, too.

Try to get people to talk about why they want to stop. It may be difficult for them to bring this up in the group because they are already feeling uncomfortable and may not want to make the other members angry or disappointed. If people cannot talk about this in the group, you might bring up the problem without saying who wants to drop out.

*FACILITATOR: Someone in the group has told me that they want to drop out. I would like all of us to help this person to stay. Has anyone felt this way?*

*ALICE: Last week when I was talking about how sad I feel, I wanted to quit. It was just too hard. But in a few days I felt better, and I decided to come back today. But it's still hard to talk here.*

*FACILITATOR: Thanks, Alice, for telling us this. I know it can be hard to be in the group. But I'm happy that you came back today, and could tell us about your feelings. Sometimes when we talk about the problems in our lives we feel worse and we don't want to keep talking about them. But the way to stop your depression is to keep talking about the problems in your life that are making you feel that way, and to keep trying out new ways of dealing with your problems. I'm happy we can talk about your feelings about dropping out. And I'd like everyone to know that it's important to talk about this sort of thing in the group. This is the place for us to talk about all of our feelings.*

## Chapter 7

# CASE EXAMPLES OF IPT PROBLEM AREAS

### 7.1 Grief

**Case 1:** Paula is a 20-year-old woman who experienced two recent deaths in her close family. Two years prior to attending Group IPT her husband died of TB and 11 months prior her infant daughter also died. Paula could not get over their deaths. She cried every day and had trouble taking care of her two remaining children; she was not eating, could take care of her home and felt worthless and believed that the future held no happiness. She said that she never cried after her husband died because she did not have time. She was numb after her infant daughter died. Her husband's family claimed most of her possessions. When friends come to visit, Paula did not want to talk and quickly found reasons to have the friend leave. She stayed at home whenever she could. Paula was fearful that she might also die and leave her other children without any parent. The facilitator identified Paula's problem as grief. She did not go through the type of mourning period that is considered normal in her culture after either death. It was the job of the facilitator to help Paula grieve the loss of these two important people. This was done by helping her to discuss in detail the circumstances of the deaths; how she learned about each; the quality of her relationship with her husband and how they met; the time when he became ill; and also to talk about her infant daughter. She was also helped to find people and activities that would comfort her and to see if she could get back some of her most cherished personal possessions, which were taken after her husband's death.

**Case 2:** Jihane was a married woman in her early 60s who lived with her husband and had depression. After initial reluctance, she agreed to join group sessions. The first HIV-related death had struck her home in 1990 and by 2002 she had lost 4 of her 8 children, who lived nearby. In 2003, her eldest son – who lived in another town – disappeared and after a while she received information that her married daughter, who also lived far away, had died. She did not know exactly what happened and never saw her son's body. She and her husband had educated their children up to university level and most of them were breadwinners for their families and for their ageing parents. During the initial group phase, she spent most of the time crying, talking very little about her problems and contributing almost nothing to the discussion of others' issues. She spoke slowly and reported having difficulties sleeping, walking and eating, was suffering loss of memory and was feeling emotionally exhausted, fearful, sad and very angry. She mentioned that she was sick but did not know what she was suffering from. The facilitator identified Jihane's problem as grief.

During the middle phase of the sessions, she started to talk about her experiences. With encouragement, comfort and support from the group, she was able to tell her story. She described how she had been like a "zombie" for many years, how she was always crying at home, irritating her husband to the extent that he was no longer able to work on his land. She told how she had been struggling to make mats because she was mixing the wrong colours. She explained how life had become impossible. Her remaining two children had stopped visiting, since they and the grandchildren found her very difficult.

Over the weeks she had begun to change her attitude and behaviour in the group as she began to discuss her children and review her relationships with each of them and the circumstances of their deaths. She began to accept their deaths and the changes in her life since they had passed way. She began to smile, be friendly and actively contribute in group discussions. After sharing in the group and hearing the experiences of other women, she realized that she was not the only one who was suffering loss. As the sessions ended, she had few symptoms of depression. She had revived her mat-making activities (this time without mixing the wrong colours).

In the process of setting her goals and listening to the younger women in the group, she learned that, although her own children had died, she still had a role to play for other young girls as an elder woman. She chose to be a wise teacher for them in the group and even outside it and in the wider community. She seemed very happy about this new role.

**Case 3:** Simon, an old man, was mourning the death of his son, who had been his only helper. Simon joined the group in the hope of getting material help. He explained that the trigger for his depression was grief plus the loss of assistance from his son. The boy's belongings were still in a far-away town, but the father did not have the money to collect them, which made him feel even worse. His goals were to collect his son's belongings the town, begin the mourning process and move on with his life. Group members suggested that he needed to go to the town and sell one or two items to enable him to pay for the transportation of the rest of his son's belongings. Simon took up the suggestion and implemented it. He was almost in tears when he reported back to the group how he had succeeded in collecting his son's belongings and how helpful the group had been to him. At termination, his depression symptoms had disappeared, he felt good about himself and he seemed well adjusted to his changed way of living.

## 7.2 Disputes

**Case 1:** Carol was a 32-year-old-woman, married with 4 children. Since falling sick 9 months earlier, she had been unable to care for her children, husband or home as she had in the past. She tired easily and frequently felt so sick that she could not get out of bed. Carol and her husband had been arguing more over the past few months. Her husband criticized her because the house was dirty, the dinner was not cooked and she was not herself. He did not seem to understand that she did not feel well and he wanted to leave her. In the past they had been happy, but now they argued and did not listen to each other. Carol felt like giving up. She cried every day, was not eating or sleeping, was angry all the time and felt that she was letting her husband and children down. Carol had depression, which began when she got sick and could not do the jobs of a wife and mother. The facilitator helped Carol to think about how to talk to her husband so that he could understand how sick she was and how this was affecting her ability to do her work, and also to tell him that she was getting help with her depression. Her depression reduced substantially as a result.

**Case 2:** Most members of the Group IPT group in a particular village were men who were drinking a lot. For a long time they only talked about material problems: no money, no job, no food and no school fees. They did not talk about problems in their relationships. But that changed for one man in the 6th session. He began talking

about a family problem that was affecting his mood. He admitted that he had a problem with his wife: he had been married for 5 years but she did not seem to like or love him, and that bothered him a lot. The others immediately came up with suggestions and support. Some said that they had had similar problems. Others suggested that he should seek help from a village elder and ask for advice. One week later the man came to the session, smiling. After the previous session he had immediately gone to the elder, who gave him advice. He did not want to explain this advice to the group, but it seemed to have worked. At termination, his depression had virtually disappeared.

## 7.3 Life changes

**Case 1:** Rosa was a 40-year-old woman and mother of 3 children. The previous year she and her family moved to another village, and her depression began with her move. At first she was happy because her husband had found a better-paying job. For the 7 months before the IPT group, however, she had not felt as happy as she did when she first moved. She missed her old friends and did not feel close to her new acquaintances. In her former home, she saw her two sisters and mother every day, but since the move she had seen them only once. Her husband was not at home as much as he was in his former job, as he had to work longer hours. Rosa found that she was more angry than she used to be, she felt sad all the time, she did not have any energy and she could not sleep at night. She wanted to move back to her old home. The facilitator helped Rosa to understand the connection between her depression and her transition, mourn the loss of her past life, find ways of keeping up contact with her family and look for ways to make new friends. Rosa no longer had depression by the end of the treatment.

**Case 2:** Eyas, a middle-aged man in a small village, had his own business, but it had gone bankrupt 10 years earlier. He tried again, but again failed. At this point he felt useless, like he was a failure of a man, and became depressed. He joined the group with the hope of dealing with his depression and finding something to do. During the initial phase, he was rather quiet but appeared attentive and listened carefully while others in the group shared their problems. He saw his depression as being clearly related to the difficulties associated with the failure of his business, which disrupted his life and left him without a role in the village. Over time his symptoms improved, and he felt somewhat better about himself. Though he still had good and bad days, he associated feeling better with the realization that other group members had what he described as more serious problems compared with his. He had also realized that staying in the village was only making him more frustrated. While discussing his options in the group, he chose to make contact with some of his old colleagues and explain his problem. The former colleagues agreed to support him in a new enterprise, and he began a business in a nearby town while the sessions were still going on. About halfway through the sessions, he informed the group that his business was going well and he no longer had the time to continue attending. Eyas did not complete all the sessions but when he left his depression symptoms had almost disappeared.

## 7.4 Loneliness/social isolation

**Case 1:** Kayla was a 68-year-old woman who came for help because she was feeling very lonely after her sister died 3 years earlier. While she reported still missing her sister, it became clear that her depression was linked to her lack of social connectedness, not to her grief. Kayla said that her sister had been her only friend.

Kayla's early history was important. When she was 2 years old, she had a serious accident that eventually caused her to lose her leg. She spent most of the next 4 years in hospital. When she finally got home, she was not able to attend school. Her only friend and social connection was her sister, and she remembered going out to attend family events with her. Kayla liked going out, but only with her sister. Her sister talked to others, and Kayla said that she "just listened", and this was enough to satisfy her need for connectedness. She never married or had a relationship because she felt others would be scared or disgusted by her physical disability.

Kayla was uncomfortable about attending the Group IPT sessions because she was afraid to be around others and to have to talk, but she felt so lonely and desperate that she was willing to try. In the individual pre-group session, the facilitator assured her that she would not have to talk unless she felt ready.

During the first few group sessions, Kayla was quiet. The facilitator did not force her to talk in the group, but let her know that her participation was very welcome when she felt ready. The other group members began talking about the situations that were contributing to their depression. They asked for and got support and ideas from other group members about how they might handle situations and relationships differently. Kayla did not offer ideas, but she continued to come to sessions. Her depression score did not change, however. About halfway through, group members began asking her to spend time with them between group meetings. At first Kayla would not go. She always said that she had something to do, which the facilitator knew was not true, though she decided not to challenge her. The facilitator was concerned that Kayla was not making any progress in building relationships.

The following week an important holiday was approaching, and group members were talking about how they were preparing for it by practising their singing. As usual, they asked Kayla if she would like to join them. She said that this was something that she used to love to do with her sister, and she agreed to join them. The group was very supportive of her decision, and assured her that they would stay with her throughout the practice. At the next session, Kayla's depression score had improved, which she connected with attending the singing practice. By the end of the group treatment, Kayla's only social connection was with the group members who she sang with, but this seemed to be enough to reduce her loneliness, which was the main contributing factor to her depression.

**Case 2:** Ali was a 48-year-old man who had fled his country for safety. His wife and two sons were killed during conflict in his country 3 years earlier. There was nothing he could have done to help them that day: he was away for work when a bomb exploded. While Ali continued to grieve over the death of his family members, he was sure that his depression was linked to his extreme loneliness, as there was no one in the new country he could trust and who could understand him. In his own country he had a few friends whom he saw from time to time. He did not trust many people displaced from his country to the new one. He had also had a high-ranking, responsible job in his homeland, but for the 8 months since he fled he had been unemployed.



When Ali started in the group, he did not engage much with the other members and he felt that his problems were very different from theirs. He described his current life as being very lonely, and said that he was not in touch with anyone from his country of origin. At first, the group made suggestions about how Ali might meet people. He told the group with some anger that this was not helpful, since he was sure that he would find no one in the new country like his old friends. Some members gave up trying to help him but a couple of others persisted, inviting him to go out with them during the week. At first he thanked them for thinking of him but refused. However, midway through the group sessions, Ali agreed to go out because he “did not want to offend” them any more. When he came to the next session, he told the group that he felt a little better following a visit to a coffee shop. Although the coffee was not as good as he was used to, at least he was not alone that day. He said that he would like to go out again that week. He did, and while he was out he met someone he knew from his village. He saw this man several times that week and got a lot of updates on his community. Ali reported to the group that he was feeling much better. He linked his improvement to going out with the group members, which led to his reconnection with the man from his village. Within a few weeks Ali’s depression had lifted. During that time he met other people from his own country, he reconnected with others through the Internet and he started a peace movement website to prevent the destruction of other families.





# GROUP INTERPERSONAL THERAPY (IPT) FOR DEPRESSION

## ANNEXES

## ANNEX 1: KEY RESOURCES AND REFERENCES

### KEY RESOURCES

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## ANNEX 2: ASSESSMENT OF THOUGHTS OF SUICIDE

*FACILITATOR: We have just been talking about different emotional difficulties that people can experience. Sometimes when people feel very sad and hopeless about their life, they have thoughts about their own death or even ending their own life. These thoughts are not uncommon and you should not feel ashamed about having such thoughts if you do. The following questions I have for you are about these kinds of thoughts. Is that OK with you? Can we continue with the interview?*

1. In the past month, have you had serious thoughts or a plan to end your life?	YES	NO	
	If “yes”, ask the person to describe their thoughts or plans. Write details here:		
<p><b>If the person responded “no” to Question 1, thank them for answering your questions and you can end the assessment.</b></p> <p><b>If the person responded “yes” to Question 1, please continue with Question 2.</b></p>			
2. What actions have you taken to end your life?	Please write details here:		
3. Do you plan to end your life in the next two weeks?	YES	NO	UNSURE
	If “yes” or “unsure”, ask the person to describe their plan to you. Write details here:		
<p><b>If the person answers “yes” to Question 3, they have a plan to end their life in the near future and you must contact your supervisor immediately. Stay with the person while you do this. (See script below if needed.)</b></p> <p><b>If you are unsure whether the person will end their life in the near future, tell them you would like to contact your supervisor to ask them follow-up questions.</b></p>			

**Script for people with a plan to end their life in the near future:**

*FACILITATOR: From what you have described to me, I am concerned about your safety. As I mentioned before, if I believe you are at risk of ending your life I must contact my supervisor. This is very important so we can get you the best kind of help for these problems as soon as possible. I am going to do this now, OK?*

## Guidance when assessing thoughts of suicide

### Ask direct, clear questions:

- Ask the questions as they are written in the assessment.
- When asking questions about suicide, avoid using less direct words that could be misunderstood.
- Direct questions help the person feel that they are not being judged for having thoughts or plans of suicide or having made attempts in the past.
- Some people may feel uncomfortable talking with you about suicide, but you can tell them that it is very important for you to clearly understand their level of safety.
- Asking questions about suicide will not put ideas into a person's head to end their life if they had not thought about this before.

### Responding to a person with a plan to end their life in the near future:

- Always contact your supervisor.
- Create a secure and supportive environment.
- Remove means of self-harm if possible.
- Do not leave the person alone. Have carers or staff stay with them **at all times**.
- If possible, offer a separate, quiet room while waiting.
- Attend to the person's mental state and emotional distress.

## ANNEX 3: IMPAIRMENTS POSSIBLY DUE TO SEVERE MENTAL, NEUROLOGICAL OR SUBSTANCE USE DISORDERS

**FACILITATOR:** The following items are based on your observations and judgement of the person's behaviours. Do *not* ask the person any questions here. Circle "yes" or "no" to indicate your judgement and give details if needed.

Behaviour	Details
<p>1. Does the person understand you (even though they speak the same language or dialect)?</p> <p>(E.g. can they understand basic words, questions or follow instructions?)</p>	<p>YES / NO</p> <p><b>If no, give details:</b></p>
<p>2. Is the person able to follow what is happening in the assessment to a reasonable extent?</p> <p>(E.g. can they recall recently discussed topics, do they understand who you are and what you are doing with them, do they seem to understand why you are asking them questions? Please consider if the person is so confused, or intoxicated from alcohol or drugs, that they cannot follow what is happening – then circle the response.)</p>	<p>YES / NO</p> <p><b>If no, give details:</b></p>
<p>3. Are the person's responses bizarre and/or highly unusual?</p> <p>(E.g. using made-up words, long periods of staring into space, talking to him/herself, stories are very bizarre or unbelievable.)</p>	<p>YES / NO</p> <p><b>If yes, give details:</b></p>
<p>4. From the person's responses and behaviours, does it appear that they are out of touch with reality or what is happening in the assessment?</p> <p>(E.g. delusions or firmly held beliefs or suspicions that do not make sense (they are bizarre) or are not realistic in the person's local context, unrealistic paranoia, such as a highly unrealistic belief that someone is trying to harm them.)</p>	<p>YES / NO</p> <p><b>If yes, give details:</b></p>

Consider not offering Group IPT if you answered **NO** on questions 1 or 2, or **YES** on questions 3 or 4. **CONSULT** your supervisor.



## ANNEX 4: SESSION-BY-SESSION PROTOCOL

### Initial group phase – Session 1

#### **Task 1. Introduce the group members and talk about depression (30 minutes)**

- Step 1: You and the group members introduce yourselves to each other.
- Step 2: Remind the group about confidentiality
- Step 3: Talk about depression in general.
- Step 4: Give hope.

#### **Task 2: Discuss depression and the IPT problem areas that the group members are facing (45 minutes)**

- Step 1: Discuss in general links between depression and IPT problem areas.
- Step 2: Review each person's problems and goals.
- Step 3: Ask group members to talk about their lives.

#### **Task 3: Discuss how the group will work (15 minutes)**

- Step 1: Describe how Group IPT works (duration, length and structure of the sessions).
- Step 2: Cover group rules.
- Step 3: End the session.

### Tasks of middle group phase – Sessions 2–7

#### **Task 1: Start each group session by reviewing group members' depression (15–20 minutes)**

- Step 1: Start the group.
- Step 2: Review depression symptoms.

#### **Task 2: Link depression to events from previous week (10–15 minutes)**

- Step 1: Discuss events in the previous week.
- Step 2: Link these events to the group member's problem areas.

#### **Task 3: Use strategies specific to each IPT problem area (45 minutes)**

- Strategies for grief
- Strategies for disputes
- Strategies for life changes
- Strategies for loneliness/social isolation.

#### **Task 4: Assign practice exercises and end the session (15 minutes)**

## Termination group phase – Session 8

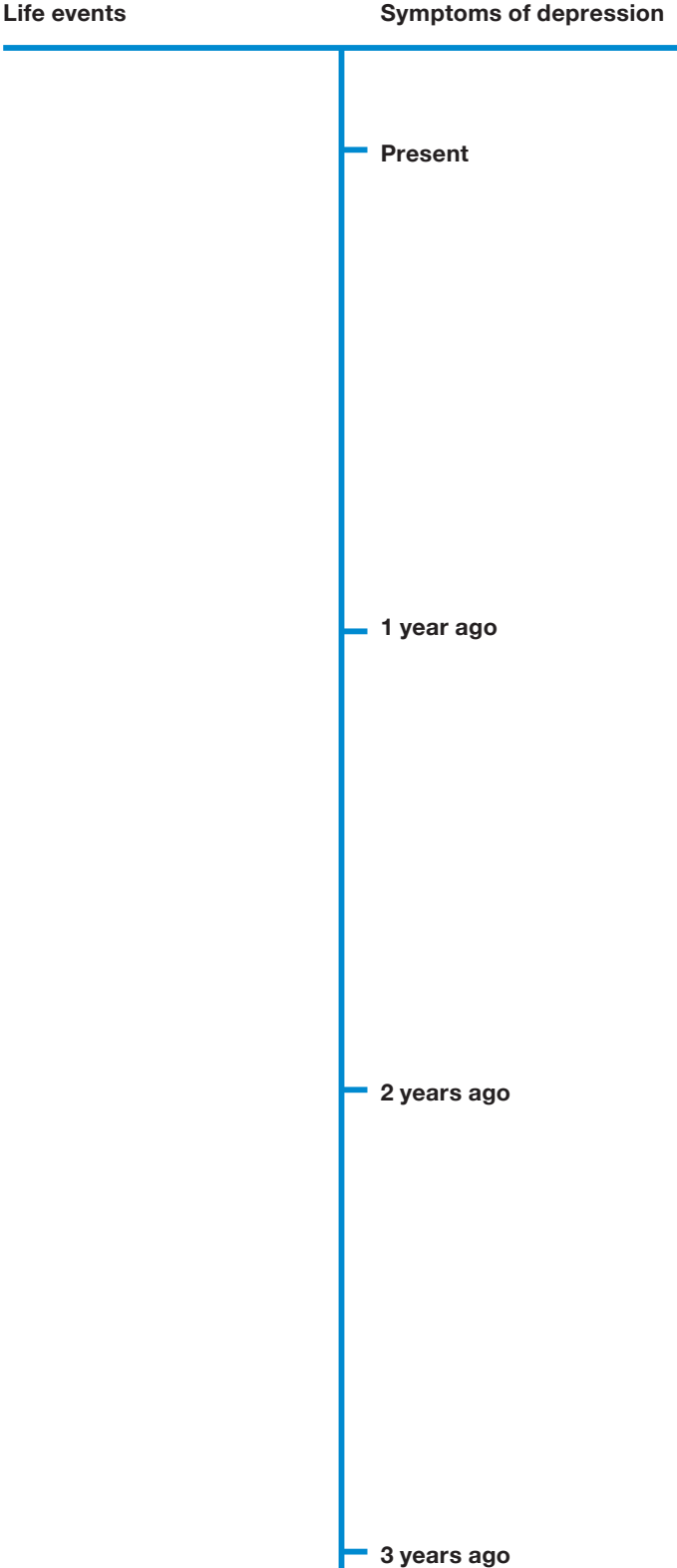
The overall aim is to give group members an opportunity to review what happened during the group sessions, say goodbye to other group members and make plans for how to address problems that might keep coming up or new problems that emerge.

Strategies may include:

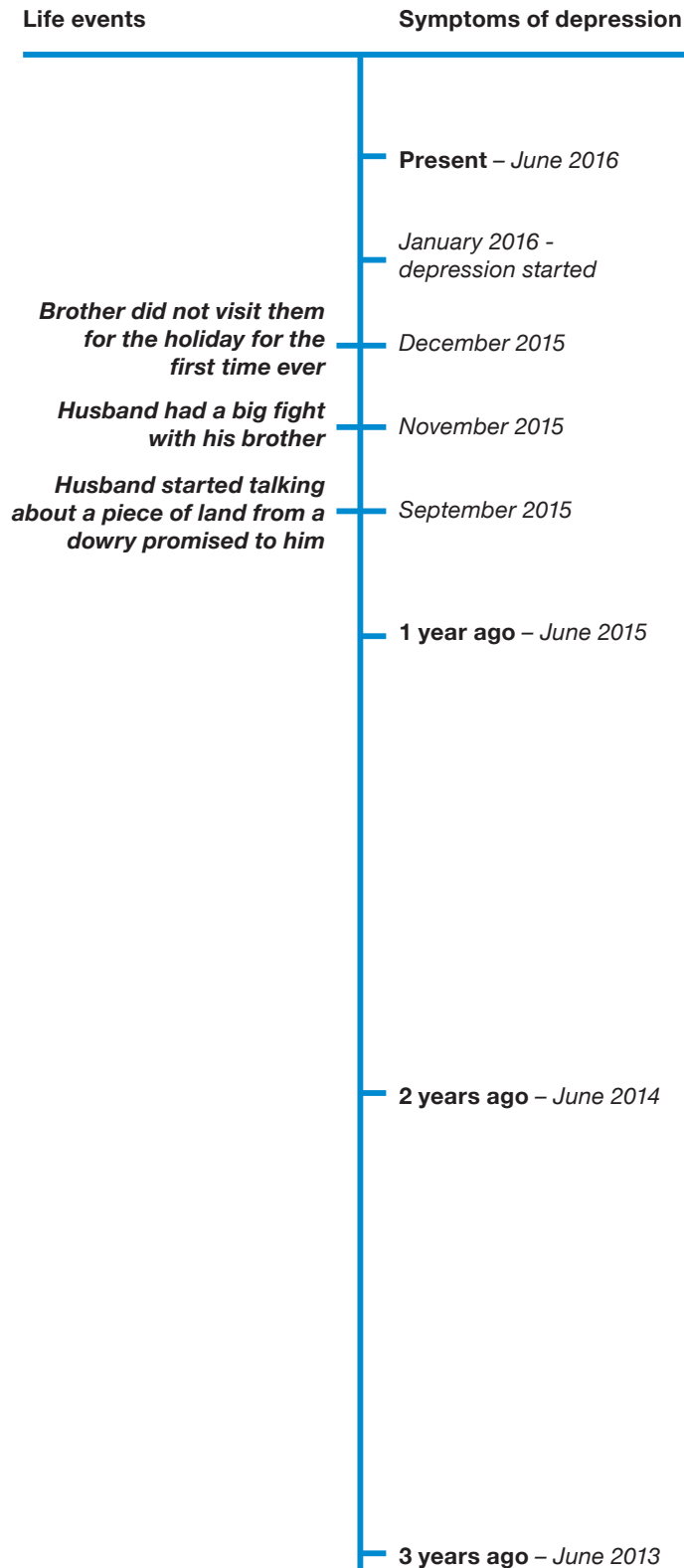
- Review with each group member changes in symptoms, mood and interpersonal problem areas.
- Express feelings about termination.
- Discuss possible sources of problems in the near future, and skills to help prevent depression.
- Help members identify signs that depression is returning and make an action plan.
- Support group members who have not improved or who have only partially improved.
- For literate groups, prepare a reminder sheet of the Group IPT.
- Remember that a culturally appropriate termination ritual chosen by the group can at times be helpful.

# ANNEX 5: TIMELINE OF DEPRESSION AND INTERPERSONAL EVENTS (WITH EXAMPLE)

Timeline to be completed (one by each group member)



Example of completed timeline



## ANNEX 6: GUIDE FOR FACILITATOR'S WEEKLY NOTES

**Note for facilitator: Each group member should have a set of weekly notes.**

Group member's name:

Clinician's name:

Group identification (location, number etc.):

Supervisor's name:

Pre-group session (date)
<p>Depression score:</p> <p>Rating scale used:</p> <p>Notes:</p> <p>Interpersonal inventory:</p> <p>Names of people and role in the person's depression:<sup>8</sup></p> <p>IPT problem area(s):</p> <p style="text-align: center;">Goals</p>

<sup>8</sup> Example: Ali, Jasmine's husband, recently lost his job and drinks. He takes Jasmine's money and hits her.



<b>Week 3 (date)</b>	<b>Week 4 (date)</b>
<p>Group member attended: Yes ___ No ___</p> <p>Depression score:</p> <p>Notes (include progress in IPT problem areas):</p>          <p>Plan for next week:</p>	<p>Group member attended: Yes ___ No ___</p> <p>Depression score:</p> <p>Notes (include progress in IPT problem areas):</p>          <p>Plan for next week:</p>
<p>If group member did not come, state action to contact him/her. If dropped out, state group member's reason:</p>	<p>If group member did not come, state action to contact him/her. If dropped out, state group member's reason:</p>





<b>Week 7 (date)</b>	<b>Week 8 – termination (date)</b>
<p>Group member attended: Yes ___ No ___</p> <p>Depression score:</p> <p>Notes (include progress in IPT problem areas):</p>          <p>Plan for next week:</p>	<p>Group member attended: Yes ___ No ___</p> <p>Depression score:</p> <p>Notes (include progress in IPT problem areas):</p>          <p>What to do in the event of depression getting worse:</p>          <p>Plan for next few months:</p>
<p>If group member did not come, state action to contact him/her. If dropped out, state group member's reason:</p>	

## ANNEX 7: GROUP IPT TASK CHECKLISTS FOR SUPERVISORS AND FACILITATORS

Note: These forms can be used as a reminder of the different tasks to complete in each session, as a self-assessment tool for facilitators or by peers or a supervisor as part of ongoing learning and supervision.

### Pre-group phase (individual session)

Group member ID: \_\_\_\_\_

Session # and date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Supervisor: \_\_\_\_\_

( ) Audio ( ) Live supervision ( ) Verbal report only

Please rate using the following key:

Superior	Satisfactory	Needs improvement	Failed to attempt	Not applicable to session	Could not assess in supervision
1	2	3	4	5	6

Competency (take into consideration facilitator's level of experience, i.e. 1st, 2nd, 3rd group)	1	2	3	4	5	6
1. Introduces self and project to person						
2. Reviews person's depression symptoms by administering a depression rating scale						
3. Explains that depression is a common but very impairing condition and discusses person's impairment						
4. Gives hope that depression is treatable						
5. Assigns person the sick role						
6. Links beginning of depression to interpersonal problem(s)						
7. Conducts interpersonal inventory						
8. Selects and agrees with the person on 1 or 2 IPT problem areas						
9. Agrees with person on interpersonal goals						
10. Discusses number of sessions, attendance and group rules						
11. Demonstrates knowledge of Group IPT model						
12. Works at establishing a good relationship with prospective group member						
13. Demonstrates good understanding of person's problem and its context						
14. Has a collaborative style						

### Individual session: supervisor's recommendations to facilitator:

Strengths:

Difficulties:

Plans for improvement (rehearse, assign reading, etc.):

**Initial group phase (group session 1)**

Group ID: \_\_\_\_\_

Session # and date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Supervisor: \_\_\_\_\_

 Audio     Live supervision     Verbal report only

Please rate using the following key:

Superior	Satisfactory	Needs improvement	Failed to attempt	Not applicable to session	Could not assess in supervision
1	2	3	4	5	6

Competency (take into consideration facilitator's level of experience, i.e. 1st, 2nd, 3rd group)	1	2	3	4	5	6
1. Introduces self and project to group						
2. Conducts group icebreaker activities (each member introduces the person next to them, etc.)						
3. Discusses purpose of the group						
4. Explains that depression is a common but very impairing condition, and asks each person about impairment, while removing guilt						
5. Encourages each group member to talk about depression symptoms, related life problems and goals						
6. Outlines group rules (confidentiality, attendance, etc.)						
7. Demonstrates knowledge of Group IPT model						
8. Works at establishing rapport and group cohesion						
9. Shares time fairly amongst group members						
10. Is able to keep group focused						

**Session 1: Supervisor's recommendations to facilitator:**

Strengths:

Difficulties:

Plans for improvement (rehearse, assign reading, etc.):

**Middle group phase (group sessions 2-7)**

Group ID: \_\_\_\_\_

Session # and date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Supervisor: \_\_\_\_\_

( ) Audio ( ) Live supervision ( ) Verbal report only

Please rate using the following key:

Superior	Satisfactory	Needs improvement	Failed to attempt	Not applicable to session	Could not assess in supervision
1	2	3	4	5	6

Competency (take into consideration facilitator's level of experience, i.e. 1st, 2nd, 3rd group)	1	2	3	4	5	6
1. Welcomes group, reviews each member's depression symptoms for past week with the depression rating scale and obtains depression score						
2. Comments on improvement or worsening of depression and gives each group member hope						
3. Connects improvement or worsening of depression to past week's interpersonal events and links these events to the IPT problem area(s)						
4. Focuses on each group member's identified IPT problem area(s)						
5. When group member deals with grief, facilitator enables discussion of the circumstances of the loss						
6. When group member deals with grief, facilitator reviews their relationship with the deceased person						
7. When group member deals with grief, facilitator helps with reconnection with the world and future plans						
8. When group member discusses disputes, facilitator clarifies their expectations about the situation that triggered dispute						
9. When group member discusses disputes, facilitator identifies problematic communications						
10. When group member discusses life changes, facilitator helps them find positives and negatives about old role						
11. When group member discusses life changes, facilitator helps them find positives and negatives or opportunities in the new role						
12. When group member discusses life changes, facilitator helps them develop skills to better manage the new role						
13. When group member is socially isolated, facilitator helps them to acquire skills to engage in social interactions						
14. Analyses interpersonal situations in detail to find out what happened (communication analysis)						
15. Helps group members practise new communication strategies						
16. Encourages group members to help each other to generate options to deal with problems						
17. When group members have no options, facilitator encourages them to find advocates and others with more power to help						
18. Encourages group members to use role-play to rehearse desirable interactions						
19. Demonstrates knowledge of Group IPT model						
20. Works at establishing good relationships and group cohesion						
21. Shares time fairly amongst group members						
22. Is able to keep group focused						

**Sessions 2–7: Supervisor's recommendations to facilitator:**

Strengths:

Difficulties:

Plans for improvement (rehearse, assign reading, etc.):

**Termination group phase (group session 8)**

Group ID: \_\_\_\_\_

Session # and date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Supervisor: \_\_\_\_\_

( ) Audio ( ) Live supervision ( ) Verbal report only

Please rate using the following key:

Superior	Satisfactory	Needs improvement	Failed to attempt	Not applicable to session	Could not assess in supervision
1	2	3	4	5	6

Competency (take into consideration facilitator's level of experience, i.e. 1st, 2nd, 3rd group)	1	2	3	4	5	6
1. Reviews each group member's depression score (using rating scale) from start of the treatment to now and comments on progress						
2. Discusses warning symptoms of depression ( <i>How would you know that you are getting depressed again?</i> )						
3. Identifies successful strategies used in treatment						
4. Reviews group members' interpersonal goals, successes and efforts to change						
5. Discusses generalization of strategies to future situations for group members						
6. Discusses his/her own and group members' feelings about ending treatment						
7. Assesses need for further treatment						
8. Discusses possibility of recurrence of depression and plan for managing recurrence						
9. Demonstrates knowledge of Group IPT model						
10. Works at maintaining relationships with and amongst group members						
11. Shares time fairly amongst group members						
12. Is able to keep group focused						

**Session 8: Supervisor's recommendations to facilitator:**

Strengths:

Difficulties:

Plans for improvement (rehearse, assign reading, etc.):

## ANNEX 8: REMINDER NOTE (TERMINATION PHASE)<sup>9</sup>

### ENDINGS AND NEW BEGINNINGS

[Name of group member]'s group memories

How I was when I started
<p><b>Interpersonal problem area(s) (Circle the ones that apply)</b></p> <p>Grief          Disputes          Life changes          Loneliness/social isolation</p> <p><b>What was happening in my life:</b></p>
<p><b>Personal goals</b></p>
<p><b>Helpful strategies</b></p>
<p><b>Depression symptoms at the start of treatment and my depression score then:</b></p>

<sup>9</sup> This may be completed during the termination session if all members are literate.

<b>Current depression symptoms and my depression score now:</b>

**How do I know if I am getting depressed again?**

**If I experience more than 3 of the following symptoms, I will not wait more than 4 days but will contact \_\_\_\_\_ (name and phone number of person: either the same facilitator or another health worker or helper).**

Sadness

Big change in energy level, very tired all the time

Big change in sleep

Loss of interest

Feelings of hopelessness

Thoughts of ending my life

Problems with appetite

Cannot concentrate

Cannot make decisions

Feeling guilty or worthless

Talking or moving more slowly

Other symptoms \_\_\_\_\_

**Note for adaptation**

The symptom list above may need to be adapted. For example, terms should be used that are understandable to the person.

<b>Memorable group moment:</b>
Write a few sentences about a memory or experience in the group that helped you



**Please write down something about yourself or draw a memory from your group meetings:**

## ANNEX 9: GROUP IPT KNOWLEDGE TEST<sup>10</sup>

1. Please name the four types of triggers of depression in IPT define each one.
2. What are the phases of Group IPT? (Just mention them.)
3. Describe the tasks that need to take place in the pre-group phase.
4. Describe the goals and steps of the initial group phase.
5. Describe how a typical session starts in the middle phase.
6. In the middle phase, what are the strategies for working with grief?
7. What are the stages of a dispute? (Please describe each.)
8. What are the strategies for managing disputes?
9. What are the strategies for life changes?
10. What are the strategies for loneliness/social isolation?
11. What is communication analysis? Can you give an example?
12. Describe 2 other techniques that you use in Group IPT (across strategies). Please explain.
13. Describe 1 way to involve group members in group discussions, and give examples.
14. What is something you can do to distribute your time fairly among the group members?
15. What happens during the termination phase?

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<sup>10</sup> Test scoring instructions are as follows: every question gets 2 points if answered adequately, 1 point if something important is missing and 0 points if the answer is incorrect. Usually the facilitator should be able to answer 70% of the 15 questions correctly (21 points).



# GROUP INTERPERSONAL THERAPY (IPT) FOR DEPRESSION

WHO generic field-trial version 1.0, 2016  
Series on Low-Intensity Psychological Interventions – 3

