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How interpersonal psychotherapy groups support recovery from depression: a qualitative study in rural Uganda

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Abstract

Interpersonal Psychotherapy for Groups (IPT-G) is increasingly used to treat depression in resource-limited settings as an affordable alternative to expensive mental health treatments. While evidence supporting the effectiveness of IPT-G in such contexts continues to grow, a clear understanding of what makes IPT-G effective in helping people recover from depression has not been fully explored. We engaged 33 participants recruited from rural Uganda who underwent IPT-G for depression between 2022 and 2024 to identify key moments in their recovery process, signs of healing, and issues they felt did not go well during treatment. Using a semi-structured interview guide, we conducted one-on-one interviews lasting 30–45 min, which were recorded. The data were inductively coded and then analyzed thematically. Results showed that the comparison effect, thought modification, and group effect played significant roles in healing, while abandoning suicidal thoughts and improvements in sleep quality were primary signs of recovery. Additionally, ignoring age differences and breaches of confidentiality hindered the treatment process. The study offers valuable insights for mental health practitioners seeking to improve IPT-G implementation in low-resource communities.

Keywords: *interpersonal psychotherapy for groups, low-resource, depression, intervention*

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1. Introduction

People in the low-resource regions of the world face multiple overlapping crises, including high disease burdens, famine, poverty, unemployment, and gender-based violence that affect their mental health. Depression is the leading mental health challenge [1]. While access to mental health services is regarded as a universal human right, it remains a universal problem [2], and worse in resource-constrained settings where mental health services are costly due to having few trained specialists and underfunding of mental health initiatives by governments in such regions. The need to enhance the provision of psychological support to individuals in resource-limited contexts remains a pressing global concern [3].

Traditionally, psychological interventions are delivered in person by trained specialists; however, such approaches have not been successful in low-resource settings as they require a sizeable number of providers who are not present, and the beneficiaries must have reasonable resources to meet the treatment cost, yet they live in abject poverty [4, 5], making in-person therapy very expensive and not accessible to the general population [6, 7]. This partly explains why most mental health conditions remain undiagnosed and untreated in low-income countries [7–9].

Developing and promoting low-cost psychological support interventions that do not entirely depend on trained specialists but can enhance mental health, especially for people with subclinical depression symptoms in resource-limited communities, is becoming an increasingly important focus for mental health researchers and practitioners [3, 10, 11]. These programs, however, should be community-based initiatives to utilize the available resources within the communities [12, 13]. Community-based support is less expensive, builds local capacity, and provides solutions rooted in the community's cultural practices and values [12]. Additionally, in most low-resource communities, social connections and support networks serve as resources to buffer negative life experiences [14]. Therefore, mental health promotion programs in such settings should be based on existing social ties to facilitate implementation and scale-up [14, 15].

The World Health Organization [16] identified Group Interpersonal Therapy (IPT-G) developed by Klerman and Weissman as an appropriate community-based support program that can cover the mental health gap in many resource-limited settings.

IPT-G is a time-limited, manualized psychotherapy that focuses on interpersonal relationships to improve psychological functioning.

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According to this approach, depression is rooted in interpersonal connections and is caused by four relational triggers: grief, which involves dealing with the loss of a loved one; life changes such as job loss, divorce, or marriage; unresolved conflict, which can be with family members, friends, or colleagues; and social isolation, such as being separated from loved ones by distance [17]. IPT-G is based on two relationship theories: attachment theory, which posits that humans have a biological need to form relationships and that insecure attachments render them vulnerable; and interpersonal theory, which asserts that social connectedness is at the core of human existence and that its absence affects our mental health. Therefore, individual emotional experiences can be understood as social cues, and addressing them from a social perspective is therapeutic [15].

IPT-G involves forming groups of members with depression triggers who go through a series of treatment phases. In the initial stage, group members establish rules, create a comfortable atmosphere, and build rapport among themselves. Being in the group provides members with social support, an opportunity to develop and practice new communication skills, and a chance to learn how to collaboratively solve problems. In the subsequent phases, group members openly and thoroughly share their weekly struggles under the guidance of a facilitator, who can be an experienced therapist or a trained community member. Group members identify commonalities between symptoms and relationships, and work toward generating solutions. Before ending the treatment, members develop independent functioning and strategies to prevent relapse [18, 19].

The WHO recommends IPT-G as an appropriate first-line treatment for depression and has developed a manual comprising eight simplified sessions, currently translated into eight languages and adapted for different contexts and health conditions [16]. Cognizant of the challenges of accessing mental health services, IPT-G can be delivered by non-specialists or community members who receive basic training in group facilitation, counseling, and psychotherapy, and who use shared conversations to help people generate helpful ideas that improve their situation [20]. Studies evaluating the effectiveness of IPT-G in treating depression in resource-limited settings, such as Uganda, have found positive effects [21–23], with some suggesting that IPT-G has similar efficacy to interpersonal psychotherapy (IPT) and offers an additional benefit of wider reach in non-clinical settings [17]. Relatedly, several studies gauging implementation outcomes of IPT-G have found it acceptable to many people and feasible to implement in low-resource settings [24, 25].

While the effectiveness of IPT-G for use in low-resource contexts has been underscored, accelerating the uptake of mental health interventions goes beyond measures of efficiency and effectiveness to consider the interplay of factors that influence continued use and participation, such as treatment experience [26]. Although IPT-G is evaluated positively in non-clinical populations, the question of 'what is helpful in IPT-G or causes people in certain settings to heal from depression' has not been well explored. The WHO IPT-G manual lays out a program delivery structure, highlighting practical group and individual exercises that help people navigate their problems to identify solutions. However, such universalistic procedures do not entirely capture individual healing moments across varied contexts.

Relatedly, since mental health is contextually experienced, what is helpful in treatment might vary across contexts, even when the treatment procedure remains the same [27]. Thus, collecting perspectives of people who have experienced the program in a low-resource context can help highlight the most critical/salient components of the treatment process for such people and lay the groundwork for the development of revised versions of the program with selected processes that are more helpful to those undergoing treatment [28].

2. Materials and methods

2.1. The intervention (using Interpersonal Psychotherapy for Groups to treat depression in Uganda)

The use of IPT-G to treat depression at the community level has been adopted by StrongMinds (SMU), a global non-profit organization operating in Uganda since 2013. SMU aims to use innovative and cost-effective approaches to treat depression and reduce the impact of untreated depression on the Ugandan community. Cognizant of the costs associated with accessing psychotherapy in Uganda, SMU promotes self-help group treatments at the community level, which are simple, cost-effective, impactful, and scalable. In the SMU approach, community members with similar depression triggers find safe spaces where they share their struggles with peers over six sessions guided by a lay counselor [23]. The lay leaders are respected community members with some basic education who receive training in group facilitation and basic counseling skills from SMU. During sessions, group members collaborate to creatively identify solutions to their problems and explore ways to continue supporting one another even after therapy ends.

In 2013, StrongMinds' treatment cycle involved 16 weeks of IPT-G. However, issues with session load and attrition led to the development of shorter treatment models, which can improve participant retention and facilitate program expansion. Currently, SMU offers a six-week IPT-G model in various regions of Uganda, and as of February 2024, it has treated over 500,000 people for depression.

2.2. Study design, setting, and participants

This qualitative case study was conducted in central Uganda, within the rural communities of the Kayunga and Buikwe districts, from August to November 2024. The central region, with its diverse population, is the most densely populated area in Uganda and has been a significant presence for StrongMinds since 2013. The study participants were clients of StrongMinds who had received IPT-G treatment for depression between 2022 and 2024. We aimed to recruit 50 participants from both districts. From the clients' database, a total of 314 were identified. We randomly selected 50 participants from each district. Then, using maximum variation based on village of residence, age, and gender, we purposively selected 25 participants per district to form the final sample of 50. The inclusion criteria were residing in the specified region/district, attending StrongMinds IPT-G as treatment for depression during the targeted period, being at least 18 years old, and willing to provide written informed consent. Potential participants were contacted by phone calls using numbers from the database. Seventeen participants who had moved to other districts, had their phone numbers disconnected, or declined to participate were excluded.

2.3. Characteristics of participants

Table 1 below summarizes the participants' demographics. In total, 33 people were involved in the study. Most (20 out of 33, 60.6%) were between 31 and 50 years old. Most were female, accounting for 30 of 33 (90.9%). Over half (19 out of 33, 57.6%) were single or widowed. See **Table 1**.

The participants were primarily subsistence farmers, comprising 24 out of 33 (72.7%). A significant number did not reveal their number of children (36.4%) or their highest level of education (51.5%) (see **Table 1**). After receiving verbal consent, participants were followed up at their homes based on directions provided during phone calls. Written informed consent was obtained from each participant before conducting interviews, which were held in quiet, private areas near their homes to ensure comfort and confidentiality. This was a follow-up study to a randomized trial evaluating IPT-G in Uganda [29].

2.4. Data collection

The data collection team consisted of four interviewers who conducted in-depth, in-person interviews with the participants. Two of the interviewers were women and two were men. All interviewers were bilingual in Luganda and English and had training in qualitative research. Before collecting data, we created an interview guide to address the main research questions: "What changes did you experience?", "What was helpful/worked in IPT-G?", and "What was not helpful?" Sample questions from the guide included "Was there a single moment that helped you as an individual?" and "Did you notice any change(s) in yourself or your situation because of participating in the program?" (A complete interview guide is included in the Supplementary Materials). The guide was then translated into Luganda (the most spoken language in central Uganda), back-translated into English, and tested for equivalence by two professional translators from the Department of Languages at Makerere University, Kampala. The few inconsistencies observed were discussed and resolved.

Table 1 • Characteristics of participants (N = 33).

Characteristics	Frequency (n)	Percentage (%)
Age (years)		
30 and below	6	18.2
31–40	10	30.3
41–50	10	30.3
51 and above	7	21.2
Sex		
Females	30	90.9
Males	3	9.1
Marital status		
Married	14	42.4
Single	11	33.3
Widow	8	24.3
Occupation		
Subsistence farming	24	72.7
Professional job	3	9.1
Business	3	9.1
None	3	9.1
Number of children		
None	4	12.1
1–5	9	27.3
More than 5	8	24.2
Not reported	12	36.4

The interviews, which lasted 35–40 min, were audio-recorded and transcribed by the four interviewers. Since all the interviews were conducted in Luganda (the preferred language of the respondents), and yet analysis and reporting were planned to be performed in English, the original transcriptions were translated into English by two independent bilingual speakers of Luganda and English who had been involved in tool development. The lead researcher, a bilingual native speaker, sampled three translated transcripts and followed them through transcription and audio recording to ensure no data was lost.

2.5. Data management and analysis

Two members, K.M. and E.K., coded and analyzed the data collaboratively, working with other members at regular intervals throughout the analysis. Both analysts hold PhDs and have sufficient experience in qualitative data analysis. The data were inductively coded and then analyzed thematically, following the flexible six-step thematic data analysis framework by Braun and Clarke [29]. First, the analysts read through all 33 transcripts to understand the data's direction and identify relevant demographic information. After familiarization, they independently open-coded three similar transcripts to generate the initial set of codes. In step 3, the analysts met to discuss the emerging codes. They compared their individually generated codes, identified areas of agreement and departure, and manually computed intercoder reliability, which was 73%. In computing reliability, the coders manually counted the number of times they both agreed on a coding decision. They then divided this count by the total number of codes generated and multiplied by 100. Finally, the areas of disagreement were discussed, resolved, and a consensus was reached. The analysts then defined the codes and developed a codebook that guided further analysis. In step 4, using ATLAS in TI (version 23), the analysts applied the generated codes to the remaining transcripts, carefully allowing new codes to emerge that did not fit the predefined categories. The codebook was revised three times during the coding process. In the final step, the analysts systematically grouped related codes with similar patterns of meaning under the three research questions to create an analysis framework (see **Table 2**). Since the 29th transcript identified some new information, we decided to analyze all 33 transcripts, even though the last 4 transcripts did not offer any additional new information. Once the data analysis was complete, the writing of the results began.

Table 2 • Analysis frame.

Themes	Codes
Changes experienced	Abandoning suicidal thoughts
	Resilience
	Sleep quality
What was helpful that supported healing	Social comparison
	Modifying thoughts
	Group effect
	Opening up
	Social learning
	Self regulation
	Easy access
	Treatment process
	Acceptance
	Hope and optimism
What was not helpful	Group composition
	Confidentiality issues
	Lack of follow-up
	Quick termination
	Session duration

3. Results

Results are presented in three thematic categories: "What changes were experienced as a result of attending the program", "What was helpful in supporting healing", and "What was not helpful?". Refer to **Table 2** for the themes and their corresponding codes.

3.1. The change experienced

Participants shared the changes in their lives that occurred after completing the IPT-G program. The changes indicated healing, with the most notable ones being abandoning suicidal thoughts, better sleep quality, and increased resilience, as described below.

3.1.1. Abandoning suicidal thoughts

Some participants reported abandoning their initial suicidal thoughts and ideas after completing the IPT-G program. They acknowledge having a new outlook on life and feeling they can use their lives positively.

> *"Ahaa, it was very relevant to me because the thoughts I had of wanting to kill myself, hating myself the whole time, changed. The program came at the right time." (36-year-old-female)*
>
> *"Initially, I wanted to kill my children and then take my life so that my husband feels the pain wherever he is, since he abandoned me for a young girl, but now this is something of the past. Coming to the group helped me make peace with that." (40-year-old-female).*

Participants reported that the program enhanced their resilience in managing life's challenges. They acknowledge that challenges will always be part of life, but feel prepared to face anything that comes their way.

> *"... I don't cry anymore; truthfully, I am now strong, even though the problems have never gone away." (37-year-old-female)*
>
> *"I came to realize that staying in misery and pity will not solve any of my problems, as a man, I need to work for myself and my future family." (26-year-old male)*

3.1.2. Sleep quality

Participants reported that participating in the IPT-G program enhanced their well-being, as evidenced by improved sleep quality.

> *"I used not to sleep, but now I sleep better, even when I wake up in the night, I can catch sleep again, I know how to handle myself." (39-year-old-female)*
>
> *"I would sleep for about 3 h, then I get up and start thinking about the man I built from scratch, and he's taken now! [laughs] Eh, it hurt me. There was no child support, and I wondered how the situation would have been if I hadn't been educated. I let go and now sleep better." (40-year-old-female)*

3.2. What was helpful in supporting healing

Participants shared their experiences of reaching a pivotal moment in the treatment program, emphasizing issues they believed were most helpful for improving their well-being during ITP-G sessions. As explained below, the most common factors were comparison effects, thought modification, group support, the opportunity to open up, and social learning (see **Figure 1** below).

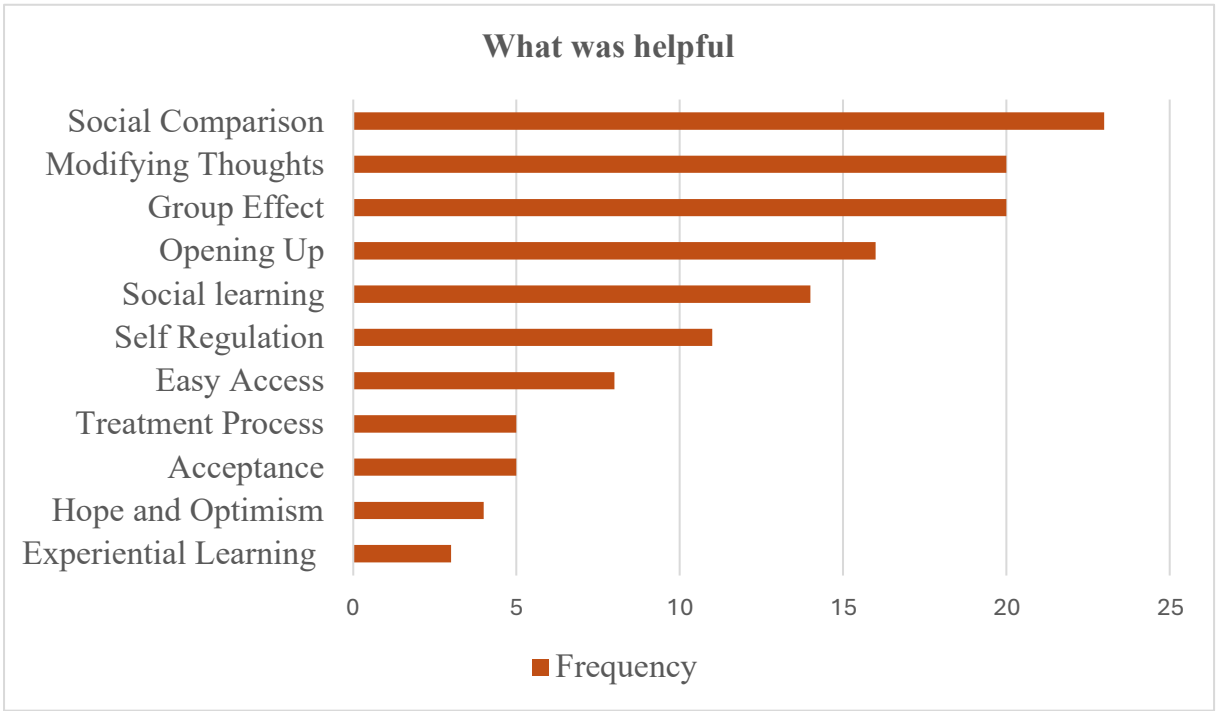

Figure 1 • The frequency of what was helpful in the Interpersonal Psychotherapy for Groups (IPT-G) treatment.

3.2.1. Comparison effect

Participants reported that listening to others discuss their problems prompted them to evaluate the severity of their own issues relative to others. Several mentioned feeling a sense of relief after realizing that their problems were less severe than others. This became a moment of healing for them.

> *"That lady over there lost her child, who was burnt to death while living in South Africa; they returned ashes, yet he was the one taking care of his parents, so when that lady shared, I realized that mine was a tiny problem" (39-year-old female)*

> *"I always thought I was cursed, and the only one living with problems since my husband was often beating me; however, when people started talking about their problems, including strange diseases, in my heart, I was like, I am lucky I haven't seen such problems yet. To me, that's how I got better, I am even glad I joined" (30-year-old-female)*

3.2.2. Mastery of thought modification

For some participants, this was their first opportunity to learn how to handle painful thoughts that preoccupied their lives. Many reported that mastering the skill of changing thoughts and finding a balance between pain and hope led to healing, as illustrated in the quotes below.

> *"I had bad thoughts, I had no peace, full of self-pity and self-harm, but when I joined the StrongMinds program, I started letting go of them because we were taught how to do it." (36-year-old female)*

> *"At first, it sounded like a joke to me. I wondered how one could avoid stress, since it was the first time I had heard of it. Along the way, I learnt how to change thoughts when they take over. Funny that now I do it and I feel I am a new person." (39-year-old-female) "Dealing with thoughts was the best for me. I've learned this very well; most often, when those bad thoughts show up, I focus on something nice I have achieved, which helps me have a good day. In the past, the entire day would be ruined" (20-year-old-female)*

3.2.3. Group support

Participants emphasized the importance of group support in the healing process. Being part of a group fostered mutual support, leading to the development of solutions to various challenges. Group involvement also allowed those with similar issues to offer one another advice, as shown in the quotes below.

> *"We were in groups of 12 people, then in each group, every individual would openly talk about the problems that were making them depressed, then we would discuss as a group and identify solutions, that's how we got better as a group." (37-year-old-female)*

> *"… Yes, so people give their opinions about what you have shared, so if some people share today, the next time, we get others to share and give them advice. This worked for me." (22-year-old-female)*

3.2.4. Opportunity to open up

Some participants said their lives worsened because they had no one to talk to, which led them to keep painful thoughts to themselves for a long time. The program provided an opportunity to connect with others and openly share their struggles.

> *"I was always lost in thoughts, so I wanted to find someone to open up to so that I could take it off my chest. I feel like I achieved this, although there are other things I have not yet achieved." (30-year-old female).*

> *"What was killing me most was keeping everything to myself because I had no one to talk to. This program gave me people to trust and talk to. When I started sharing, the weight reduced." (40-year-old-female)*

3.2.5. Social learning

Participants reported that being in the treatment group helped them learn how to regulate themselves by observing others, which they considered necessary when dealing with depression. Many admitted they learned to stay calm and manage their relationships with their husbands from the group, and said it changed their lives.

> *"I even thought about buying a rope to hang myself so many times. But ever since I came to the training, I learnt to become calm, I realized that people had similar problems but acted differently." (39-year-old-female)*

> *"I had developed a habit of shouting at my husband whenever he said something I didn't want, and this made him beat me. Someone in the group said her husband used to be tough, but she never talked back to him; she remained composed and acted as a wife. I picked that on day one, and things improved in my home and life." (20-year-old-female)*

3.3. What was not helpful?

Finally, we asked participants to share what was not helpful (had not worked out) based on their experience with the program and what they thought needed to be changed to improve it. As shown in **Figure 2** below, these factors included issues with group composition, confidentiality, and a lack of follow-up.

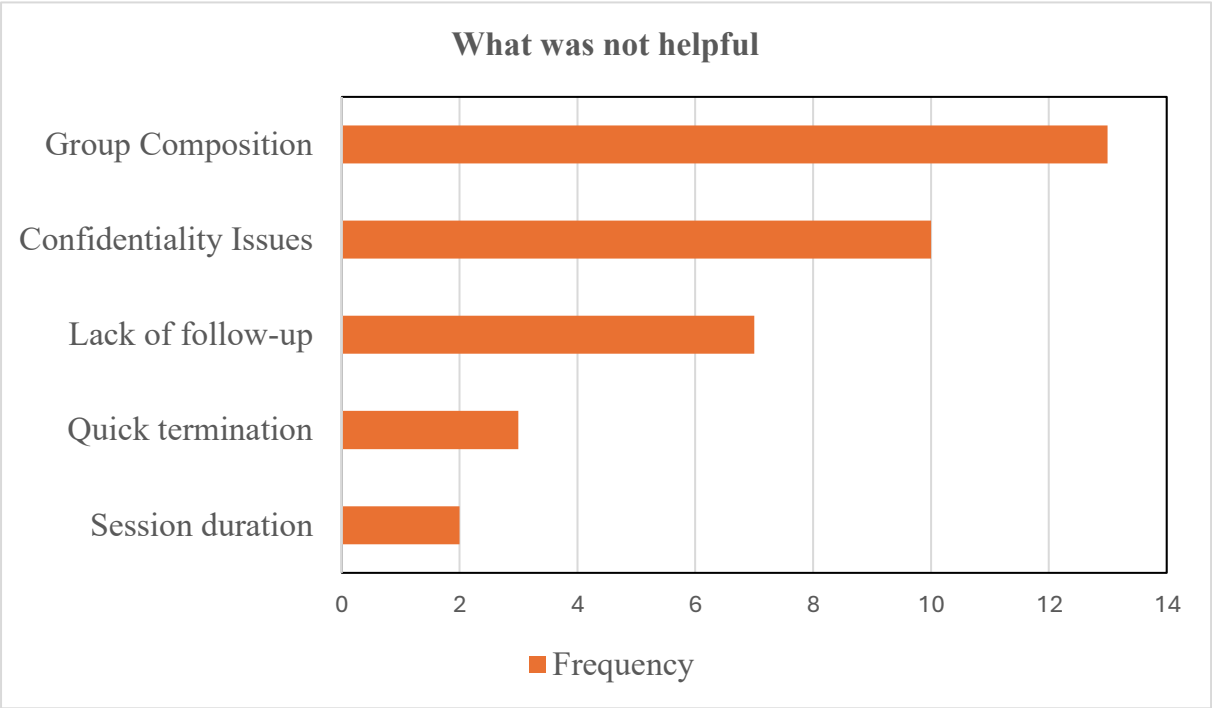

Figure 2 • Factors that were not helpful in IPT-G.

3.3.1. Group composition

Some participants expressed concern about the formation of groups that overlooked aspects such as age. Older women felt uncomfortable around younger women, and some found the reactions of young people offensive when the older ones shared their struggles.

> *"The problem was that we had young girls in the group, and whenever people of our age shared problems, they would laugh. So, we decided to make a group of our age mates where we would share our problems, and we left young girls in theirs." (40-year-old-female)*

3.3.2. Adherence to confidentiality demands

Sharing personal experiences in a group led to unexpected challenges. Although facilitators emphasized confidentiality, some participants shared personal details outside the group, leading to gossip in the village. This impacted those who had shared deep secrets.

> *"Telling other people about our secrets, there is one I confronted for gossiping about our problems, and she left and did not finish the program." (39-year-old-female)*

3.3.3. Lack of follow-up

Participant responses expressed unmet expectations about follow-up. Many thought the program was ongoing and assumed the implementers would regularly check in to track progress, which never happened.

> *"Rather than the fact that you take long to come back to talk to us, the rest of the program is good the way it is. Imagine we forgot about what you taught us because it has been long." (39-year-old-female)*

3.3.4. Quick termination

A contentious finding was that, although reducing the number of sessions has often been discussed to improve IPT-G uptake, some participants in this study still wanted the program to continue beyond the prescribed number of sessions, citing that continued attendance had become slowly normalized and was important to them.

> *"To repeat it, as you know, when you give birth to a child, they have to first crawl, sit, and stand. So, we still needed to continue with therapy, but it all ended" (22-year-old-female)*

> *"We were getting used to it. At least you could look forward to Saturday, knowing you were going to meet your people and discuss the problems. However, we were told it's over, and this was not good. We had gotten used to" (36-year-old-female)*

3.3.5. Session duration

Some participants felt the sessions were too short and, as a result, they never had enough time to fully experience the program. The limited session time was mainly due to some people arriving late after tending their gardens, while others took too long when given the chance to speak.

> *"There are times when we studied and needed clarification or discussion according to our challenges, but the scheduled time wasn't enough, and yet we were very many" (39-year-old female)*

"I wish we could have long sessions, but because of the limited time, we studied for 2 h, yet we would have sat for 3–4 h. Late coming and people talking too much also affected us" (40-year-old-female)

4. Discussion

In this study, we worked with clients living in a rural area of a low-income country who received treatment for depression using Group Interpersonal Therapy to understand which specific aspects of the treatment process supported their recovery. We also broadened our focus to explore the changes they experienced, which they viewed as signs of healing, and what they felt did not work well during the treatment. This study amplified participants' voices and provided important insights for mental health organizations, practitioners, and researchers considering IPT-G as a treatment option.

Although several studies have assessed the acceptability and feasibility of IPT-G in low-resource settings, the effects of the treatment from clients' perspectives have not been thoroughly examined. In this study, we interviewed 33 participants in a six-week version of the method, offering potentially useful insights for mental health organizations, practitioners, and researchers considering the use of IPT-G in similar settings. The study reports which change participants viewed as signs of healing, as well as which factors appeared to mitigate against achieving success.

The first key result is that attending IPT-G generates an important comparison effect. Participants tend to evaluate the severity of their depression-related issues in relation to the reports of other group members. Thus, they experience relief when they realize their problems are less severe than those of others. This accords with social comparison theory, which indicates that people naturally compare themselves to others they view as similar in both positive and negative situations [30]. It also accords with Yalom's list of therapeutic factors in group work, particularly his emphasis on how groups foster a sense of universality and combat feelings of loneliness [31]. Conversely, the findings also offer a different perspective from the literature, highlighting that the main components of group treatments are shared understanding and collective empathy [32]. Nonetheless, contextual factors shape how people relate to and interpret psychotherapy.

Findings also showed that participating in IPT-G increases mastery of thought-modification and suppression techniques, which contribute to the healing process. Since depression involves experiencing prolonged negative thoughts, learning how to change such thoughts can provide a new life perspective. In this study, participants may have benefited from reconnecting with their unwanted thoughts in a safe environment, exploring them with curiosity, and cognitively defusing them from previously fused negative ideation. In a study exploring psychological changes during therapy, altering dysfunctional thoughts and attitudes was linked to a reduction in depression, and the authors concluded that psychotherapy that modifies negative thoughts can lower depression symptoms [32]. While thought modification may not fully capture the emotional processing component often identified as a goal of IPT-G [20], it closely aligns with this component and may be a step people in low-resource settings use to process extreme life events and move past them.

The findings further highlight the importance of the group in providing a space for participants to share challenges, discuss potential solutions to problems, and build interpersonal relationships—again, a potential antidote to loneliness. The literature supports this outcome since group support and relationship building are considered core objectives of IPT-G. Yalom's work also suggests that groups encourage information sharing and imitative behaviors that help participants solve problems [31]. Socialization and relationship development—important contributors to healing for some participants—were perhaps more easily achieved in the current setting because African communities highly value social cohesion. Communities in African countries typically feature interdependence and collectivism [33].

The prominent indicators of healing in this study were a reduction in suicidal thoughts and an improvement in sleep quality. Evidently, discussing problems in a group helped individuals cope with their challenges and find solutions. These life changes resulted in less suicidal ideation and better sleep patterns. Although the literature showing a straight path connecting IPT-G to suicide is scant, some studies have shown that IPT (used at the individual level) can reduce suicide ideation independent of its effect on depression [34]. Thus, we can assume this effect persists with group IPT. Furthermore, literature that connects an indirect path has shown that therapies that treat depression can change suicidal behaviors and also improve sleep quality [35].

Finally, group composition proved to be an important consideration in determining outcomes. Older participants felt uncomfortable being paired with younger ones. The disrespect they experienced from younger members hampered their ability to express themselves and contribute fully. Some reported being laughed at by the younger group members. In Africa, age differences are significant in social interactions. Thus, as the literature indicates, cultural factors, such as age, need to be taken into account when planning group treatments [27, 36].

4.1. Strengths and limitations of the study

The study had several strengths. First, collecting data from participants allowed us to obtain firsthand information from program beneficiaries. Second, gathering perspectives from 33 participants allowed us to capture a diverse range of ideas and viewpoints.

The study had several limitations. First, we recruited participants who had attended IPT-G sessions between 2022 and 2024; therefore, due to the passage of time, some may have forgotten parts of the treatment experience. However, including both older and more recent participants would have offset that imbalance. Second, we received limited feedback from men, as 91% of participants were female. Men and women may have experienced the treatment differently. Nonetheless, this demographic is in accord with the fact that women tend to participate more than men in such group treatments.

5. Conclusions

Understanding the relevant components of IPT-G from the perspectives of depressed clients from underserved communities offers a starting point for improving treatment formats. Since treatment load has often been a significant challenge in scaling

group psychotherapy, understanding what contributes to change can help design interventions that maximize rapid change. This study has shown that factors such as social comparison, group support, and thought modification are key ingredients in promoting healing in IPT-G. Additionally, while trigger concordance has been considered the main factor in group formation for IPT-G (i.e., grouping participants with similar depression triggers), this study indicates that age should also be considered. Older individuals should be placed in separate groups from younger ones to boost their confidence and encourage open sharing.

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Author contributions

Conceptualization, K.M. and E.K.; methodology, E.A. and M.M.B.; formal analysis, K.M. and H.M.M.; investigation, J.M. and G.M.N.; data curation, G.M.N.; writing—original draft preparation, K.M. and H.M.M.; writing—review and editing, M.M.B.; supervision, R.K.; project administration, K.M. All authors have read and agreed to the published version of the manuscript.

Conflict of interest

The authors declare that they have no competing interests.

Data availability statement

The data supporting the findings of this publication can be made available upon request.

Institutional review board statement

The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Ethics Committee of Makerere University School of Health Sciences (protocol code MAKSHSREC: 2022-364 approved on 2024 Aug 15).

Informed consent statement

Informed consent for participation was obtained from all subjects involved in the study.

Supplementary materials

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