TECHNICAL REPORT

COLLABORATIVE PILOT PROGRAM BETWEEN VIDA PLENA FOUNDATION AND THE SECRETARY OF HEALTH TO IMPLEMENT COMMUNITY-BASED SUPPORT GROUPS

Executive Summary

This report presents the results of the collaborative pilot program between Vida Plena Foundation and Quito´s Secretary of Health, which implemented Interpersonal Therapy (g-IPT) in community settings between September 2024 and April 2025. The foundation trained **nine community psychologists** in this intervention model, **recommended by the World Health Organization** as an effective treatment for depression. The program reached 148 **participants,** with an average of 5**.41 group sessions attended,** out of a maximum of eight. An **average reduction in depression symptoms** was observed**, from 11.4 to 2.62,** as measured by the **PHQ-9,** a validated scale that assesses the intensity of depressive symptoms. An improvement of 5 **points is already considered clinically significant, and** the results show a highly positive impact.

The group therapy model proved to be an effective, accessible, and scalable tool for improving emotional well-being in vulnerable communities.

1. Background

The Quito City Council's government program proposes prioritizing local policies to strengthen health, including: "Implementing post-COVID mental health programs focused on suicide prevention," one of its areas of action is service. To comply with this policy by 2023, the Quito Municipal Health Secretariat is developing, as one of its milestones, the "***Mental Health and Suicide Prevention Strategy***," whose objective was to implement actions for the promotion, prevention, care, and community management of mental health from a human rights perspective, promoting a comprehensive and community-based care model that favors recovery and social inclusion to improve the approach to mental health issues, with an emphasis on suicide prevention among the population of the DMQ.

Article 569.9 of the municipal code states that the "Health Secretariat shall coordinate with all municipal government and non-governmental agencies and academia, based on the guidelines issued by the National Health Authority, to promote plans, programs, and projects that contribute to the promotion, prevention, care, and community management of mental health in the Metropolitan District of Quito." (Quito Metropolitan Council, 2024)

Within the framework of the inter-institutional agreements and coordination established in August 2024, a collaborative pilot project was launched between the Quito Municipal Health Secretariat and the Fundación Vida Plena. The main objective of this initiative was to strengthen community-based approaches to psychological distress by incorporating Interpersonal Therapy (IPT-G) as an operational tool and key intervention in community settings.

The Fundación Vida Plena is a US organization that began its activities in 2022 and is legally recognized as a non-profit entity by the Ministry of Economic and Social Inclusion. Its main mission is to provide evidence-based treatment for depression to refugee communities and Ecuadorians in situations of vulnerability or social exclusion. To this end, it implements a highly scalable model of care: Group Interpersonal Therapy (GIP), a methodology backed by scientific evidence and recommended by the WHO.

During 2024, the Fundación Vida Plena and the Ministry of Health held technical coordination meetings to establish collaborative support for the implementation of a pilot program of community-based support groups based on the TIP-G methodology. As part of the initial process, in August 2024, nine

community psychologists were trained in the TIP-G model. Once the training was completed, the professionals implemented therapeutic groups based on this model in various areas of the Metropolitan District of Quito. This implementation was accompanied by complementary processes aimed at monitoring, supervising, and following up with participants to ensure the quality of the intervention and its adaptation to the community context.

2. Objective

To report on the results of the collaborative pilot project developed between the Ministry of Health and the Fundación Vida Plena, aimed at implementing support groups in community contexts during the period from September 2024 to April 2025.

3. Pilot methodology

The methodology proposed three stages for implementation: training for psychologists (skills development), implementation (following the phases in Figure 1), and dissemination of results.

3.1. Training process

The training process was carried out by Fundación Vida Plena for nine psychologists (six women and three men) from the Ministry of Health. It lasted two weeks, with half-day sessions in person, for a total of 36 hours.

At the end, all participants took a knowledge assessment, which was satisfactorily approved by the group, and obtained adequate scores (70% or more correct answers). The content of the capacity-building sessions covered the following topics:

- Ability to conduct group therapy sessions effectively, following the principles and techniques of the g-IPT model
- Ability to create a safe and supportive environment in the group, fostering trust and participation among members.
- Ability to facilitate the therapeutic change process in participants, helping them identify their dysfunctional thought and behavior patterns and develop strategies to address them in a healthier way.
- Ability to assess participants' progress and adapt interventions as necessary.

3.2. Implementation process

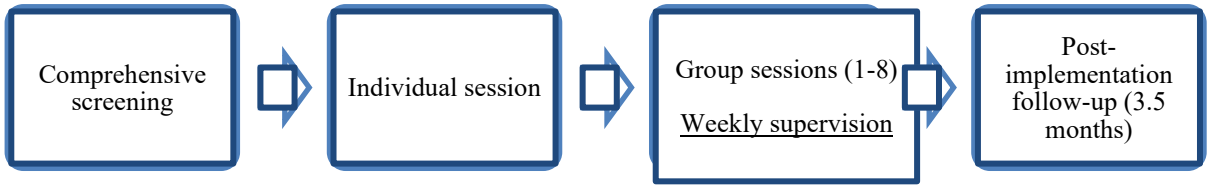
Within the framework of the 2024 Community Mental Health Strategy, each assigned psychology professional carried out interventions in prioritized parishes in the Metropolitan District of Quito (DMQ), selected based on technical criteria such as the 2023 Urban Health Index and the epidemiological profile of suicide, following the guidelines for Community Mental Health Management 2024. As part of the process, the professionals prepared a situational analysis, formulated intervention plans, and implemented actions with a participatory approach in the community.

With this in mind, each psychologist carried out activities in their assigned parishes. As part of the TIP-G support group pilot process, a goal was set for each trained psychologist to form three support groups.

The groups identified for the pilot program are: independent merchants, women, neighborhood leaders, mothers participating in the CNH project, older adults, members of the LGTBI community, a group of coach drivers, and dockworkers, among others.

The implementation and management of these groups followed a previously defined plan, which includes monitoring and technical supervision activities by the technical teams of Vida Plena and the Ministry of Health, as detailed below:

Graph 1. Support group pilot program outline



1. **Comprehensive screening**: This allows for the identification of individuals with psychological distress and at risk of substance use in the defined population, serving as a preventive tool within the Community Mental Health approach. Its application represents a starting point for the development of specific activities according to the level of distress identified, classified into three categories: low, medium, and high.

   Identification is carried out using the following tools: Okasha Scale (suicide risk), DASS Scale (anxiety and depression), and ASSIST Scale (problematic substance use).

2. **Initial individual session:** Aimed at determining problem areas, linking the identified problem to time and events, and determining life satisfaction (SWLS Scale).

3. **Structured group sessions (1-8)** (maximum of 8 participants per group): based on the TIP-G model, with content and objectives defined for each session. For each session, each participant completes the PHQ-9 test to assess depressive symptoms.

   Weekly supervision: by the technical teams of Vida Plena and the Ministry of Health through technical support, case follow-up and analysis, information recording, and time optimization. These spaces are part of the g-IPT methodological approach, which allowed the psychologist to provide technical support during the intervention and ensure the quality of the therapeutic process.

4. **Follow-up**: Follow-up sessions are established to monitor emotional status and are conducted three and six months after the last assisted session. Given the timing of this report and considering that the last group was completed in April, these results will not be included in this report.

The process was documented using the Kobo Toolbox information collection system. The screening forms, initial interview, group sessions, and follow-up were administered by the psychologists in print form, and the data was subsequently digitized by the professionals on the established platform.

4. Sharing of results

The results obtained during the pilot study are presented below, considering the population treated with g-IPT, the number of sessions attended, and the scores obtained on the depression, anxiety, and life satisfaction scales before and after the intervention, including variations in distress per session and the systematization of experiences.

4.1. Variable 1- Population treated with TIP-G

This variable allows us to measure the coverage achieved by the Interpersonal Therapy (g-IPT) processes and the scope achieved by the team of psychologists during the implementation period. For the purposes of this analysis, the population served is considered to be any person who has participated in at least one group session.

A key distinction is made within the care flow:

- 214 people were identified in the comprehensive screening and continued to the individual interview phase.
- Of these, 148 people (69%) participated in at least one group session.
- There is qualitative evidence that at least five groups that began the process were suspended before session eight, the most important reason for their withdrawal being the prioritization of work activities (mostly informal trade) over mental health care, considering that this is their main means of subsistence.

The analysis of the results focuses on 148 participants who actually participated in the group intervention, organized into 21 groups, in which 161 group sessions were conducted. The territorial distribution of these groups covered three areas of the district: north (9 groups), center (6 groups), and south (6 groups), as shown in Table 1.

In addition, the data collected, as well as the experiences reported by the operational teams, allow us to identify a relationship between continuity and adherence to the g-IPT therapeutic process among the already established groups (captive) and those that were specifically formed for the intervention (organized), with greater challenges arising in the call for participants, as detailed in Table 1.

Table1 . Summary of group sessions and population served by professionals

Professional	Sector	Sector	Group characterization	Groups	Effective group sessions	Population served
A.C.	North	Bellavista	Organized	General population that uses the services of Casa Somos Bellavista	8	2
	North	San Isidro del Inca	Captive	General population responding to a call from the neighborhood leader	8	
	North	Iñaquito	Captive	Captive population in the workplace.	8	
A.J.	North	Calderón	Captive	SIS users who care for people without autonomy - Casa Somos Carapungo	8	2
	North	Calderón	Organized	Relatives of SIS users and entrepreneurs from the Calderón administration	7	
	North	Iñaquito	Captive	Captive population in the workplace.	8	
D.B.	North	Lower basket	Organized	Women neighborhood leaders, mothers from the CNH project, and the community at large	8	2

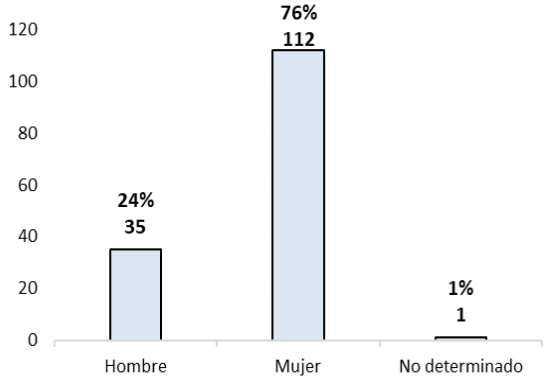
	North	Carcelén Alto	Organized	Older women, mothers participating in the CNH project, members of the LGTBI community	8	
	North	Iñaquito	Captive	Captive population in the workplace.	8	
C.A	Center	Check	Captive	Senior citizens' group	8	10
	Center	Tababela	Captive	Senior citizens' group	8	
J.G.	Center	Cumbaya	Cautivo	Senior citizens' group from the Corazones Solidarios Foundation	8	2
	Center	Cumbaya	Cautivo	Senior citizens' group from the Corazones Solidarios Foundation	8	
	Downtown	Tababela	Cautivo	Senior citizens' group in Tababela	8	
S.O.	Centro	Commander	Captive	Captive population in the workplace.	8	9
D.J.	South	Santospamba	Captive	Senior citizens' group	8	7
	South	Santospamba	Organized	Caregivers for people with disabilities	2	
G.S.	South	Quitumbe	Captive	Group of coach drivers, stevedores, and small traders at the Quitumbe Bus Terminal	8	2
	South	Quitumbe	Captive	Group of coach drivers, dockworkers, and small traders at the Quitumbe Bus Terminal	8	
	South	Aymesa	Captive	Group of senior citizens	8	
K.S.	South	San Bartolo	Captive	Municipal Dining Hall Population IESSFUT	8	5
Total					**161**	**14**

Source: Own elaboration

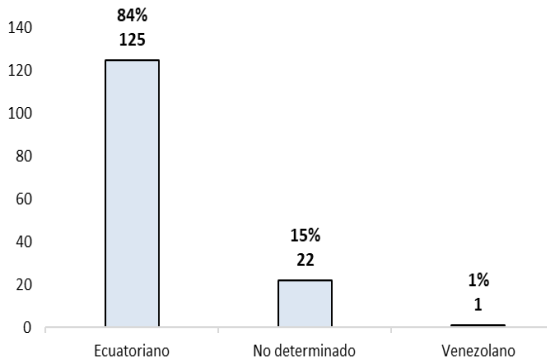
Among the participants (148), the majority are women (112) (Graph 1), of Ecuadorian nationality (125) (Graph 2), with a secondary education level or lower (19) (Graph 3), and employed (65) (Graph 4). The average age is 48.1, and the majority are of mixed ethnicity.

1 . Distribution of participants by gender

2 . Distribution of participants by nationality

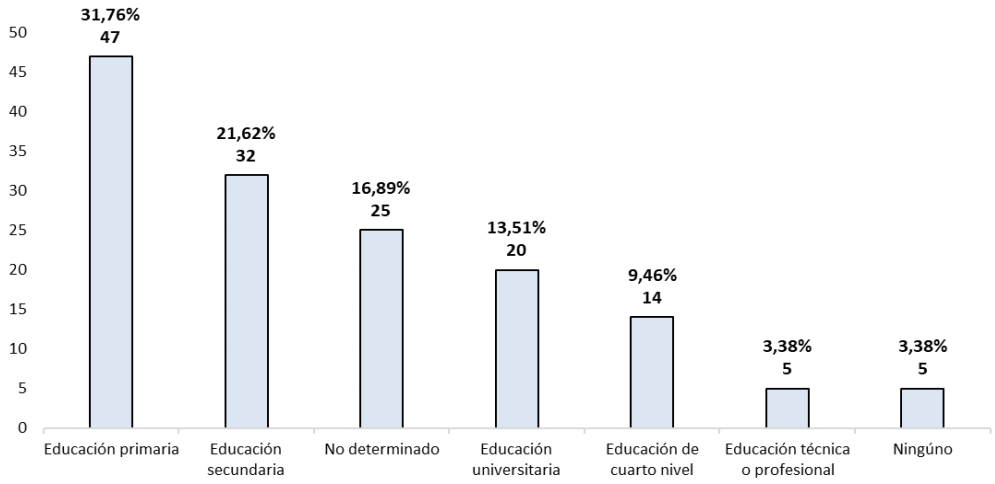


Source: Own elaboration



Source: Prepared by the author

Graph**3** . Distribution of participants by educational level

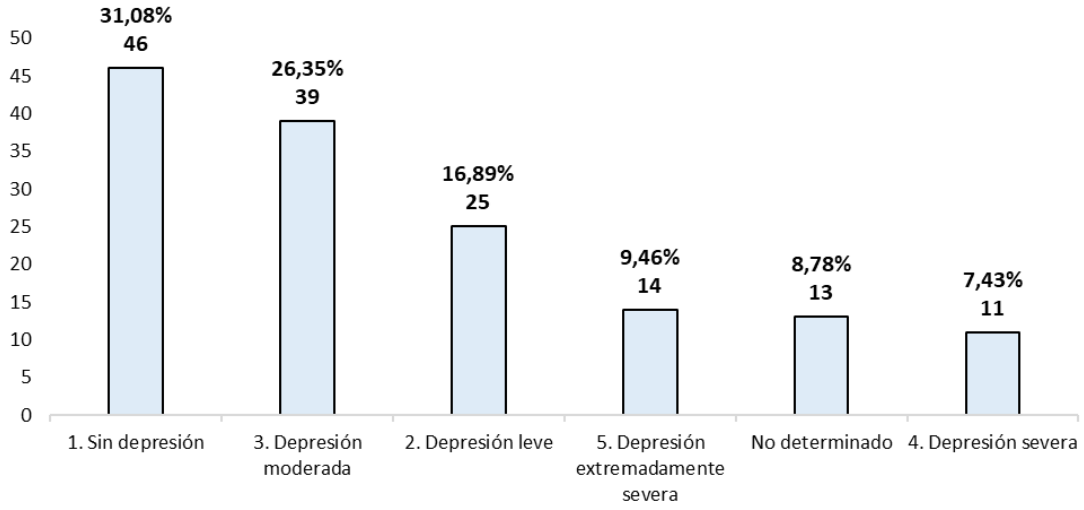


Source: Prepared by the authors

With regard to symptoms of depression, participants at the beginning of the process were categorized according to the DASS depression subscale applied in the screening and the PHQ-9 scale applied during the group sessions. The latter will be explained in detail in the following section of Graphs 10 and 11.

The depression subscale results for participants show that the majority are concentrated in the categories of no depression (46), mild depression (25), and moderate depression (39), while a much smaller number are in the categories of severe depression (11) and extremely severe depression (14).

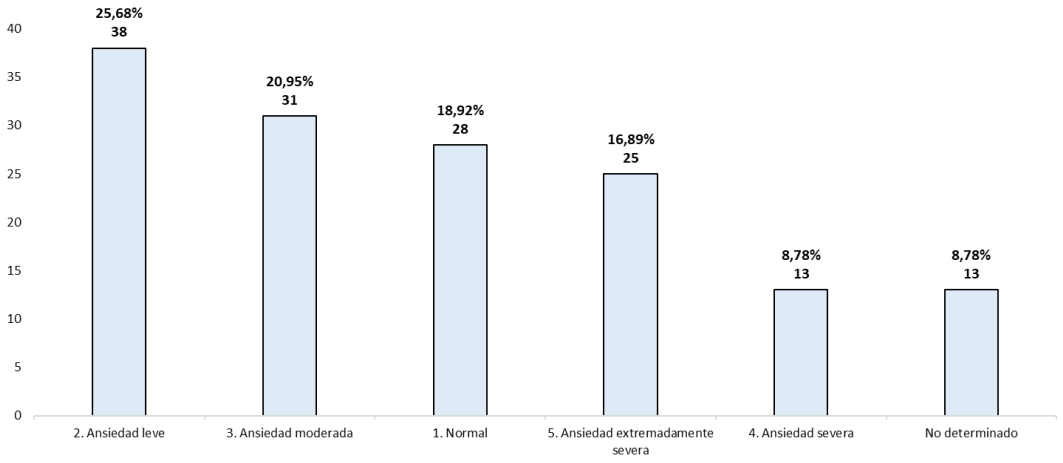
Graph4 . Distribution of participants by initial depression score, in screening.



Source: Own elaboration

Similarly, with regard to the anxiety subscale of the DASS Scale in the screening, a majority were identified in the categories of mild anxiety (38), moderate anxiety (31), and no anxiety (28), while a smaller number were in the categories of severe anxiety (13) and extremely severe anxiety (25).

5 . Distribution of participants by initial anxiety score in screening.



Source: Own elaboration

In general, it can be established that most of the categories identified in the screening correspond to discomfort ranging from normal to moderate.

The category "Not determined" in Figures 5 and 6 describes people who do not have the initial results of the anxiety and depression subscales, totaling 13 people.

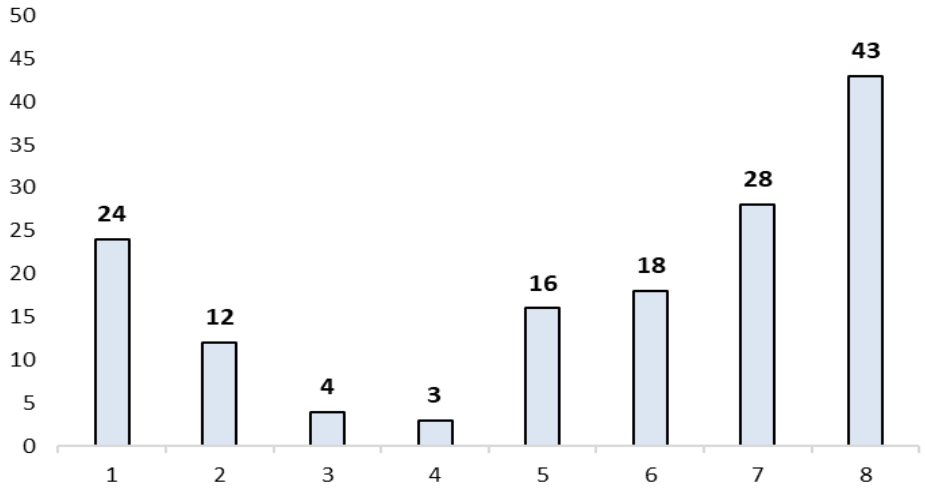
4.2. Variable 2 - Number of sessions attended

The analysis of the results shows that the average number of sessions attended per participant was 5.41, with a standard deviation of 2.61, reflecting moderate variability in retention levels throughout the group intervention cycle.

The minimum attendance recorded was 1 session (24 people), while the maximum was 8 sessions (43 people), which corresponds to the total planned for the intervention cycle.

Likewise, it was observed that the majority (73%) attended 4 or more sessions, completing at least half of the planned therapeutic course. On the other hand, there was also a smaller number of people who attended only one or two sessions (24 and 12 people, respectively), indicating that a significant proportion attended up to two sessions.

6 . Number of sessions attended per participant



Source: Own elaboration

Looking at the number of attendees per week (Graph 7), there is a drop in attendance during the first four sessions and a stabilization from that point on. Thus, there were 121 to 97 (-24, -19.8%). From session 4 onwards, the flow of participants per session stabilized between (97 to 88), with a participant retention rate of 74% compared to the initial group.

This suggests that the risk of dropout is concentrated in the first three sessions and that, once this "adaptation phase" has been overcome, greater adherence and commitment can be expected.

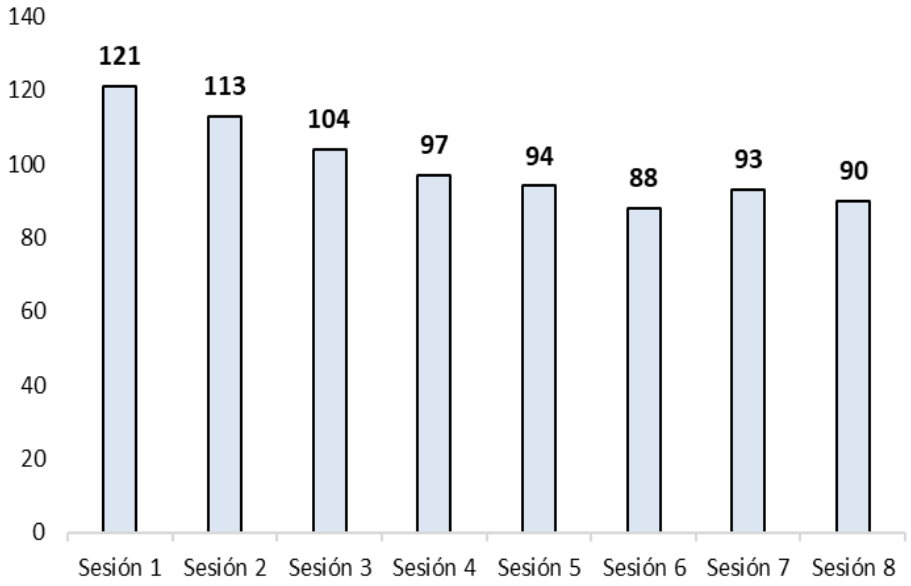
Likewise, this dropout rate may reflect several phenomena that have been highlighted by some authors, as detailed below:

- Difficulty adapting to group processes and preference for individual factors (Sedgwick & Hardy, 2021) .
- The group care modality implies that there is social commitment and interaction between group members. Considering this, people with poor social skills may experience discomfort in this process. (Sedgwick & Hardy, 2021)
- Authors point out that the importance of an adequate therapeutic relationship may explain adherence to the process, as well as the establishment of strict definitions of dropout (Linardon & Fitzsimmons, 2018; Mundorf & Arti, 2018).
- One study indicates that dropout from group therapy is associated with low educational attainment, unemployment, and perceived lack of social support (Elin & Mg Rovik, 2023) .

- Lack of incentives for attendance (Ottile Sedgwick, 2021) identified that participant adherence improves when they receive some form of incentive.

In addition, it can be established that participants may experience a period of adjustment in terms of their schedules and routines, and that dropouts correspond to people who do not adapt to the group's schedule, despite the fact that the location is determined with the group prior to the start of the program. In any case, attendance figures between weeks four and eight show that it is possible to consolidate a group that attends until the end of the program (session eight).

7 . Participant attendance by session



Source: Own elaboration

Looking at attendance according to initial depression level (PHQ-9), there is a greater correlation between symptom severity and attendance at the TIP-G process. The group with severe depression showed higher attendance, with an average of 6.52 sessions and a standard deviation of 2.31, indicating more sustained and consistent participation.

On the other hand, participants with depression levels between minimal and moderately severe had very similar attendance averages, ranging from 5.14 to 5.25 sessions, with higher standard deviations (between 2.46 and 2.88), indicating a dispersion in attendance patterns.

Table2 . Average attendance by PHQ 9 category and standard deviation from first session

PhQ Category 9 - First session	**Average attendance**	**Standard deviation**
1. Minimal depression	5.1	2.6
2. Mild depression	5.25	2
3. Moderate depression	5.	2

4. Moderately severe depression	5.	2
5. Severe depression	6.52	2

Source: Own elaboration

Table 2 describes a relevant finding. Participants with more severe depressive symptoms (severe depression category) show higher adherence, with an average attendance of 6.52 sessions, suggesting a higher level of therapeutic commitment possibly associated with a greater perceived need for care.

In contrast, participants with mild to moderate levels of depression show lower average attendance (between 5.14 and 5.25 sessions), accompanied by greater dispersion (standard deviations between 2.46 and 2.88).

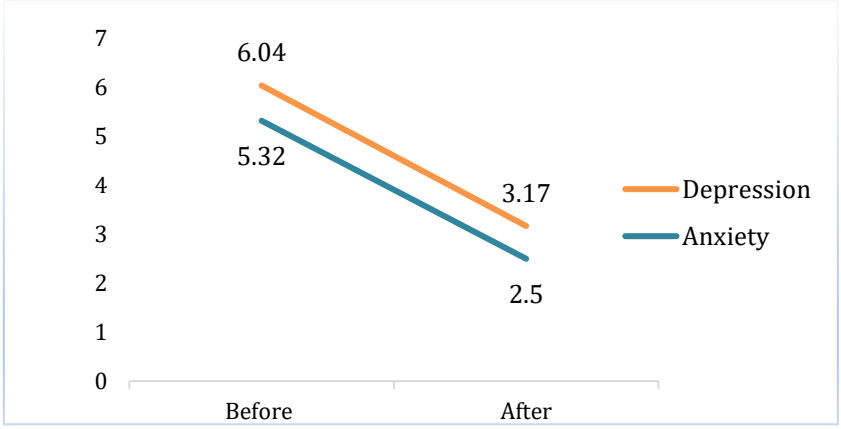
4.3. Variable 3. Depression, anxiety, and life satisfaction scores (pre- and post-intervention)

In order to assess changes in levels of depression, anxiety, and life satisfaction, cases with complete records in all three phases of the process were selected: initial screening, individual interview, and closing form, corresponding to a sample of 75 participants.

Differentiated analyses will be performed: on the one hand, changes in depression and anxiety scores will be evaluated based on the DASS subscales; and on the other hand, changes in life satisfaction levels will be analyzed using the SWLS item. This delimitation is intended to provide comparable results and an equivalent sample between those who have baseline and end records, in order to ensure that the results reflect changes attributable to the TIP-G process.

In Figure 8, in a sample of 75 participants with complete pre- and post-intervention records, a significant reduction in depression and anxiety levels is observed. The average depression score decreased from 6.04 to 3.17, representing a reduction of 2.87 points, and anxiety decreased from 5.32 to 2.5, representing a reduction of 2.82 points.

8 . Average depression and anxiety scores before and after the intervention.

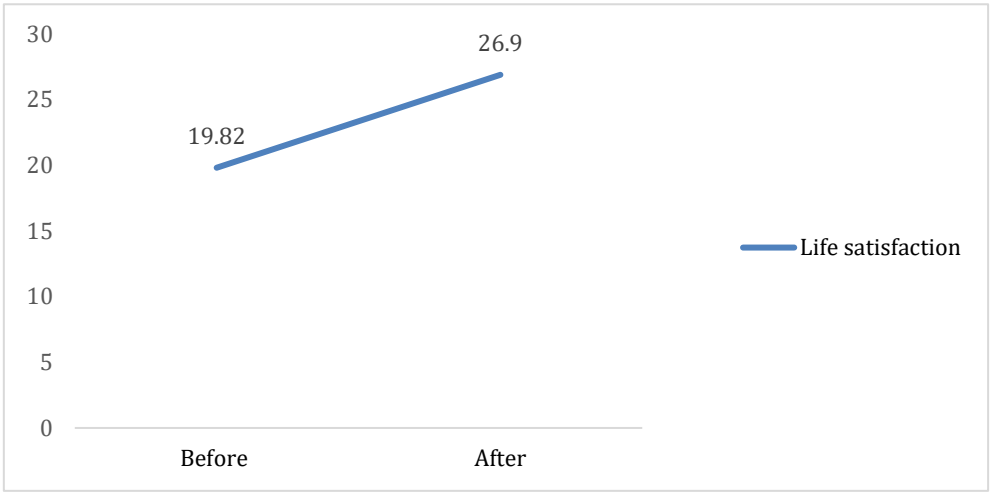


Source: Own elaboration

On the other hand, in relation to the life satisfaction scale, taken from the records of the initial interviews and the closing form with a total of 64 people. The results show an average increase of 7.08 points, from 19.82 before the intervention to 26.90 at the end of the process. This variation reflects a significant

improvement in the participants' overall perception of their lives, suggesting a positive impact of TIP-G, not only in reducing emotional distress but also in strengthening subjective well-being.

9 . Average life satisfaction scores before and after TIP-G

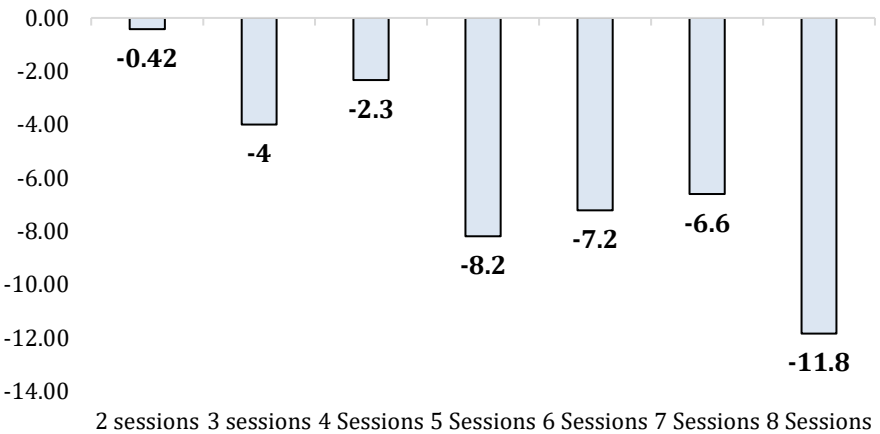


Source: Own elaboration

A key result of the intervention process is the variation in the depression score (PHQ-9) recorded from the first group session attended. To perform a reliable comparative analysis, only cases with two or more measurements of the instrument were considered, i.e., those who attended at least two sessions, comprising a subsample of 124 participants.

The results (Graph 10) show a decrease in the PHQ-9 score in all cases, regardless of the total number of sessions attended. However, significant differences were observed according to the level of adherence: those who attended four or more sessions showed more marked reductions, with variations between –6.61 and –11.84 points, while those with three or fewer sessions recorded more limited decreases, between –0.42 and –4 points. This suggests that the greater the exposure to group treatment, the greater the improvement in depressive symptoms.

10 . Average decrease in PHQ-9 score according to number of group sessions attended.

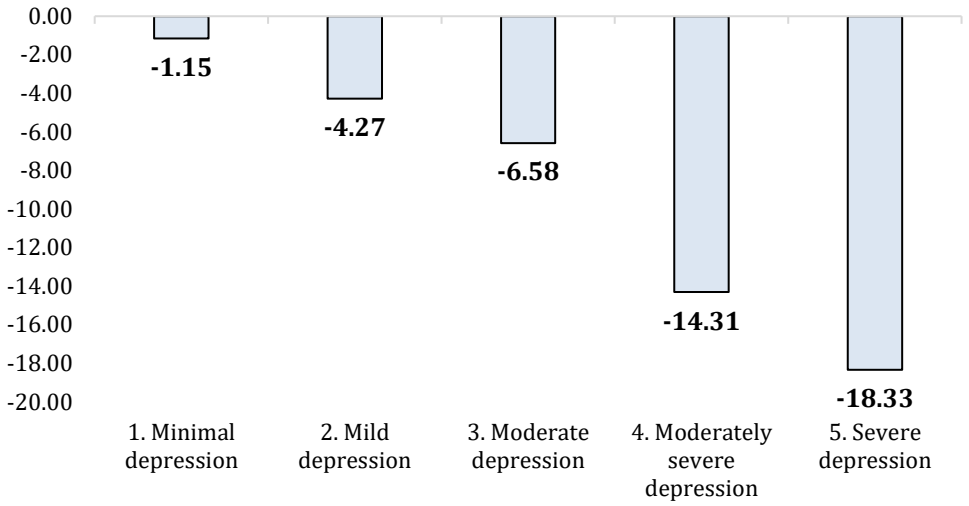


Source: Own elaboration

On the other hand, analysis of the PHQ-9 score according to the initial category of depression (Graph 11) shows an average decrease across all levels of severity, indicating an overall positive effect of the TIP-G intervention. However, a differential pattern in the magnitude of change is identified, with a growing trend in score reduction as initial severity increases.

In the mildest categories (minimal and mild depression), the decrease in scores is relatively moderate, while at higher levels, particularly from moderate to moderately severe, a more pronounced reduction is observed. This suggests that the greater the initial emotional distress, the greater the margin for improvement during the group process.

11 . Final average decrease in PHQ-9 scores according to initial category identified



Source: Own elaboration

4.4. Variable 4. Variations in distress per session

In order to analyze the evolution of emotional distress throughout the intervention process, the variation in the average PHQ-9 score was evaluated by the number of group sessions actually attended (Graph 4), regardless of the order of the sessions. This was done to identify at what point in the process participants experienced changes in their symptoms.

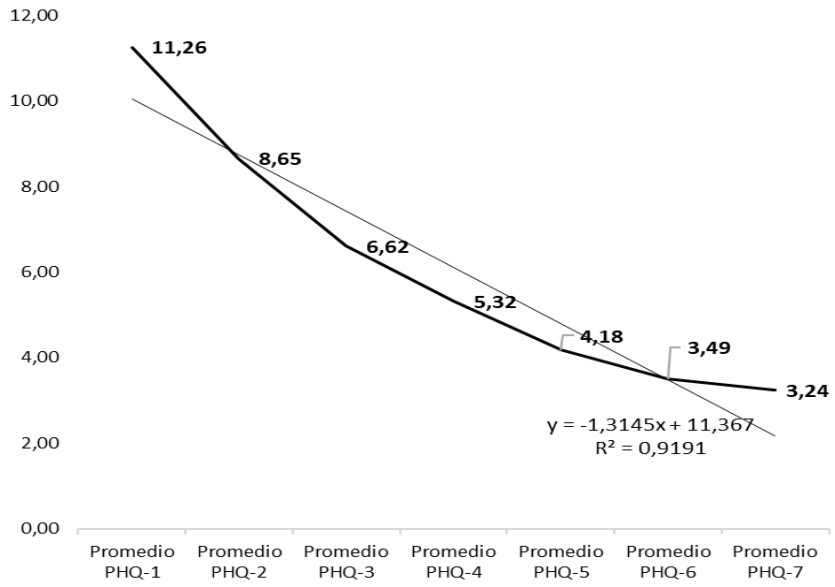
Given that some participants did not attend all sessions continuously, the PHQ-9 scores were reorganized according to their ordinal position in **each participant's** personal trajectory. For example, if a person attended sessions 1, 2, 4, and 7, then they have four PHQ-9 scores that are reordered as first, second, third, and fourth session attended.

The results show a sustained and progressive reduction in the average PHQ-9 score as participants attend more sessions. In the first session attended, the average score was 11.26, while in the last session it dropped to 1.93, representing a cumulative decrease of 9.33 points.

There is a downward pattern with the established sessions, with the most pronounced or evident drop occurring in the first three sessions. It is noteworthy that by session 5, the average PHQ-9 score for participants is already in the minimal depression category according to the scale (0 to 4).

It should be noted that by the fifth session attended, the average score is within the minimal depression range (according to the PHQ-9 categories), suggesting that a significant proportion achieves a significant reduction with at least four sessions.

12 . Analysis of the decrease in PHQ-9 distress per session



Source: Own elaboration

PHQ-9 scores, which reflect symptoms of depression, decrease as the therapeutic group sessions progress. The black line represents the average scores for each session, and the thinner dotted line represents the overall trend: the more sessions participants attend, the lower their emotional distress.

The formula indicates that, on average, scores decrease by 1.31 points per session. In addition, the R^2 value of 0.91 means that this decrease is very consistent, showing improvement per session.

5. Critical issues during the intervention process.

During the implementation of the support groups, critical issues were identified by the psychologists and Fundación Vida Plena, which are described below.

5.1. Critical issues associated with logistics and operations

Long periods of time in the group formation process, due to territorial dynamics, as well as limited availability of the group or the professional accompanying the intervention.

Interruption of the weekly continuity of the sessions due to planned vacations or emerging activities delegated to the psychologists.

Lack of adequate physical spaces that guarantee confidentiality for the optimal development of group sessions, which hindered the regular implementation of the sessions.

5.2. Critical issues associated with comprehensive screening.

The scope of comprehensive screening generates sustained implementation times, considering its comprehensiveness (mental health, substance use, and violence).

In some comprehensive screening processes, a significant number of people were involved.

5.3. Critical issues associated with participant adherence and willingness

Low adherence of certain population profiles despite awareness-raising efforts: 31% of people with individual interview records did not attend group sessions. In the case of market traders, for example, it was found that they prioritize their subsistence work activities, which hinders their sustained participation in therapeutic processes. Despite attempts to restructure and merge groups, low attendance forced some of them to close.

There is greater adherence among captive groups that have been previously consolidated, in contrast to those without this background.

5.4. Critical issues associated with the management of priority care cases

It was reported that, despite immediate referral to the Metropolitan Health Units, some patients with high psychological distress and suicide risk experienced considerable delays before receiving face-to-face care.

6. Recommendations

a) It is advisable to implement Interpersonal Therapy and, at the same time, assess how appropriate its application is in those who are most vulnerable, whose subsistence needs take priority over psychological care.

b) It is suggested that priority be given to comprehensive screening in populations willing to participate in group dynamics. At the same time, it is recommended that the tool be redesigned to create a shorter version.

c) Strengthen awareness and dissemination strategies in the community for group-level intervention and improve adherence to the process.

d) Coordinate with municipal authorities to ensure adequate and accessible physical spaces for the support groups, prioritizing locations that guarantee privacy, comfort, and continuity of the intervention in the different territories.

e) Allocate a specific time during the workday to complete data records. In addition, it is recommended to train staff on the usefulness of data to evaluate the impact of the program and improve the quality of the intervention.

f) Continue technical supervision processes to ensure the quality of the intervention.

7. Conclusions

a) The implementation of the g-IPT model consolidated a territorial intervention process covering the three areas of the Quito Metropolitan District, reaching 148 participants distributed in 21 groups, with a total of 161 effective sessions.

b) The results suggest that captive groups—those that regularly attend a common space to receive some type of social or educational support—have higher levels of adherence.

c) The average attendance of g-IPT groups is 5.41 sessions per participant, with 73% of users attending four or more sessions. In addition, attendance shows a significant initial drop during the first three sessions and then stabilizes with a 74% retention rate.

d) The data show a relationship between the severity of depressive symptoms and adherence to the process: people with severe depression have the highest attendance (average of 6.52

sessions), while those with mild or moderate symptoms show a lower adherence rate (average of 5 sessions).

e) Analysis of pre- and post-intervention scores describes significant clinical improvements in the dimensions, showing an average decrease of 2.87 points in depression and 2.82 in anxiety, according to the DASS scale, reflecting a decrease in emotional distress after participation in the group process. Likewise, life satisfaction increased by 7.08 points, evidencing a strengthening in the perception of well-being.

f) Analysis of the PHQ-9 results applied per session shows a general reduction in depressive symptoms, with participants who attended four or more sessions showing reductions of up to -11.84 points, compared to those who attended three or fewer sessions with reductions between -0.42 and -4 points. Likewise, analysis by initial severity categories indicates a clear pattern: the higher the initial level of distress, the greater the magnitude of change observed.

g) The decrease in distress is concentrated in the first three sessions, and from the fifth session onwards, the average score is already within the range of minimal depression.

h) The process revealed critical issues that must be considered in future implementation phases. These include logistical difficulties, lack of adequate physical space, low adherence among certain population profiles, and the need for better institutional coordination for management, which require priority attention.

i) The experiences of participants who took part in the sessions were collected (Annexes 1, 2, and 3), showing that the process allowed for the development of complex emotional processes such as grief- , despair, and caregiver burden in a safe and empathetic environment.

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Appendices

Annex 1. Qualitative interviews with therapy group participants

INTERVIEW 1

03/19/2025

Name: User 1
Age
Name of facilitator/psychologist in charge of the group: A.J.

When she sought help, it had been only 15 days since her mother's death. At that time, she felt desperate, with deep pain and a strong sense of guilt for not having been able to spend more time with her in her final moments. Sadness, emptiness, and uncertainty led her to seek a space where she could express what she was feeling. At first, she found it difficult to talk about her emotions and, above all, she felt ashamed to expose her thoughts in front of other people. However, from the first session, she decided to give it a try, albeit with some reservations. Little by little, she began to feel more comfortable in the group, and around the third or fourth session, she began to notice that her discomfort was diminishing.

The group became a safe haven for her. She felt welcomed, not only by the facilitator, whose work she deeply values, but also by her peers, with whom she built a relationship of trust and mutual support. During the process, she worked through her grief, allowing herself to express and process her emotions, as well as face other difficulties that arose after the loss of her mother. The family disputes that emerged after her death increased her stress and discomfort, but over time she learned tools to manage the situation and improve communication with her loved ones. This allowed her to strengthen her bonds and cope with her grief in a healthier way.

One of the most significant aspects of the process was the connection she formed with her peers. Although the group has ended, they remain in contact via WhatsApp, where they support each other by sharing images, books, and videos that keep them connected. In addition, she has strengthened her relationship with one of the participants, who introduced her to yoga. This activity has become a fundamental pillar in her life, helping her to significantly reduce anxiety and reconnect with herself in recent months.

Today, although it is still a sensitive subject to talk about her mother, she has learned to remember her with love and longing. She has incorporated various tools learned in the group into her daily life, such as breathing exercises to manage anxiety and planning strategies to organize her time. In addition, she frequently consults the relapse prevention manual developed in the last session, which helps her face moments of greater distress with greater clarity and emotional control.

She feels that her life has changed for the better thanks to the group. Her gratitude toward the facilitator remains intact, and she often sends her messages expressing how important this process was for her. In her own words, she now feels that she has a "fulfilling life," something that seemed impossible to achieve when she first joined the group.

INTERVIEW 2

03/27/2025

Name: User 2
Age: 75
Facilitator: D.B

In February, the support group process came to an end. At the beginning, the participant mentioned that she felt embarrassed talking to other people, as she had the idea that going to a psychologist was something "for crazy people." During the first session, although she did not talk about her personal problems, she felt very comfortable. Over time, she understood that going to therapy is something anyone can do when facing difficulties.

She sought help because, after the death of a close cousin two years ago, she began to experience hopelessness, loneliness, and "desires to die," feeling that she had lost her "meaning in life." As a result, conflicts with her daughter, with whom she lives, became recurrent, and she began to isolate herself completely. For months, she spent most of her time locked in her room, not understanding what was happening to her. She believed it was normal to feel this way and to react irritably toward her daughter. She never imagined that she could change her "character and become more flexible and empathetic toward others."

The support group allowed her to accept the loss of her cousin and change the way she "looked at life." She also discovered that by helping others, she felt helped herself. At the end of the process, she felt that her life had improved in many ways: she began to communicate better with her daughter, got involved in activities for older adults, resumed activities outside the home, and learned to enjoy her own company.

Among the tools she now applies in her life, she highlights the importance of expressing herself without fear, planning uncomfortable conversations, facing problems instead of avoiding them, and analyzing them before reacting. She also emphasizes actively seeking solutions, developing empathy, and accepting others. She mentions that she never imagined she could be mentally flexible in the face of change.

She highlights the group facilitator's teaching approach, empathy, and professionalism, which enabled participants to understand the message through practical exercises. She also values the support of the group with whom she shared the process: *"I felt happy to be listened to by other people. Although I am only in occasional contact with some of them, I appreciate them all and would definitely help them if they needed it."*

Finally, she sums up her experience with this sentence: "*Being in the support groups gave me back the peace and tranquility I deserve, and even the people around me notice it*."

INTERVIEW 3

4/1/2025

Name: User 3
Age: 59
Facilitator: G.S

During the interview, the participant expressed deep gratitude for the support provided. She commented that, on several occasions, she has felt that the assistance for her sector has been insufficient, especially considering that she leads a group of older adults who meet for various activities. However, she emphasized that the spaces provided by the Ministry of Health have been essential in supporting this population.

From the outset, she mentioned that she had high expectations of the support group, as she was going through a difficult situation and needed urgent help. She said that she had been a nurse and caregiver for older adults for 25 years, but in recent years she had taken on the role of caregiver for her mother. This responsibility began to cause emotional conflicts, leading her to experience annoyance, irritability, and little patience with her mother.

At the beginning of the process, she felt "ashamed" to share her story for fear of being judged. However, as the sessions progressed and she saw other people sharing their experiences, she found the "strength" to talk about her situation. She emphasized that the facilitator did an excellent job from the first session by emphasizing the importance of confidentiality, which gave her more confidence to express her discomfort.

Before joining the group, she mentioned that she felt sad, hopeless, upset, and a loss of meaning in life, even thinking that she "wanted to die." Throughout the process, she learned to be more "self-compassionate" and to establish spaces for self-care outside of her work and her role as a caregiver at home. She now feels more patient and recognizes that, although her life is still difficult, she has the resources to cope with the situation with greater peace of mind.

She also highlighted the lessons she learned from other people's experiences, which allowed her to appreciate the human "capacity" to recover and be "resilient." She realized that she was not the only one suffering and that there were even more serious problems than hers.

A significant aspect of her experience is the connection she formed with the group, to the point of considering them family. They are still in touch and participate in community activities to strengthen the social integration of more people. As a final reflection, she shared a phrase that sums up her experience: "*We have come out of the hole, and now we are stronger because we are not alone*."