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Interpersonal Psychotherapy for Lebanese and Syrian Refugees in Lebanon

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OVERVIEW

Lebanon is a small, middle-income country of 6.7 million, with a long history of war and political unrest. It hosts the highest number of refugees per capita worldwide, including 1.5 million registered Syrian refugees and 13,715 refugees of other nationalities.[1] The current context of collective stress and adversity in Lebanon is the culmination of more than 4 decades of continuous hardship and instability. The populations residing in Lebanon withstood a 15-year civil war (1975–1990); a series of bombings and assassinations from 2005 to 2021; the July 2006 war; the impact of the exodus of Syrian refugees (since 2011); the 2020 Beirut port blast[2]; and a spiraling economic crisis exacerbated by the COVID-19 pandemic (2019–present). The United Nations Office for the Coordinator of Humanitarian Affairs stated that 82% of the Lebanese population now lives in what is called multidimensional poverty.[1] The country is currently scoring the lowest minimum wage in the world, and there are immense shortages in basic need services and products, including medicine, fuel, electricity and water cuts.[3]

The chronicity and magnitude of adversities have placed millions of Lebanese at a high risk for depression and post-traumatic stress disorder (PTSD), creating a complex collective trauma.[4]

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MENTAL HEALTH CARE CONTEXT IN LEBANON

Across Lebanon, the treatment gap is largely caused by the low availability of specialized mental health care resources and community-based mental health services.[5] Especially with the influx of displaced Syrians, local communities have been under unprecedented pressure to provide for the massive new and high-need population, overstretching resources and infrastructures already insufficient for the hosting communities. To address these needs, in 2015 the National Mental Health Program at the Ministry of Public Health (MoPH) of Lebanon, led by the psychiatrist Rabih El Chammay, initiated a 5-year mental health strategy (2015–2020), currently extended until 2030, to provide comprehensive, integrated, and responsive mental health services in community-based settings for vulnerable populations.[6] The strategy, which emphasizes human rights and evidence-based, community-centered services, is currently being implemented nationally. It aims to benefit both Lebanese and displaced populations, thus avoiding the creation of parallel systems.

In 2015, as part of the MoPH in collaboration with the Global Mental Health Lab (GMHLab) at Teachers College (TC), Columbia University, set the foundation for a sustainable national capacity-building in interpersonal psychotherapy (IPT) through the implementation of a series of trainings, with the aim of training psychologists working within the humanitarian response service system. Following consultations with Lebanese academic institutions, nongovernment organizations (NGOs), and mental health care practitioners and administrators, the MoPH became keen on adopting and endorsing IPT as the recommended evidence-based treatment for depression for the following reasons: IPT has been recommended as a first-line treatment for depression by the World Health Organization (WHO) *Mental Health Gap Action Program* (*mhGAP*) *Intervention Guide* for mental, neurological, and substance use disorders in nonspecialized health settings[7]; it has been adapted and tested with persons who have undergone severe adversities in a number of low- and middle-income countries (LMICs) in both community and primary care settings and is being disseminated globally by WHO (the digital version of the group IPT manual written by Verdeli, Clougherty, and Weissman has been copyrighted by WHO and translated in 8 languages.[8] Moreover, its focus on grief, life changes, disputes, and loneliness/social isolation were deemed to be particularly well aligned with the core mental health needs of both the displaced and host populations.

APPROACH AND ADAPTATION OF IPT ADOPTION IN LEBANON

A training-of-trainers model was used in Lebanon, largely based on the "apprenticeship model" of psychotherapy training, initially articulated by Verdeli and Clougherty and adopted by other global mental health researchers.[9,10] This 3-tier cascade model involves coordination on 3 levels of training: *providers* with direct

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patient contact without prior exposure to IPT; *supervisors* with previous exposure to IPT; and master trainers with expertise in IPT.

The Lebanese IPT capacity-building project followed a competency-based training model that took place within a continuing education framework. It was implemented over 3 phases and funded by grants that the GMHLab team in collaboration with the MoPH received over the years. The team was systematically tracking provider and patient outcomes. Provider outcomes involved indicators of knowledge (IPT knowledge test); attitudes (attitudes toward evidence-based treatments, qualitative feedback on trainees' perceptions of the training); and skills (adherence to and competence in the IPT model). In addition, attendance at the training workshop and supervisions were tracked. Patient outcomes included depression scores and, in the last 2 phases, PTSD and generalized anxiety disorder scores. The patients were Lebanese and Syrian and were referred by NGOs and primary care staff or were self-referred in private practice. For all 3 phases, ethical approval was obtained by TC, Columbia University Institutional Review Board, in the United States and Saint Joseph University Institutional Review Board in Lebanon.

Phase I, in collaboration with the International Medical Corps and funded by the International Development Firm (2016–2017), explored the feasibility of training Lebanese providers in individual IPT. It started with a series of meetings of the GMHLab team with Dr. El Chammay's team from the MoPH, Lebanese academic institutions, the International Medical Corps and other NGOs. Selection criteria of the providers, informed by the discussions in these meetings, were drafted (Lebanese mental health care providers willing to make a 2-year commitment). The training consisted of a 4-day didactic workshop and a 2-day advanced workshop 6 months later (described below), during which proposed adaptations in IPT content and delivery were solidified. Predetermined competency criteria (passing the knowledge test at 75%, 100% attendance in the workshop, and meeting competency in 3 individual IPT cases). In addition, suicide risk assessment and safety planning adapted for contextual relevance were implemented. Provider and patient-level outcomes for all phases are described below.

Phase II, funded by the Grand Challenges Canada Transition-to-Scale grant mechanism (2018–2020) involved the training of a new and larger group of providers as well as supervisors selected by the previous trained providers. In the beginning of this phase, a group of representatives from the MoPH, academia, mental health professional associations, research institutions, and primary care providers and administrators and NGO providers met with the GMHLab. This time, a larger group of 62 candidates applied to be trained in IPT, indicating greater knowledge about and acceptance of IPT among the Lebanese mental health community. A didactic workshop on group IPT was conducted, for which the team followed the same criteria of competency milestones of phase I. For the training of supervisors, additional competency criteria were developed by the GMHLab team. The IPT master trainers (Verdeli and Clougherty) cosupervised the new group of supervisors as they in turn supervised new providers, as the master trainers progressively phased out.[11–13] For phase II, the national VA

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evidence-based psychotherapy dissemination and implementation model was followed, which tracked multilevel indicators (policy, provider, patient outcomes, local systems, and accountability mechanisms) of implementation and adoption in community clinics and primary care settings.[12,14]

For phase III, funded by the Economic and Social Research Council, UK Research and Innovation—R4HC MENA mechanism (2020–2022), a number of the supervisors were trained as trainers.[11,14] In this phase, following the newly established Order for Psychologists in Lebanon, a national initiative for the regulation of the practice was adopted, whereby only licensed clinical psychologists or psychiatrists were eligible for IPT training and certification. Therefore, the selection criteria for trainees in phase III included only licensed mental health professionals. There is increasing evidence on the importance of using a combination of active learning strategies, ongoing supervision, feedback, and coaching in sustaining skill acquisition and promoting adoption of newly learned treatments.[15] Thus, the training program was designed to start with a 4-day IPT didactic workshop where didactics were supplemented by video and live demonstrations, small- and large-group discussions, role plays, and feedback. Weekly 90-minute online supervision sessions were held in groups of 4 to 5 providers, a master trainer, and a supervisor. Approximately 6 months into training (when most providers completed their first or second clinical cases), a 2-day advanced IPT workshop is conducted, serving as both a refresher and collaborative learning platform where providers can hone their IPT skills and have more in-depth clinical discussions as a team. In this model, weekly supervision continues until all providers are deemed competent, dropped out, or withdrawn because they were deemed incompetent in IPT.

In addition to the manual, the IPT toolkit led by the first and second authors of this chapter also served as a guide for providers' ongoing self-evaluation and supervisors' discussion of the providers' progress with their assigned master trainer. Adaptations in both the content and delivery of IPT were implemented across the 3 phases in Lebanon, such as IPT application as a treatment-to-target intervention and its implementation within primary care as part of the collaborative care model. Predetermined criteria for patient-level improvement were defined as response (50% reduction in total baseline score) and/or remission (≤4) in depression scores as assessed on the Patient Health Questionnaire-9. Additional adaptations such as contextualized communication strategies and family engagement techniques are described elsewhere.[12]

RESULTS

Provider level

As part of the capacity-building work, from the series of trainings, we have 15 (phase I), 25 (phase II), 28 (phase III) providers; 9 (phase II) and 9 (phase III) supervisors; and 7 trainers (phase III). Of these, so far, 31 clinicians are certified

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by the International Society of Interpersonal Psychotherapy, with the rest planning for certification in the near future.

Patient level

Systematic tracking of patient-level outcomes was started at phase II. Eighty-eight accessed IPT, and 76 completed IPT, 3 were referred to higher care, and 9 were dropped due to relocation or lost to contact. Of the 88 that accessed, 72 patients (81.8%) met improvement criteria remission or response for depression, 1 patient (1.13%) was referred for higher care, and 3 patients (3.4%) were lost to contact or relocated. The tracking of patient outcomes continued in phase III, and data are being analyzed. Patients across phases II and III also reported significant reductions in PTSD and generalized anxiety symptoms, and these outcomes will be reported elsewhere.[12]

MAJOR BARRIERS AND FACILITATORS OF IMPLEMENTATION

During the IPT capacity-building work in Lebanon, the unending series of hardships and traumatic events had a deep impact on both patients and providers. Specifically, IPT providers who were enrolled in the training were themselves the survivors of several adversities and tragedies. However, the close collaboration with the GMHLab team over the years served as a contributing factor in establishing a nurturing environment and a nourishing network of support to provide stability, safety, and stimulation to the Lebanese community of IPT learners.

Finally, strained by the economic collapse in the country, some of the IPT-certified therapists in Lebanon have sought work opportunities in the gulf area, Europe, and the United States. Despite leaving the country, these therapists have continued offering their support to their home country through their active and close contribution throughout the different phases of the capacity-building work.

NEXT STEPS

Based on the IPT experience, the GMHLab and team and MoPH developed key recommendations for future work in Lebanon: The MoPH in collaboration with the GMHLab plans to link the capacity building of IPT to continuous mental health professional education in collaboration with the Ministry of Education. As a step forward, MoPH plans on integrating IPT within the curricula of post-graduate clinical psychology programs at different public and private universities. As such, these efforts in research and service capacity building through academic programs aim to serve as a canvas for the generation of local researchers and ensure sustained IPT training of future generations of clinical psychologists.

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For strengthening the network and provision of continuing education to IPT practitioners of all levels, trained across the 3 phases, a digital, interactive platform—IPT Learning Collaborative—funded in phase III is currently under development. GMHLab is currently collaborating with University College London in a randomized controlled trial in both Lebanon and Kenya that aims at testing IPT for perinatal depression, through the provision of group IPT to the intervention arm of the study. Currently, several IPT therapists and supervisors are assisting the GMHLab in the dissemination of IPT in other regions worldwide, including in the Middle East/North Africa region, Africa, and Latin America.

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