

The Effectiveness of Integrated Group Therapy on Prolonged Grief Disorder among Internally Displaced Persons: The Case of Shimalacko IDP Center, Northwest Ethiopia

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Abstract

Background: Prolonged grief disorder (PGD) is a debilitating condition that significantly impairs the well-being and functioning of Internally Displaced Persons (IDPs) due to compounded disruptions. Integrated group therapy approaches have shown promise in addressing complex grief reactions, yet their effectiveness remains understudied.

Objective: This study is aimed to evaluate the effectiveness of integrated group therapy in alleviating prolonged grief and depression symptoms among IDPs at the Shimalacko IDP Center in Northwest Ethiopia.

Method: A nonequivalent groups pretest-posttest quasi-experimental design was employed. Participants were divided into treatment and control groups. Pretest and posttest assessments measured changes in grief symptoms using the Prolonged Grief Disorder Scale (PG-13-R) and the Beck Depression Inventory. Data were analyzed using descriptive statistics, independent sample t-tests, and one way ANOVA, Cohen's d was used to measure effect size.

Result: A total of 352 participants (128 male and 224 female) reported various losses, with 9.4% developing prolonged grief symptoms. Over 13% reported symptoms of severe depression. While no significant mean difference was found between male and female participants, One way ANOVA revealed statistically significant differences among demographic variables, including marital status, educational background, and age category ($p < .005$). The effect size for PGD symptoms was large ($d = 1.49$), indicating the intervention's effectiveness and substantial differences between experimental and control groups.

Conclusion This study underscores the urgent need for targeted mental health interventions for internally displaced individuals experiencing prolonged grief. It is crucial for policymakers and humanitarian organizations to integrate grief-focused interventions into care for internally displaced communities to enhance psychological well-being and foster resilience in the face of loss.

Background

Conflict, intercommunal violence, natural disasters, and the impacts of climate change have led to significant displacement in Ethiopia. An estimated 4.2 million individuals are currently internally displaced, with approximately 1.5 million seeking durable solutions for their resettlement (23). Preliminary data from UNHCR/IOM displacement tracking (June–July 2021) indicate that nearly 1.8 million people are displaced across more than 1,220 sites in Ethiopia, with 68% of displacements due to conflict, 19% due to drought, and 6% due to seasonal flooding (24). In response to this crisis, UNHCR reached over 1.7 million individuals across nine regions in 2021 and provided support to over 580,000 IDPs residing in communal settings through camp coordination and management efforts (8).

The Shimalacko IDP Center in the Northern Gondar Zone of the Amhara region is one of the largest collective sites. It houses approximately 3,024 IDPs Predominantly from Tigray and conflict-affected areas of northern Amhara and currently accommodates 2,039 residents from areas including Shire, Mekele, and Axum, many of whom report the loss of loved ones due to intercommunal violence (11, 26). A community-based descriptive cross-sectional study conducted between October 1 and December 15, 2021, highlighted that military invasions and attacks resulted in over 100,000 IDPs in the Debark and Dabat districts (14). Recent conflict reports also document substantial fatalities and injuries (1,229 fatalities and 1,393 injuries during 2018/2019), illustrating the scale of violent loss experienced in affected communities (3).

Experiencing the loss of a loved one under violent circumstances is profoundly traumatic and can interrupt customary mourning processes that support healing. Prolonged Grief Disorder (PGD), now classified in DSM-5-TR and ICD-11, is characterized by persistent, distressing grief reactions lasting beyond culturally expected time frames and causing significant functional impairment. Core symptoms include intense longing for the deceased, preoccupation with memories of the lost person, and clinically significant impairment in daily functioning (2). Evidence indicates that unexpected or violent deaths (e.g., accidents, homicide, suicide) are particularly associated with PGD (26), and that disrupted mourning practices—common in displacement contexts—can exacerbate grief severity and complicate recovery.

In collectivist cultures such as Ethiopia, death and mourning rituals carry substantial social and psychological importance. Oral traditions and expressions—such as "የሕይወት ሕሳብ" (What matters more than losing a loved one is the manner of their passing) and "የሕይወት ሕሳብ" (This prayer suggests that timely deaths, accompanied by traditional rituals, lessen trauma)—underscore the relevance of culturally sanctioned rituals for meaning-making and coping. When individuals are deprived of the opportunity to engage in such practices because of sudden violent loss and displacement, the risk for prolonged and complicated grief reactions increases (17, 21).

Given this context, there is a pressing need to identify effective, culturally appropriate interventions for PGD among internally displaced populations. Integrated Group Therapy (IGT) is a promising approach that blends psychoeducation, cognitive-behavioral techniques, mindfulness, exposure-informed processing, and group support to address complex grief reactions. Research indicates that multicomponent group interventions can reduce prolonged grief symptoms and foster social support and resilience; combined psychosocial and pharmacological approaches have also been effective for comorbid conditions in some populations (12, 16, 20). However, most evidence derives from high-income settings or refugee samples with heterogeneous characteristics, and there is limited empirical work assessing the effectiveness and cultural adaptation of manualized group grief interventions delivered within IDP camps in low-resource, communal settings.

Despite the scale of violent bereavement among displaced Ethiopians and the recent classification of PGD in DSM-5-TR and ICD-11, empirical research on PGD within internally displaced populations in Ethiopia is sparse. Prior studies have largely focused on violent deaths in other contexts or on refugee

populations in high-income countries; few have examined how disrupted mourning rituals in collectivist cultures influence PGD prevalence and presentation among IDPs. Moreover, there is a lack of research on culturally adapted, manualized group interventions for PGD in humanitarian settings that documents translation/adaptation procedures, facilitator training, fidelity monitoring, attendance handling, and feasibility. These gaps limit the ability of practitioners and policymakers to implement evidence-based, contextually appropriate mental health services for bereaved IDPs.

This study aims to address these gaps by evaluating a culturally adapted, manualized Integrated Group Therapy program for individuals at the Shimalacko IDP Center who experienced violent bereavement. Specifically, the study examines the intervention's effect on prolonged grief and depressive symptoms and reports on feasibility and implementation considerations (including translation into Amharic, facilitator training, fidelity monitoring, and attendance management) relevant to humanitarian settings. By focusing on a defined IDP population within a collectivist cultural context and documenting adaptation and delivery processes, the study seeks to contribute actionable evidence for culturally sensitive interventions for PGD among displaced communities. In the present study, we address the following research questions.

1. What is the prevalence of prolonged grief disorder among internally displaced persons at the Shimalacko IDP Center?
2. Is there a statistically significant difference in PGD among demographic variables (gender, age, educational background, and marital status)?
3. Is integrated group therapy effective in treating prolonged grief disorder among internally Displaced persons at Shimalacko IDP center

Method

Research Design approach

This study employed a descriptive cross-sectional survey and a non-equivalent groups pretest-posttest design in succession to assess the prevalence of Prolonged Grief Disorder (PGD) among internally displaced persons (IDPs) in Ethiopia. Participants were screened using the Prolonged Grief Disorder Scale (PG-13-R) and the Beck Depression Inventory to identify those who met the criteria for PGD.

A nonequivalent groups pretest-posttest quasi-experimental design was utilized, as random assignment was not feasible for this vulnerable population. Participants were assigned to experimental and control groups based on their pretest scores, facilitating balanced comparisons of the effectiveness of Integrated Group Therapy (IGT).

This design allows for rigorous evaluation of intervention outcomes by measuring pretest and posttest differences in grief symptoms. Two rationales support this design: firstly, group assignment was based

on pretest scores to ensure comparability, and secondly, ethical considerations permitted participants to maintain their usual social interactions, which may influence outcomes.

Given Ethiopia's collectivist culture, where communal support is integral to well-being, the cultural context will be considered in interpreting the results.

Participants

Setting and target population

The study was conducted at the Shimalacko IDP Center and targeted adult war survivors who had lost family members due to intercommunal conflict.

Sampling and screening

From the center population of 2,039 residents, 352 individuals reported bereavement and were therefore eligible for initial screening. Using convenience sampling to identify bereaved residents and purposive sampling to prioritize those reporting persistent grief, we administered the Prolonged Grief Disorder Scale (PG-13-R) and the Beck Depression Inventory (BDI) as pre-tests. Of the 352 screened, 32 individuals scored above the predefined cutoffs on both instruments.

Selection of study participants and group assignment

From these 32 high-scoring individuals, we applied inclusion and exclusion criteria to select the study sample.

Inclusion criteria include adult residents of the Shimalacko IDP Center (age ≥ 18), loss of one or more close family members due to intercommunal conflict, scores above the cutoff on both the PG-13-R and BDI during screening, Capacity to provide informed consent and attend group sessions. The exclusion criteria are current psychotic symptoms or severe cognitive impairment that would preclude participation, active suicidal intent requiring urgent clinical intervention, current use of psychiatric medication that was initiated or changed within the past 4 weeks, and concurrent participation in other structured psychosocial support programs.

Applying these inclusion and exclusion criteria led to the exclusion of eight of the 32 screened individuals. The remaining 24 participants provided informed consent and were enrolled in the study. They were then assigned to two groups of equal size ($n = 12$ each) for the experimental and control conditions using simple random assignment. This study used a small, focused sample ($n = 24$) for pragmatic and exploratory reasons. Given resource and access constraints at the IDP center and the intensive group-based intervention format, a small sample allowed close monitoring and high-fidelity delivery of the intervention. Although underpowered for detecting small effects in between-group comparisons, the sample size is appropriate for a quasi-experimental investigation intended to evaluate or estimate effect sizes (Cohen's d) to inform sample size calculations for future larger trials.

Measures

The study used established, previously developed and validated instruments: the Beck Depression Inventory (BDI; 21 items) and the Prolonged Grief Disorder scale (PG-13). (28,27) These tools were not developed for the present study. They were administered according to their original scoring procedures, and the instrument sources are cited in the manuscript.

Both instruments were translated into Amharic using forward back translation and reviewed by bilingual experts to ensure linguistic and conceptual equivalence. Although a cognitive pilot was not conducted due to time/resources constraints, we mitigated this by consulting local clinicians and language experts during translation and by reviewing item phrasing for cultural relevance; we also examined instrument reliability α in the study sample. Statistical analyses were conducted using SPSS.

Intervention procedures

The intervention was a manualized integrated grief program designed for humanitarian settings to support individuals experiencing marked distress due to loss. Sixteen 90-minute group therapy sessions were delivered to the 12 experimental participants. The program combined psychoeducation about grief and prolonged grief disorder, behavioral activation, relaxation and somatic processing, emotion-regulation training (grounding, breathing, and distress-tolerance techniques), cognitive coping and restructuring to address maladaptive beliefs, trauma-informed exposure exercises to process loss-related memories, and guided group processing to foster mutual support. Additional components included interpersonal therapy (communication skills), mindfulness-based stress reduction, expressive arts activities, and culturally appropriate commemoration.

Session structure and delivery

Each session followed a standardized format in the manual: preparation, statement of session goals, opening, check-in and recap of previous material, the main therapeutic work (instruction, demonstration, and participant practice), and a structured closing with home-practice assignments. Sessions were facilitated in groups and typically began with a brief participant check-in and review of homework, proceeded to instructor demonstration and participant practice of new skills, and concluded with a summary and assignment of home practice. Facilitators completed fidelity checklists after each session and received weekly clinical supervision to ensure adherence to the manual and to address any implementation issues.

We had 16 sessions with the participants, which starts in Session 1 with an introduction to the course and an emphasis on safety. Next, Session 2 focuses on understanding grief, including prolonged grief disorder (PGD). After that, participants are introduced to cognitive behavioral approaches (CBT) in Session 3, while Session 4 applies CBT techniques specifically to grief through cognitive coping and restructuring. Moving forward, Sessions 5 and 6 explore interpersonal therapy (IPT) and communication skills to support healthier relationships. Then, Session 7 introduces the Gestalt empty-chair technique for unresolved loss. Following this, Sessions 8 and 9 guide participants through mindfulness-based stress reduction, starting with an overview and continuing with mindfulness practices and integration. Session

10 shifts to expressive arts therapy, helping participants process emotions nonverbally. Session 11 then focuses on coping strategies and behavioral activation, and Session 12 strengthens resilience while introducing relapse prevention skills. In Session 13, supportive group activities promote mutual aid, and Session 14 addresses culturally appropriate commemoration and meaning-making. Toward the end, Session 15 reviews progress and helps participants set future goals. Finally, Session 16 offers closure and a farewell.

Data Processing and Analysis

Data was analyzed using SPSS version 25. Descriptive (such as frequency, percentage, mean and standard deviation) and inferential statistics (such as independent t-test and one way ANOVA) were used to analyze the data. Cohen’s d was used to assess effect sizes between the quasi-experimental and control groups pre- and post-intervention. A significance level of $p < 0.05$ was adopted for all comparisons.

Ethical approval and consent to participate

Ethical approval for this study was obtained from the University of Gondar College Research and Ethics Review Committee (Ref. C/S/S/H/R/P0078/08/2016, dated 16 May 2024). Written informed consent to participate was obtained from all participants prior to data collection. Participants were informed about the study objectives, procedures, potential risks and benefits, the voluntary nature of participation, and their right to withdraw at any time without penalty. Measures were also taken to protect participant confidentiality throughout the study.

To promote equity and beneficence, participants in the control group were provided the intervention after the study conclusion.

Table 1: The Socio-Demography Data of Study Participants (N=352)

Demographic Variable			Category	Frequency	Percentage
Gender			Male	128	36.4
			Female	224	63.6
Age category	Mean 32.49	Std. 10.2	≤18(Adolescence)	33	9.4
			19-35(Young Adulthood)	216	61.4
			36-50(Middle Adulthood)	73	20.7
			51-80(Late Adulthood)	30	8.5
marital status			Married	97	27.6
			Single	122	34.7
			Divorced	73	20.7
			Widowed	60	17.0
educational status			read and write	73	20.7
			primary education	138	39.2
			Secondary & higher education	141	40.1
Total				352	100

As shown in table 1 from the 352 participants, 128 were male and 224 females. The mean age was 32.49 years

Table 2: Prevalence of prolonged grief and depression(N=352)

PGD and Depression symptom severity	Frequency	Percent
No Prolonged grief symptoms	319	90.6
Develop Prolonged grief symptoms	33	9.4
Total	352	100
Normal Depression level	41	11.6
Mild Depression Level	150	42.6
Moderate Depression Level	112	31.8
Severe Depression Level	49	13.9
Total	352	100

Table 2 illustrates that 9.4% of participants developed PGD symptoms, with varying levels of depression reported (42.6% Mild, 31.8 Moderate and 13.9 severe depression levels)

Table 3: Independent Samples t-test result of Gender difference in prolonged grief disorder and depression

	Gender	N	Mean	Std. Deviation	t-value	Sig.
sum of Pg-13-r	Male	128	14.61	6.432	-2.526	
	Female	224	16.54	7.175	-2.602	.208
sum of depression	Male	128	19.23	9.378	-3.279	
	Female	224	22.81	10.108	-3.346	.145

Table 3 t-test revealed that there was no statistically significant difference between male and female on both Prolonged grief disorder scores for males (M=14.61, SD=6.432) and females (M=16.54, SD=7.175) and depression males (M=19.23, SD=9.378), and females (M=22.81, SD=9.378), $p \leq 0.05$.

Table 4: One way ANOVA summary result of educational back ground difference, age and marital status in Depression and Prolonged grief Severity

Predictors			Sum of Squares	df	Mean Square	F	Sig.
1.Educational B.G	Change in pg-13-r	BG	1962.769	2	981.385	22.762	.000
		WG	15047.000	349	43.115		
		Total	17009.770	351			
	Result BDI	BG	2598.759	2	1299.380	20.042	.000
		WG	22626.104	349	64.831		
		Total	25224.864	351			
2.Age	Change in pg-13-r	BG	764.550	3	254.850	5.449	.001
		WG	16276.541	348	46.772		
		Total	17041.091	351			
	Result of BDI	BG	1704.087	3	568.029	5.937	.001
		WG	33293.868	348	95.672		
		Total	34997.955	351			
3. Marital status	Result of pg-13-r	BG	2668.655	3	889.552	21.539	.000
		WG	14372.435	348	41.300		
		Total	17041.091	351			
	Result of BDI	BG	6541.692	3	2180.564	26.667	.000
		WG	28456.262	348	81.771		
		Total	34997.955	351			

As shown in Table 4 One-way ANOVA revealed there is statistically significant differences in all the three Predictors at the $p \leq 0.05$ in Prolonged Grief and Depression across educational background, age, and marital status. For educational groups there were significant differences in Prolonged Grief and Depression [$F(2,349) = 22.762$ and 20.042 respectively]. For age categories there were significant differences in Prolonged Grief and Depression, [$F(3,348) = (5.449$ and $5.937)$ respectively]. In addition, significant differences were found for marital status categories in Prolonged Grief and Depression, [$F(3,348) = (21.539$ and $26.667)$, respectively]

Table 5: Effectiveness of group therapy

	group of clints	N	Mean	Std. Deviation	Effect size <i>d</i>	<i>r</i> - value
Change in pg-13-r	Experimental	12	6.83	2.480	2.54	0.78
	Control	12	1.75	1.357		
Change in BDI	Experimental	12	8.75	3.696	1.49	0.59
	Control	12	3.67	3.085		

The above Table 5 shows The effect sizes indicated by Cohen's *d* was (2.54, $r = 0.78$) for prolonged grief symptoms and (1.49, $r = 0.59$) for depression symptoms.

These findings underscore the effectiveness of the integrated group therapy in significantly reducing both prolonged grief and depression symptoms among participants, with effect sizes that reflect the practical significance of the intervention.

Discussion

Descriptive analysis indicated that 42.6% of participants experienced mild depression, while 31.8% and 13.9% exhibited moderate and severe levels, respectively. Notably, 9.4% of participants displayed symptoms of Prolonged Grief Disorder (PGD). These findings align with existing research; for instance, (19) reported a 10% prevalence of PGD among bereaved individuals, while (13) found a prevalence of 7.6% in adults experiencing loss.

(7) noted that 38.1% of refugees reported bereavement, with 15.8% showing probable PGD, highlighting the compounded mental health issues faced by vulnerable populations. Similarly, a study by (1) documented a 12% prevalence of PGD among Saudi university students, indicating its widespread relevance across diverse groups. This consistency emphasizes the universal risk of PGD associated with bereavement and the urgent need for targeted mental health interventions that consider cultural factors.

All 352 participants reported various forms of loss. Specifically, 8.8% lost a spouse, 11.4% lost a child, and 25.6% experienced the death of a parent. These results highlight the profound impact of significant losses on psychological well-being. The loss of a spouse, often linked to severe psychological distress (23), and the loss of a child, which can lead to complicated grief (15), underscore the complex emotional challenges faced by bereaved individuals.

Participants also reported sibling loss (24.1%), grandparent loss (9.4%), and the loss of extended family members, reflecting the pervasive nature of grief within familial relationships. Understanding these diverse experiences is crucial for developing effective support systems for those in mourning.

Independent t-tests revealed no significant differences in PGD and depression symptoms between men and women, challenging conventional assumptions regarding gender-specific grief responses. This aligns with findings from (4), which also reported similar prevalence rates for PGD in displaced populations.

One-way ANOVA indicated significant differences in mental health outcomes across educational levels ($p \leq 0.005$), with lower education correlating with higher levels of PGD and depression. This suggests that educational attainment may act as a protective factor against mental health issues, consistent with (18), who note that higher education enhances coping resources.

One-way ANOVA demonstrated no significant differences in PGD and depression symptoms across age categories. This finding resonates with (10), indicating that younger individuals may experience greater mental health challenges due to disruptions during critical life stages.

Significant differences were found among marital status categories ($p \leq 0.005$), with married individuals exhibiting better mental health outcomes, likely due to enhanced social support. Conversely, single, divorced, or widowed participants may face increased vulnerability to PGD and depression, supporting findings by (22) on the influence of marital status on mental health.

The intervention's impact was assessed using effect size measures, revealing Cohen's d of 2.54 for depression and 1.49 for prolonged grief symptoms, indicating a substantial clinical effect. These findings are consistent with the literature; a meta-analysis by (5) found a mean effect size of 1.32 for PGD, while (9) reported superior outcomes for depression interventions. However, discrepancies in effect sizes among different studies suggest the need for context-specific adaptations in therapeutic approaches.

In conclusion, the findings underscore the need for culturally responsive and tailored interventions for displaced populations. Future research should further explore the dynamics between mental health and demographic variables to refine therapeutic strategies effectively.

Implications

Given the complex emotional experiences of grief, tailored interventions must consider demographic variables and cultural contexts to enhance therapeutic effectiveness.

Conclusions

The significant effect of integrated group therapy on reducing symptoms underscores its potential as a valuable intervention for this population.

Limitations

The study's small sample ($n = 24$) and nonequivalent pretest–posttest design limit statistical power and increase risk of selection bias. Recruitment from a single IDP centre via convenience/purposive sampling restricts generalizability. Although the BDI and PG-13-R were translated into Amharic with forward–back translation and expert review, full local validation was not conducted. Intermittent attendance and reliance on facilitator checklists may have affected fidelity. The control group received the intervention after study completion, and follow-up was limited to the immediate posttreatment period.

Declarations

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Data availability the datasets used and analyzed during the study are available from the first author on reasonable request.

Declarations Ethical approval and consent to participate This study protocol was approved by the Institutional Review Board of the University of Gondar, College of Social Sciences and Humanities- College Research and Ethics Review Committee (Ref. C/S/S/H/R/P0078/08/2016 on May 16, 2024). The study was performed in accordance with the ethical standards of the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. All participants provided their consent to take part in the study. They were also informed of their right to decline to answer any questions that caused discomfort or to take a break whenever needed.

Consent for publication Participants in the study were informed, and they gave their consent for the publication of the study's findings

Competing interests the authors declare no competing interests.

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