“We're not in love with the model”: Cat Lukach and Sean Mayberry of StrongMinds on constant innovation in community-based therapy

Jessica Kantor
October 24, 2025

Jessica Kantor: Can you both please introduce yourselves?

Sean Mayberry: I'm Sean Mayberry, CEO and founder of StrongMinds.

Cat Lukach: I'm Cat Lukach, Chief Development Officer of StrongMinds.

Jessica Kantor: Can you tell me about your work in youth mental health? What makes your work distinctive from others?

Sean Mayberry: StrongMinds, in general, is all about improving the mental health of all people in Africa. We do that by focusing on depression, using a simple form of group talk therapy recommended by the World Health Organization. We treat all ages of individuals from age 12 up.

Our youth program is different from our adult program for obvious reasons, with different kinds of expectations and behaviors on the youth side. The youth forums happen both in and out of school. In the African context, there's a large number of youth who are not in school, hence the in-school and out-of-school approach.

How we treat those two youth demographics is understandably different. In most cases, we're providing those groups in school settings with a lot of our educational programs in the countries where we work. We're in a number of African countries, with large office presences in Uganda and Zambia. We're also in Kenya, Tanzania, and Malawi. Most of the youth work is happening in Uganda and Zambia.

Typically, in the school settings, we're conducting the groups ourselves, but increasingly, we're transitioning leadership of the groups to the teachers themselves. There are no teachers in the out-of-school groups. Typically, none of the StrongMinds groups are run by ourselves, but by community health workers or volunteers who have graduated from

groups and are either independent volunteers, or many times, get rolled into the community health worker cadre. All those volunteers are paid.

Cat Lukach: In addition to our basic group therapy model, another priority of ours is just to increase awareness and prioritization within national health plans. We work through the government as intimate partners throughout the health system. At the national government, we advocate with ministers of health, education, and youth economic development because mental health affects so many different sectors.

We're helping them write policies and integrate these into their own plans, so that it trickles down throughout the system and can be integrated into existing infrastructures. One example of this is our work at the district level so our model can be implemented by the government themselves. We've fully transitioned StrongMinds into no longer delivering this model of group therapy ourselves. We only do it through our government partners. This way we ensure it's a sustainable solution that's completely owned not by us, but by government.

Jessica Kantor: How did you build out your curriculum? You said it's based on the WHO recommendations, but does it go further than that?

Sean Mayberry: Yes. Our form of psychotherapy is called Interpersonal Psychotherapy Group-base, or IPT-G, recommended by the World Health Organization. We've been using that since StrongMinds started work in Africa and Uganda in 2014. The model itself is a bit different on the youth side.

We started the youth programs in 2017 or 2018, mindful that it just makes so much sense to treat depression in an adolescent. Given a choice, would you treat someone who's depressed when they're 15 or when they're 35? Knowing that so many cases of mental illness and depression arise in a person's life history during their adolescence, it just makes so much sense for us to make sure we're addressing depression in youth.

When we decided that in 2017 or 2018, we also recognized that a 15-year-old is very different from a 35-year-old. We spent about a year researching, using a lot of human-centered design to understand how we need to adopt and adapt our current group therapy using IPT-G for youth, doing a lot of focus groups with youth, trying to understand what their life is like, their strengths and weaknesses, and the forms of depression they're suffering.

At the end of the day, it's the same model, and we're still using the same IPT-G. The groups are different. If you were to sit in a group for 15-year-olds and then 35-year-olds, you would definitely see the differences. A youth group tends to be a lot more interactive, but [we need] a lot more bells and whistles to keep a 15-year-old engaged.

We also learned in the human-centered design approach that African youth tend to be more challenged with their emotional literacy, certain levels of discomfort, and expressing their feelings. For us, that was a big concern, because in a depression group, you're typically sharing your feelings, which helps us identify your triggers, and solutions or resolutions to your triggers.

The concern was that if youth in groups aren't able to express their feelings clearly enough [right away], they will over time, but the groups will take very long to pull it out of them. It's quite simple, but one of the solutions we used was to create emotional cards, like a deck of playing cards, and each one shows an emoji with a different emotion, such as happiness, sadness, fear, or anger. We often use that in these groups, just to break the ice by putting the cards out. The leader would ask, “What are you feeling right now? Pick a card.” If you pick a card that says anger, we’d say, “Why are you feeling anger?” It's a facilitation mechanism to get them comfortable to express those emotions.

There's lots of rewarding going on. If somebody volunteers something, there's a little bag of tricks with baubles and things like that. A lot more interaction is needed to keep the attention of a 15-year-old, to be sure they want to come back to the group. At the end of the day, it's the same therapy.

Jessica Kantor: How do youth voices and perspectives shape your work?

Sean Mayberry: In the 2017 and 2018 program, the human-centered design team [led] tens, if not hundreds, of focus group discussions with youth to understand what's going on. We received a lot of feedback early on, from at least 80% of the population we treated. We've now treated a total of almost 1.5 million depression sufferers, including several hundred thousand youth.

Early on, we thought we’d just be treating female youth. In the focus group discussions, the girls were very clear, telling us they wanted boys in the groups. They said they didn't want to have groups in school that exclude the boys. Mixed gender groups, we call them. They didn't want girl groups and boy groups. We're always listening.

As we transition to groups run by students themselves, with older students, it's another opportunity for a 17 or 18-year-old group leader to give feedback to their StrongMinds supervisor, about what's working well in a group and what's not. That could be as simple as a school’s logistical issues. Some schools in Uganda have morning sessions and afternoon sessions with different populations. They can identify logistical challenges, for example, that we can't do it from 12:00 noon to 1:00pm because that's the transition time, or we can't do it for the next two weeks because it's the exam period.

There are a lot of built-in mechanisms for that information from group leaders, and interactions with groups themselves. It's very interactive. We're listening to the clients. We conduct a number of surveys on client satisfaction, such as how happy are they with the group? What would they recommend for improvements or changes down the road?

Cat Lukach: Because it's group therapy with a facilitator, we're not just talking about depression, we're contextualizing it through their own experiences. The questions are very open-ended so that children can bring and answer questions about why, where is it coming from, what’s triggering it? In that sense, it feels very organic and authentic to what is occurring in these particular children's lives, and in this particular community where all share a lot of commonalities. Whether it’s gender-based violence or poverty-related, the facilitation and support is directly linked to their needs.

At our school-based group therapy, we've observed a ripple effect outside the children's group. We've noticed, and teacher facilitators have also told us, that the children's own conversations around emotions and this new psychosocial education and awareness is extended to other teachers. The teachers at school are also getting sensitized to conversations around depression, which then has affected administrators, and they've even connected it to the parents of these children. While the group therapy might be starting with the students, it has grown in a wave of change in the school environment, the parents and family, and throughout the community.

Sean Mayberry: The fact we're using African teachers to run groups is something we never thought we'd be able to do. There's a generalization that African teachers tend to be very stern and disciplined-oriented, not warm and fuzzy. Not just for StrongMinds but many other stakeholders, if you said you were going to use African teachers to run therapy groups, they'd say don't do it. We tried, and we've found it to be very effective.

Not every teacher can be a group leader, nor every individual in the community. We screen and test them, and there's certain skills and characteristics we're looking for, but we now have many teachers who are running groups, which is something we and others thought would never be possible.

We hear feedback from teachers who say their classroom is so much better now that they've addressed depression. Teachers feel they're better teachers because they understand a child's challenges coming into their room. It warms your heart to hear this. Having an empathic, supportive, caring teacher is so important in human development.

Jessica Kantor: You didn't plan to have African teachers facilitating this. What prompted that? Did you try something else, and those teachers didn't work as well, or couldn't identify with the students? Was it a cost item?

Sean Mayberry: No. We pay the teachers to run the groups, just as we pay everybody to run a group. What it comes down to is a StrongMinds culture of innovation and trying new things, not assuming that this is the formula, so we will do it blindly. I can't tell you exactly where it started, but I'm sure it was in a StrongMinds' group with a particularly forward-leaning and supportive teacher. We tried, and then we tried another one, and realized it was working. It's continuous improvement, ongoing iteration, let's try this.

Certainly, teachers add advantages. They're already there. There are advantages to a 35-year-old running a group over, say, a 17-year-old. There are also disadvantages. If you look at the history of the StrongMinds group talk therapy program across all populations, it's wildly different today than it was 13 years ago, based on a strategy of continuous improvement. How do we make it faster, cheaper, more effective, and always try new things?

Jessica Kantor: You learn from things that don't work as much as things that do. What did you try that didn't work, but taught you some major lessons?

Sean Mayberry: On the youth side, for example, we had originally planned just for girls and then boys, and that was the feedback. There are a lot more examples. In 2022, we

launched a separate program called StrongMinds America to treat depression in the United States. For three years, it focused mostly on New Jersey and New York, mostly with older teens and young adults aged 18 to 24, mostly on college campuses.

Obviously, this was very different from Africa. We closed that program at the end of 2024 because it was a stark raving failure. We learned a ton. One thing was we had the wrong assumption, or hubris, that our model would work for anyone, anywhere in the world. We came to the US and realized, “Oh my God, the US is different from Africa. Go figure.” The youth here are different. They don't want to be in a group. They want to be anonymous. They're afraid in a college setting of self-identifying with depression in a group because their roommate or classmate will see them.

I could go through the litany of reasons why it didn't work, but we got tons of learning from it. Administrators didn't really support it. They felt it was almost in competition with their paid social workers, since we were providing free therapy. Overall, while you read a ton about youth depression, the crisis in the United States [happens] almost daily.

If you ask StrongMinds America the seven whys, if you're doing the fishbone quality analysis, the ultimate reason it didn't work was a startling lack of urgency by major stakeholders, from college administrators to local funders who want to treat depression among youth in the United States with a grant of $25,000, which pays my program manager for about three months. With high school principals, we’d say, “We know your high school has a serious depression problem. We're offering to provide free depression treatment,” and they didn't take us up on it. Just a lack of urgency there. Lots of failures on the American side.

While we're African-headquartered and focused, we do have a strategy if other geographies reach out to us, say Asia, and ask if we can launch there. We're not going to create StrongMinds Shanghai, but we're certainly open to those individuals coming to see our work, and send some technical teams to plant the seeds. StrongMinds America is very helpful, but it doesn't work everywhere for everyone. We have to be a lot more careful to understand the culture, launch some pilots, see what works and iterate before we try to bring it to scale, which sounds quite logical, but that's a learning we had.

Jessica Kantor: Aside from funding, are there any challenges that you're either currently facing, or have faced, that you haven't yet been able to solve?

Sean Mayberry: Yes. Top of mind right now is the fact that for StrongMinds we're still tied to the Western clinical approach for depression. We use IPT, which originated in the United States and is taught in public health schools. We use global international depression diagnostic screening tools, one of which is the PHQ-9 [Patient Health Questionnaire], which is used to screen for depression at a doctor’s office. Those tools are costly, time-consuming, and not necessarily accurate.

Up till now, we’ve been anchored in the Western clinical approach as to how the West treats depression. We've held onto those anchors, or tenets, in our Africa program. We're in plans right now to finally cut that tether, and are in the process of developing

our own African-centric depression treatment program that does not tie ourselves to western standards that make no sense to be used in Africa.

The PHQ-9 screening test is used so widely globally. We're looking at a point, one or two years from now, in some new models that will not use the PHQ-9 test because it's not highly accurate. There are many other things we could be doing to better screen for depression, and to better measure and monitor depression after treatment, things like biomarkers, measuring blood pressure, and voice recognition efforts. Those are a lot of the challenges we have in not being boxed in by the Western approach. It's a challenge that's also a huge opportunity. It just depends how you want to frame it.

Cat Lukach: In the same vein of being led by Western clinical standards, we're also held to the same Western research gold standard of the RCT [randomized controlled trial]. We're finding that without a current, latest RCT to validate our six-week model, we're held back from influencing big global conversations around best practices.

We're investing over a million dollars into conducting an RCT, when we'd rather reallocate that amount and invest it in innovation, iterating the model even further and testing new things. We're constantly adapting and trying to find a better solution, and a cheaper solution, to treat more people with depression. We're trying to walk a fine line of complying to Western and best practices set by the Western world or the global north, and also doing what we know works and being driven by who we really are, which is we're innovators.

Jessica Kantor: Based on what you just shared, outputs versus outcomes, it sounds like people want you to be tracking your outcomes further down the line than you would necessarily want to do. I'm sure you're tracking outputs. Outside of an RCT, what does that look like for you?

Sean Mayberry: Outside the RCT, we are data-focused and obsessed. We can show you not just the depression outcomes or impact itself, but a whole range of wellbeing indicators, in terms of people's time, hours worked, meals consumed, classes attended, grades improved. We spend a lot of time and effort collecting all that impact to report back to donors who must see this to continue to fund us.

Jessica Kantor: How does your model serve other mental health issues or disorders that people might be facing? If you come across a youth who has signs or symptoms of a serious mental illness, do you have referrals in the community?

Sean Mayberry: We focus on depression. Starting January 1st next year, we'll also be including anxiety. We can treat anxiety using our same model, and we already do, but we don't do a good job of actually measuring it. Next year, it'll be a change for us. We'll be talking about treating depression and anxiety, but in all of our groups, youth will be screened individually one-on-one, twice, before they come to the group.

During those screenings, we will be able to identify if they have other mental illnesses going on, in which case, we would get them into a referral system. StrongMinds does not work anywhere without a referral system. If we cannot establish a referral system in

a certain community, we will not work there, because how could we help you? It would be a disservice, and it would just be wrong.

At the same time, it's very difficult to establish referral systems in Africa, with a low level of mental health expertise in the medical system. A lot of times, we might put an individual in the StrongMinds truck, drive them three hours to the closest hospital for a consultation, and maybe continue to help the person to get medications and other resources for weeks and months. We do provide that support. We don't just walk away.

Cat Lukach: One of the critical first screenings is on suicide. That's urgent. Clients do not enter group therapy if there's risk of suicide. That's a referral we make immediately.

Jessica Kantor: Can you share an example to illustrate the impact of your work?

Cat Lukach: My colleague, Chilu, is a single mother from Zambia. Somewhere between five and eight years, she was severely depressed. One of our facilitators visited her at home for an initial screening and educated her about the common symptoms and signs of depression. Chilu recognized right away that she was suffering from depression, even though she didn't know this was a condition. She joined a group, and recovered within six weeks. In that time, she radically transformed herself and was able to parent.

She had been so debilitated by her depression that she admitted yelling at her children. She had not been able to step into her parental caretaking duties. By the end of her treatment, she was feeling such a radical difference that she saw improvements in her children at home, and they were going back to school. Chilu became a facilitator and treated thousands of clients for depression. Then StrongMinds started to adapt a coaching and supervisory layer into our model. She's a coach now, and we bring Chilu to global stages to share her story and advocate why treating depression is such an important investment. It completely put her on a different life path.

We have so many examples of clients who have graduated from the program and used their own healing journey as a recovery story, as it's inspired them to be facilitators themselves. There's an organic viral effect on individuals who recover from depression.

Sean Mayberry: Chilu, who is from the compounds of Lusaka, was on the main stage at the WHO World Mental Health Forum in Buenos Aires last year, telling her story to hundreds of WHO representatives and government ministers. She had the entire room in tears with her story, which is just so inspirational. She had courage just going from Zambia to Buenos Aires. It's very hard to go from Africa to South America because you have to fly over Antarctica. It was so inspiring to see her on that stage, sharing her pain, suffering and struggles to help that audience understand why becoming depression-free and treating depression is so important.

Jessica Kantor: Do you also have a youth example?

Cat Lukach: Yes. I was visiting a school and talked to two teachers who were group therapy facilitators, and they said that there was a girl that was hiding her depression, not even knowing that this was a condition. She just felt so isolated. She was living

away from her parents, staying with relatives. Her parents lived in a different community, and had no idea about the state of their child. Before she entered therapy, she was planning her own suicide. It was a parent visitation night. A teacher we were training to facilitate group therapy found the supplies she was preparing to take her own life. Because the teacher found this and intervened, we brought her to referral care. The teacher prevented her from following through with suicide.

The next day, the father came to the school and had a meeting together with the child and the teacher. Because we were partners with this school, and had trained teachers to facilitate group therapy, the response to this incident was one that inspired great learning and positive impact that affected the greater community. The girl ended up going through our group therapy program. She healed and recovered in such a way that her grades improved a lot. She actually skipped two grade levels because she was just so happy, vibrant, and able to participate.

Then she started to build friendships. She normalized talking about depression, since she was so courageous about sharing this within her school. It's almost seen as a club. Initially, there was stigma, but because of her courage, the whole community in this school was talking about suicide and depression in a way that never would have happened before. Particularly in schools, we hear a lot of stories about suicides that were never been followed through, because of our intervention.

Jessica Kantor: How would you define current attitudes on youth mental health?

Sean Mayberry: Outside of Africa, everybody understands that if one had to make a choice, youth mental health is the right priority to provide additional years, if not decades, of life well-lived. The West understands that youth mental health matters and is super important. We're seeing that pendulum turning as well in Africa, where mental health awareness has certainly improved over our 13 years in existence. More recently, it feels like that pendulum is swinging even faster.

We've seen significant improvements in Uganda where a couple years ago, through our advocacy efforts, the Ugandan Parliament made a law requiring all Ugandan public schools to devote one hour to mental health a week, which to our knowledge and research is the only law of its kind on the planet.

The Ugandan government is becoming much more mental health-friendly, and I think StrongMinds has played a key role. 13 years ago they would barely talk to us. Now we're partnering deeply with them, and see them ultimately as the owner of our program for years down the road. In the West, the focus on youth mental health awareness is where it should be, but we're also getting there in Africa.

Jessica Kantor: What else do you think has contributed to that shift in attitudes?

Sean Mayberry: In Africa, we're now working in Malawi. For the most part, the Malawian government invited us in, which would have been unthinkable 13 years ago. Typically, we'd go into a country, work through non-profits on the ground, and then get

on the radar of the government. Now we're able to skip over that step, and go straight to the government.

A lot of things, certainly mental health awareness and appreciation, increased post or during the pandemic. In Africa, the Ugandan and Zambian governments are doing a much better job at championing StrongMinds and depression treatment. There are a lot of regional conferences. The Ugandan Ministry of Health and Ministry of Education talk us up, and that's helpful. It's both from global trends shifting towards mental health awareness and friendliness, plus more local trends. We played a part in some of that.

Jessica Kantor: Many people who want to work in youth mental health wonder how you secured so many strong partnerships with governments all over Africa. Have you been submitting to calls for curriculum, or has it been mostly word of mouth? How was the first partnership secured?

Sean Mayberry: Through patience and perseverance. In Uganda, 13 years ago, it was just about pushing the wall. We were there, at the table, just chipping away at it. Some key things we did early on was to put the then-deputy director of mental health in Uganda's Ministry of Health on our board of Directors for StrongMinds Uganda. She's now been on our board over a decade, almost since the beginning. Over time, she became the director of mental health, so that was a very strategic move. She could have left the ministry. Life is partly luck. We made some good conscious moves, but a lot of [our success was] just being at the table. Not just at the national capital level, but also at the district level, both high and low levels. Great relations and a great reference from a local or district government official can be helpful.

In the US, a mayor can mention it to their local state representative, who mentions it to their federal representative, who mentions it to the senator, and it bubbles up, but you're also in Washington trying to push it down [to local levels], so you meet somewhere in the middle. It's ultimately just patience and perseverance. Having worked in Africa for a long time, the easy way to go in is to do your program and be a rogue, in other words, to do it separately from the government, but that's not sustainable long-term.

The real way is to work it through the government, knowing that only the government in these countries can reach every corner, every last mile, every last person. No NGO or other organization is going to be able to do that. While it's slower and sometimes more costly, it's the right answer. If you're a new organization going in, it's going to take a long time to start to move that wheel. It's so easy to think, let's just do it ourselves and be rogue, but going rogue will not pay in the long term.

Jessica Kantor: Other insights or teachable lessons that those who are interested in doing similar work might be interested to hear?

Sean Mayberry: It's funny, we're a 13-year-old organization, but we still think of ourselves as a start-up. We're always iterating our model. We are not in love with our model. We're happy to find a new one. We're constantly finding a new one. That has caused some issues for funders who say, "We need five years of evidence from your

very stagnant model.” That model from five years ago is history. We would never touch it, because we're better now.

If I were to give advice to somebody starting a new mental health group, or any group in Africa, or even globally, I’d say don't fall in love with your model. Constantly innovate it, look for improvements, know that the 2.0 and 3.0 version can only be better than 1.0.

At StrongMinds, we were always doing innovation on the ground, but a couple years ago, we formalized it with our own innovations laboratory where we can come up with crazy ideas. Wins and losses there, but it just shows our dedication to not being in love with our model. It's almost a plan to fall out of love with the model and find a new one. The number one guidance is to just learn from what's on the ground, and come up with something better.

Another interesting thing for us is that when crises come up, we always just embrace them and see the opportunity. One of the upsides of limited funding for mental health in Africa is that we've always had to have a scarcity mindset at StrongMinds. There's not a lot of money, so how are we going to get this done? Today we can treat a person for depression for about $15 total. That's amazing. Although the governments can't afford anything, so that's still very expensive, but 13 years ago, it cost us $400 each.

We realized we were never going to have unlimited funding to treat a lot of people at $400 each. That scarcity mindset of having to be cheaper, because there's just not a lot of money around, has been such a blessing for us to get treatments to $15 each, and even have the strategy and plans to literally get down to close to zero. The scarcity mindset has been a blessing. Don't fall in love. Don't spend money and you'll be good.

Cat Lukach: Something else true about StrongMinds is that we are in love with our patients. That’s what anchors us. In terms of seeing a crisis as an opportunity, we find ourselves asking better questions now than a year ago, when USAID was still a functioning department of the US government and a huge source of foreign aid. We're asking ourselves better questions. We're acting with more urgency, and we are innovating faster than ever because of the crisis situation. That’s something our leadership really embodies.

Sean Mayberry: When there's no crisis, we want to stir things up and create one when we need an endorphin rush. Drop a bomb.

Jessica Kantor: When you talk about innovation, constantly evolving, and not being in love with your model, is that the way you set up the organization, the way that you train, or even potentially the type of treatment provided to the clients?

Sean Mayberry: It's really everything. The treatment for clients drives it, but it's that flexible innovation mindset. For example, we started with 16 weeks of therapy. We're at six now, and hopefully going to one single session. Every time we do that, we have to change the curriculum and the training, because we're not doing 10 weeks, we're doing

eight weeks, or six. It's being mindful to come up with the front-end product, but then being mindful and having an innovative spirit to know we also need to change it.

The team is very nimble and flexible, knowing that we're not in love with the model, and just because we did it yesterday doesn't mean we're going to do it tomorrow. That mindset is diffused throughout the organizational culture. You can be super innovative on the front end, but if your back-end training and quality is not innovative, then that's going to be a huge clash, and will not work together.

This includes the whole organization, including finance and admin, in terms of tracking and reporting costs. If the treatment changes to six weeks from eight, then we must figure that out and change the cost allocations. It also goes for the fundraising team, who must sell the new model. We have to change the pitch, the presentation, the approach, and update our current donors who are coming with a three-year renewal, where we were going to do eight weeks, but now it’s six. We have to go back and change it with them, which we do without thinking about it, but just saying it right now sounds very exhausting.

Jessica Kantor: The Youth Mental Wellbeing Co-Lab has three focus areas. The first is building young people's resilience. The second is giving young people agency, and the third is helping young people build a sense of community and belonging. If you had to choose, which one does your work mainly focus on?

Cat Lukach: All three are true outcomes that we measure and focus on. We measure agency, and there's so many studies that tie agency to resilience. Normalization and feeling that you're not alone or isolated is also part of the depression treatment.

Sean Mayberry: It's all of them. To pick one would be a disservice to the others.

Jessica Kantor: Can you share more on your relationship with these three areas?

Sean Mayberry: On resiliency, we see it in the well-being data, the one-on-one stories, at the end of the group after an individual initially comes in very depressed, withdrawn, and not engaging, and at the end where they're very connected.

We see it up close and personal in the groups. We see it with feedback from the teachers who say, “Oh my God, the class is so much better,” or the students. We hear it in feedback from the parents who say, “My child is so much better. How has this happened? As a parent, I'm depressed. How can you help me?” That helps a youth's resiliency as well, because now they have more supportive parents. When we're able to treat an individual with depression who is reserved, withdrawn, cognitively impaired, or at least reduce that through the depression groups, that individual then has the agency to promote themselves confidently.

At the community level, a perfect example is a classroom where we see rates of depression among adolescents up to 40%. Almost half of that class is depressed. I don't need to paint a picture of how that looks. Then, when they are no longer depressed, I

also don't need to paint you a picture. The community is the classroom. Individuals will go home no longer depressed, and can interact with parents, siblings, and neighbors.

Cat Lukach: The sense of belonging, too, is baked into how we treat depression. It's in the group setting so that no one feels isolated. We often see groups that are very quiet, especially in the first or second sessions, with people afraid to share the first story. The first person that speaks might take 5, 10, or 15 minutes. Then another person shares, the stories start coming up, and everyone's realizing they are not alone in this experience. That's such a powerful catalyst in reducing the severity of depression. What's definitely distinct about our models is that they are group based. It's not individual like other models of therapy.

Jessica Kantor: What, if any, emerging work in this field are you excited about?

Sean Mayberry: The use of biomarkers. The PHQ-9 screening tool is a very antiquated, dinosaur-esque model and not very accurate. To come up with and use biomarkers on the ground to identify depression based on one's biology would be a huge step forward for us, and increase accuracy. The challenge right now is to be able to find tools like that which work reliably in difficult settings and are also cost-efficient.

As we're trying to get down to $0 per treatment, we can't use a $5 biomarker, for example. One new objective for our research team next year is to identify organizations working on biomarkers, and offer to test this for them in our work and do the research here. How can we help you to speed it up? That's something we're really excited about, just in terms of accuracy and reducing costs.

Cat Lukach: Another thing we're excited about is that we've done some pilot research on single-session intervention. We continue to iterate. We started 13 years ago with 16 weeks of group therapy. We've iterated down in two-by-two week increments, and we're down to six. We piloted this to learn the power and impact of just one single session. We saw very exciting results, almost shockingly good. We're going to study that further to see how we can leverage this, and somehow iterate between six weeks and one week, and how that might evolve. That would be a huge cost efficiency if we could make a strong impact in just one or two sessions.

Jessica Kantor: Thank you so much for speaking with me.

Jessica Kantor is an independent journalist specializing in health, human rights, and social impact. Her work can be found in Fast Company, Healthcare Quarterly, Innately Science, and others, and she has been a Solutions Insights Lab interviewer since 2023. Additionally, she provides communications strategy to nonprofits and INGOs who are working on the Sustainable Development Goals. She is a living kidney donor based in Los Angeles.

** This interview has been edited and condensed.*