

Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda

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The current prevalence of depressive symptoms in Southwest Uganda, an area greatly affected by the HIV epidemic, has been shown to be as high as 21%. Traditional healers have expressed inability to treat these symptoms. The lack of physicians and high cost of medication make the use of antidepressants unfeasible. Therefore, an evidence-based psychotherapy was considered a reasonable treatment option by a team of health researchers familiar with the local culture, who designed a randomized controlled clinical trial. Interpersonal psychotherapy in a group format (IPT-G) was selected because it was time limited, was described in a manual, and had evidence of efficacy from clinical trials. Moreover, its focus on interpersonal triggers of depression was considered compatible with the culture. This paper describes the process of adapting the psychotherapy manual and the training of the group leaders who undertook the first psychotherapy clinical trial in Africa.

Key words: Interpersonal psychotherapy, depression, Uganda, psychotherapy manual, clinical trial

Interpersonal psychotherapy (IPT) is a time-limited psychotherapy that was originally developed as an individual treatment for unipolar nonpsychotic depression (1). IPT is specified in a manual, has been tested in numerous open and randomized clinical trials and was found to be efficacious for a number of mood and non-mood disorders among adolescents and adults (2). A group adaptation of IPT was originally developed for the treatment of binge-eating disorder (3) and is in the process of being tested for depression in adolescents (4,5), for abused women with post-traumatic stress disorder (6), for social phobia (7), and for post-partum depression (8,9).

Most of the IPT adaptations were developed and tested in industrialized countries (USA, Canada, Australia, Japan and a number of European countries). An adaptation of individual IPT for dysthymic patients in Brazil is underway (2) and a group IPT manual for bipolar patients is being developed in Turkey. However, there are no data available yet on the efficacy of IPT and how it was adapted for use in these cultures. It is thus still not known what aspects of the structure of IPT would be meaningful in non-Western and developing countries (the structure includes the medical model; the interpersonal context of depression; and the four categories of interpersonal crises associated with the onset of depressive episodes, the four 'problem areas' - grief, interpersonal disputes, role transitions and interpersonal deficits). This paper will describe the rationale and the process of adapting group IPT (IPT-G) for a randomized clinical trial with depressed persons in a developing East African country, Uganda.

BACKGROUND TO THE UGANDA PROJECT

A number of studies conducted in the past quarter century indicate substantial levels of depressive symptoms in

Uganda: Orley et al (10) found a 25.3% current rate of clinically significant depressive symptoms in a community sample, using the Present State Examination. In a mental health survey conducted in 2000 in Southwest Uganda, an area severely affected by the human immunodeficiency virus (HIV) epidemic, the rate of current (last week) depressive symptoms in the community assessed by the Hopkins Symptom Checklist (HSCL) was as high as 24%. Even when the impairment criterion was added, the rate was 21% (11). These rates were higher than those in the neighboring Rwanda, which 5 years previously had undergone a devastating genocide. Using the same instrument, Bolton et al found a point prevalence rate of 15.5% of clinically significant depressive symptoms in Rwandan communities (12). On the other hand, the Epidemiologic Catchment Area Study of 5 US communities yielded a one month point prevalence of depressive disorders and clinically significant depressive symptoms of 10% (13). Comparisons of absolute rates of disorders or symptom levels across studies is always hazardous when these studies differ in methods of sample selection, measurement of psychiatric symptoms, cultural and sociodemographic characteristics of the population studied, etc. Nonetheless, these preliminary comparisons suggest that the point prevalence rate of depression in Uganda is high by regional as well as Western standards.

Depression has been associated with high morbidity and disability across countries: it was ranked second only to heart disease as a leading cause of disability adjusted life years (DALYs), the index representing the sum of years of life lost due to premature death and years of life lived with disability (14,15). In numerous studies depression has been associated with a number of high-risk behaviors for contracting HIV infection (16).

Ethnographic research in the Masaka and Rakai districts in Southwest Uganda conducted by Bolton et al in 2000 (17) showed that depression was recognized by the communities as a source of impairment in social functioning. Depressive symptoms were considered by the local people to be among the important consequences of the HIV epidemic (in the 1990s Southwest Uganda had an HIV prevalence rate of 23%, one of the highest in the world). In addition, depressive symptoms were described in two frequently comorbid syndromes, 'y'okwetchawa' and 'okwekubaziga' in Luganda, the local language, meaning self-loathing and self-pity respectively. Individuals with 'y'okwetchawa' almost always had 'okwekubaziga', but those with 'okwekubaziga' (the more common syndrome) frequently did not have 'y'okwetchawa'. The local people also reported disability associated with these syndromes: significant difficulties in performing their work, in participating in community functions and rituals, and in caring for self, children and other family members (12).

Depressed people in these communities occasionally turn to traditional healers for treatment of 'y'okwetchawa' and 'okwekubaziga'. Contrary to traditional healers in other African countries, however, a number of healers in these communities, interviewed during the 2000 survey, expressed inability to treat these syndromes (17). The lack of availability and high cost of physicians and medication made the use of antidepressants prohibitive, especially in the rural areas. Psychotherapy was seen by Bolton and colleagues as the only treatment option with evidence for effectiveness. In order to be feasible, any form of psychotherapy for this population cannot require highly trained mental health providers (due to a lack of mental health professionals trained to conduct psychotherapy in these communities) and has to be conducted in groups (to increase coverage and reduce cost). It should be noted that the feasibility and efficacy of any form of psychotherapy for depression had never been tested in Uganda.

To test whether psychotherapy could be effective in this region, Bolton and colleagues designed a randomized controlled clinical trial to be conducted in the Masaka and Rakai districts in Southwest Uganda, comparing psychotherapy to treatment as usual.

In the process of selecting an evidence-based psychotherapy for depression, Bolton and African colleagues reviewed cognitive behavior therapy (CBT) and IPT, since both are evidence-based interventions for depression and can be administered in a group format. CBT requires that individuals monitor and alter their behavior and thinking processes. IPT requires that individuals examine the interpersonal context of their depression, find the links between the depression and their environment, and make changes in their interactions. Bolton and colleagues felt that CBT was too alien to the problem-solving approach used in most Sub Saharan African cultures. In these cultures people tend to see themselves as part of a family and community unit

before they see themselves as individuals. Therefore, IPT-G appeared to be a more relevant approach.

Emphasis on group process differs among IPT-G investigators: Wilfley et al (3) encourage the use of group as an interpersonal laboratory to identify problematic communication patterns, including those among the members. Mufson et al (18), in their work with depressed adolescent groups, feel this is counterproductive, since it creates the potential for expression of hostility and criticism which interfere with IPT work in that age group. In the development of IPT-G for Uganda (IPT-GU), we decided to attempt group process work more along the lines of Wilfley's approach, but with more emphasis on supportive and cohesion-building process remarks.

DEVELOPMENT OF GROUP INTERPERSONAL PSYCHOTHERAPY FOR UGANDA (IPT-GU)

Myrna Weissman and colleagues at the New York State Psychiatric Institute and College of Physicians and Surgeons of Columbia University undertook the manual adaptation for this project, as well as the training of the group leaders in Southwest Uganda. Trainees were non-clinician college-level educated employees of World Vision, the nongovernment organization (NGO) that implemented and partially funded the study. We hypothesized that the basic assumptions of the IPT model would, at least to some degree, be relevant to the Ugandan culture. We expected that:

- Depression would be recognized as a disabling condition with distinct symptom patterns. We had prior knowledge of the ethnographic research in Masaka and Rakai districts, confirming the recognition of depression as two syndromes, 'y'okwetchawa' and 'okwekubaziga'. These syndromes contained all DSM-IV symptom and function criteria, but also other locally-reported symptoms (e.g., not responding when greeted, hating the world, unappreciative of assistance). 'Y'okwetchawa' is the more severe of the two, one of its symptoms being suicidal ideation (11).

- The four interpersonal problem areas of IPT (grief, interpersonal disputes, role transitions and deficits) would be triggers of depression in the Ugandan communities. Although loss, conflict, life transitions and social isolation seem to be universal human experiences, we were unsure whether they would be the main triggers of depression in these communities, or whether there would be other important triggers that the IPT model could not address. We planned to explore this by asking the trainees open-ended, non-leading questions about what makes local people depressed and judge whether their responses correspond to the four problem areas.

- Improvement in communication and decision-making around the problem area would result in symptomatic improvement. Evidence for this has been shown in a number of clinical trials in Western countries (2). However,

this link has not been examined in developing countries. Although the mechanisms of the therapeutic change in IPT are not clear, generating options for interpersonal communication and action, increasing mastery, clarifying expectations and reducing social isolation are some of the hypothesized ways to reduce the helplessness and hopelessness inherent in depression.

In February 2002, 2 IPT trainers (KC and HV) traveled to the Masaka district in Uganda to train the 9 prospective group leaders who were fluent in English and Luganda. Training was conducted in English and was assisted by two World Vision employees (LN, a psychologist from Kenya and experienced group therapist, and LS, a Dutch psychologist, who has considerable experience in mental health interventions with refugees). They both stayed on site to supervise the trainees after the trainers' departure.

ADAPTING THE MANUAL

Overall, the basic structure of IPT was retained in the IPT-GU training manual, but was simplified to be used by non-clinicians. The main additions were detailed scripts in simple language: grief was called death of a loved one; disputes were called disagreements; transitions became life changes; and interpersonal deficits became loneliness and shyness. Numerous modifications to improve the cultural relevance of the intervention were made on site and were later incorporated into the manual (19). The main source of information about the local culture was the trainee group members, since they grew up and lived in the districts participating in the study. The adaptations made in consultation with the trainee group leaders are described in the following sections.

Diagnosing Depression

This takes place during the initial meeting between the group leader and each group member individually. Since the IPT therapist begins by making the diagnosis of depression and clarifying its triggers and treatment, it was important during the training to develop a common understanding of depression. The trainees were asked to describe a depressed person they knew and discuss his/her behavior. The trainees were familiar with the states of depression (we used the two terms identified in the above mentioned ethnographic survey: 'y'okwekyawa' and 'okwekubaziga') and described DSM-IV signs and symptoms (sadness, poor sleep and appetite, no interest/neglecting self and family, suicidality, feeling worthless, low energy, feeling fidgety). The trainees accepted overall the concept of depression as a disabling condition and felt comfortable with letting each group member diagnosed with depression know that.

The local description of depression included symptoms not corresponding to the DSM-IV (mentioned above).

These symptoms were included in the initial diagnostic assessment and at the beginning of each session.

Explaining the treatment contract

During the initial meeting, the leader explains how the group will work. In the initial individual meeting between the leader and each group member, it was explained that the groups would be single-sex to facilitate disclosure (the sex of the leader also matched that of the members). It became necessary to emphasize to the person beforehand as well as repeatedly during the group meetings that the leader would not provide material goods (the community was used to World Vision and other NGOs providing financial and health related benefits). Instead it was explained that the leader and the group members would be supporting each other to figure out what situations contribute to the members' depression and what they can do about the situations to feel better. It was also explained that the leader and the group members could work on finding ways to identify people in the community, government and NGOs who could provide financial and medical assistance on an ongoing basis and persuade them to help. Issues regarding confidentiality were raised. The group members were asked to not disclose the content of the group meetings to people outside the group. However, the trainees pointed out that this may be misconstrued as secrecy or conspiracy (as one trainee said, 'the village will think that we are starting a new political movement or that we are encouraging women to use birth control'). The trainers and the trainees decided that some general information about the purpose of the group should be given to the community and the relatives, but discussion about the specifics should be avoided.

Sixteen weekly 90-minute sessions at a specific place (community centers, churches, open spaces) were initially planned to take place in the communities.

It became clear during the training that considerable flexibility had to be built into the structure to make the project realistic. In the case of community events, such as funerals or weddings, the whole village participates, so ways had to be worked out for the meeting to be rescheduled. In addition, interruptions during the meetings were expected, such as relatives of a group member wanting to talk to the group member, or breastfeeding children crying for their mothers. The trainees decided that the group members should handle these situations and decide about a policy for interruptions.

Problem areas

When asked about triggers of depression in these communities, the trainees identified interpersonal problems that correspond to three of the four IPT problem areas (i.e., death of a loved one, disagreements, life changes). They gave the following examples:

a) Death of a loved one: death of a family member or close friend due to AIDS, other illnesses, wars, natural causes, etc.

b) Disagreements: arguments with neighbors about boundaries of a property or stolen animals, political fights, family members claiming privileges that traditionally belong to other members (due to age, gender, or other family/social hierarchy), wives protesting or passively accepting out of fear an HIV infected husband's demand not to use condoms.

c) Life changes: becoming sick with AIDS and other illnesses, being unable to find employment, getting married and moving to the husband's home, dealing with the husband's decision to marry a new wife (polygamy is practiced in Uganda despite the fact that 67% of the population are Christian).

While three of the four IPT problem areas were consistent with problems associated with depression identified by the trainees, the fourth problem area, loneliness and social isolation, was not recognized by the trainees as relevant to their communities, since people were socialized to participate in communal activities on a daily basis and isolation from the community is rare. They felt that isolation can be the result of rather than the trigger for the depression. Isolation due to marginalization following a change in social status (death of husband, AIDS, etc.) was reported, but we considered it as an aftermath of a life change rather than a social deficit.

The trainees frequently brought up poverty as a trigger of depression and we debated whether it should be added as a new problem area. Many aspects of poverty are not interpersonal (e.g., malnutrition) and the adversities associated with it can be chronic and cumulative rather than 'here-and-now' and relatively circumscribed like the other problem areas of IPT. We decided to conceptualize poverty as a risk factor for depression rather than a trigger, and instead focus on discrete interpersonal events associated with it (change in role/status, disputes and grief). Thus, we were hoping to focus on the aspects of poverty that are within a person's control to act upon, while acknowledging the numerous ones that are not.

The following are adaptations that were made for each problem area:

- *Depression following death of a loved one.* A particularly challenging issue that came up was how to reconstruct the relationship with the dead person in a culture intolerant of any negative mention of the dead: 'the dead are living among us' is a popular saying in these communities. The closest formulation of a question that aimed to capture negative experiences with the dead was: 'were there times in your life together when you felt disappointed by (the dead)?'.

Case example. A married woman in her late 50's lives with her husband and was diagnosed with depression by the interviewers. In spite of her initial doubts about the usefulness of psychotherapy for her condition, she agreed to join group sessions. The first HIV relat-

ed death struck her home in 1990 and by 2000 she had lost five of her nine children. In 2001, her older married daughter, to whom she was very attached, disappeared and after a while the woman received information that her daughter had died as well. She did not know exactly what happened and never saw her daughter's body nor found out where she was buried. Together with her husband they had educated their children up to university level and most of the dead were the breadwinners for their families and the aging parents. During the initial phase of therapy she spent most of the time crying, talking very little about her problems and contributing almost nothing to other members' issues. In the meetings, she spoke slowly and reported profound sadness and intense anger, difficulty sleeping, walking, eating, loss of memory and concentration, and exhaustion. She mentioned that she was sick but did not know what she was suffering from. During the middle phase of the sessions, and after considerable encouragement, comforting and support from the leader and the other members, she started talking about her experiences around the loss of her children, about her relationships with them and how different life is now for her. She described how since these deaths she has been staying at home, crying most of the day, thereby irritating her husband to the extent that he was no longer able to work on his land. She described how she has been struggling making mats for a living, but this was no longer possible since, due to her concentration problems, she was mixing wrong colors. Her remaining two children stopped visiting since she was incommunicative and withdrawn with them and the grandchildren. Towards the end of the middle session she had begun to change her attitude and behavior in the group. She began accepting the deaths, and the changes in her life as a result. She started being friendlier and actively contributed to group discussions. After sharing in the group and hearing the experiences of other women she realized that she was not the only one who has suffered losses. As the sessions ended she no longer had depressive symptoms and resumed her mat-making activities. In the process of setting her goals and listening to the younger women in the group she learned that although her own daughters had died, she still had a role to play as an elderly woman for other young girls. She chose to be a 'ssenga' for them in the group and even for the whole community (ssenga is a wise, old woman who teaches the young girls about how to be good women and wives). She seemed fulfilled in this new role.

- *Depression following disagreements.* Two challenges were presented while formulating the IPT work on disputes. The first was how to get one's point across without necessarily being direct. In the West, an IPT task is to assist the person to say directly what he expects of the other person (1). In Uganda directness would be perceived at times as aberrant communication, inappropriate, disrespectful and incompatible with the customary code of interaction. For example, a woman angry at her husband could not discuss her concerns with him directly, but could start cooking bad food, which is a clear sign to the husband that something is wrong and he can choose to address it or not. It is customary for relatives to get involved in resolving disputes between two parties, or for a woman to talk about the prospect of her children becoming orphans, instead of talking about her health when pleading with an HIV infected husband to use protection. In this last case, if the woman fails to convince her husband, she can ask the help of a medical person or traditional healer, preferably an elderly male, so that the husband is not suspicious that the other man will seduce his wife. The second challenge had to do with finding culturally appropriate options when resolving a dispute: some options considered useful and

adaptive in that culture, would not be thought as such in the West. For instance, when discussing what options a woman who cannot have children has, the trainees responded that she should ask her sister or other female relative to marry her husband, so the new wife will be an ally and they can raise the children together.

Case example. A married woman in her 30's complained of depressed mood, concentration problems, persistent initial insomnia, worthlessness, low energy and irritability. The onset of the symptoms occurred around the same time her husband's drinking problem worsened, about 3 years ago. They started fighting every day and the husband became progressively more abusive, verbally and in the last year physically. Their children, 7 and 5 years old, have been frequently sick with malaria and she occasionally had to take them to the hospital. After her 2nd session in the group, she had to miss the three subsequent meetings due to her son's illness and hospitalization. When she returned to the group, she discussed how unhappy she has been with her husband and how worried she was about her son's health. The group comforted and prayed for her son. They discussed the possibility of her sleeping in a different room, away from her husband, so she can have some peace and rest during the night. She did so and reported feeling a little better. In the next meetings the group discussion revolved around her accepting that her husband may never change and exploring her options. Leaving the husband was not an option for her, as she and her children would lose financial support. During the group meetings she decided that her husband 'will always be a drunkard', and she could try not to pay too much attention to him and confront him but instead work in her garden and find ways with the other women to raise money to pay her child's tuition. In session 11, she reported feeling better because the disagreements are fewer at home as a result of her change in attitude. At session 14 she reported to the group that her children told her that she treats them better lately and does not yell at them, and she confirmed that she feels more peaceful. By the end of 16 weeks her depressive symptoms had improved significantly.

- *Depression following life changes.* The IPT work for life changes involves the identification of the positive and negative aspects of the old and the new role. While we were on site, we became aware that for many of the life changes that these communities underwent - devastation due to wars and tyrannical regimes, torture, AIDS or hunger to name a few - it was very difficult to find positive aspects. We found it more helpful instead to train our trainees to identify and focus on the elements that were under the individual's control and work on skills-building and identification of options, such as persuading potential advocates for assistance. We noted that depression makes the person feel more powerless than he really is and it is worthwhile to assist him in exploring various options instead of assuming a priori that they are not realistic.

Case example. A man in his 40's became depressed after his small business of selling sugar went bankrupt for a second time in a row due to the decline in coffee prices in Uganda. For the last two years he had been feeling sad, lost interest in trying to find a job and gardening, felt worthless, and developed insomnia and psychomotor retardation. He joined the group with the hope of dealing with his depression and finding something to do. During the initial phase, he was rather quiet but appeared attentive and listened carefully while others in the group shared their problems. He saw his depression as clearly related to the difficulties associated with the failure in his

business, which disrupted his life and left him with nothing to do in the village. The group suggested that he start another business, since he had some experience and did not seem to like the life in the village. During the intermediate phase his symptoms began improving. Though he had good and bad days, he associated this 'feeling better about himself' to the realization that other group members had what he described as more serious problems compared to his. He also indicated that he had realized that staying in the village was only making him get more frustrated. After discussing his options in the group, he decided to put his embarrassment aside, make contact with former colleagues and identify someone who could support him in starting a new business. In the next session, he reported to the group how he made contact with some of his colleagues who agreed to assist him in opening a shop in a different town. Since he started the business (at about session 10) he stopped attending the group. As time went by, he sent word to the group via the group leader that he was symptom-free and working.

TRAINING THE GROUP LEADERS

The trainers used a combination of didactics and experiential group process based on the basic principles and techniques of group IPT. Role-playing and group exercises with the trainees were used: each stage of treatment was role-played and practiced by the trainees with the trainers and one another in English and Luganda.

In addressing group process, the members of the training group brought up their own experiences and feelings regarding loss, disagreements, and life changes, and worked on supporting each other in clarifying the impact of these events on the persons and on helping each other come up with options and implement them.

Depression following death of a loved one. During the training, trainers and trainees shared their own experiences with losses, ways of expressing grief in the culture and the rituals involved.

Depression following disagreements. When training on this topic, the training group worked on a real life disagreement with the World Vision employers regarding the schedule and the amount of payment for the training and subsequent work (in Uganda it is not customary to discuss financial issues during the hiring process). The group discussed the IPT stages of defining a disagreement: define the problem, understand one's own as well as the other side's expectations, and generate culturally appropriate options to express one's views and wishes and ask for what one would like to see happen. The group applied these techniques to the problem at hand with a positive outcome (they negotiated weekly payment as opposed to at the end of 16 weeks as originally announced by the World Vision).

Depression following life changes. One of the life changes the group worked on was the change from the role of a trainee to that of a group leader. The group explored the feelings that accompany the old role, the new role and the change itself. Skills necessary to support the persons to cope better with the new role were discussed (in this case, supervision, peer support groups, record forms, etc.).

Termination. The feelings of the trainees and the trainers regarding the trainers' imminent departure from Uganda were processed: sadness, feeling of abandonment, anxiety, joy for the completion of project and excitement, etc. It was pointed out that very similar feelings were triggered during termination, and emphasis was placed on anticipated difficulties and coping plans for the future.

CLINICAL TRIAL

This adaptation was used by the trained leaders in a randomized controlled clinical trial of IPT-G for depressed persons in Uganda. One hundred and seven depressed men and women in single gender groups of 5-8 in 15 villages have been receiving IPT over a period of 16 weeks, and are being compared with 117 depressed men and women in 15 matched villages receiving treatment as usual (which in these communities means three options: treatment by local traditional healers, no treatment, or in rare cases, hospitalization). The participants were interviewed at the beginning of the study using a composite instrument consisting of the HSCL (to assess depressive symptomatology), a locally developed instrument to assess functional impairment, and separate questions based on a prior ethnographic study which assessed significant distress and duration of depression. Exclusion criteria were lack of significant depression symptomatology, current suicidality, unwillingness or inability to meet weekly for the duration of the study and age less than 18 years. In July 2002, the termination assessment was conducted by the Hopkins team using the same instrument. In addition, they asked the participants whether the intervention helped and how. The project had been sanctioned by the local Leaders Council (the local government authority) and had the approval of traditional healers.

Patients' attendance in the groups has been very high (the drop out rate was 7.8% in the IPT-GU group versus 18% in the control group), which suggests that IPT-GU has been accepted by the population. Fifty four percent of the participants attended at least 14 sessions, and 4% attended 10 or fewer sessions. The reports from the two site supervisors indicated that the group members have been supporting each other in coping with their depression and finding ways to make changes in their life circumstances (e.g., the men have been helping each other to find employment, the women have started helping each other raise pigs or chicken, and in most groups members encouraged each other to seek treatment for physical ailments).

The ultimate test of the impact of IPT on depression in these communities is, of course, the result of the clinical trial. The termination assessment was completed in July 2002 and the results so far indicate a strong effect for the IPT-GU condition in reducing depressive symptoms and impairment. A further assessment, at 6

months after the end of the intervention, will be conducted in January 2003.

CONCLUSION

We undertook the project of adapting IPT for depressed people in Ugandan communities with significant skepticism around three issues: Would the local people accept the notion of an intervention for depression? Would we be able to train non-mental health professionals to conduct IPT-GU? Would most of basic assumptions of IPT, developed in the USA, apply to the Ugandan communities? We have evidence of acceptance of IPT-GU meetings by the local patients and their relatives, since attendance of the meetings was high and no conflicts instigated by the patients themselves or their relatives about the patients' attending the groups were reported (by the patients or the Leaders Council). We have some evidence that we were able to train the group leaders in IPT-GU successfully. Subsequent supervision showed that the leaders had generally grasped the principles and techniques of the treatment (similar to therapists in Western countries, the degree of their competence varied) and were able to conduct the group sessions. Finally, our experience supports the idea that the problem areas identified in IPT as triggers of depression (death of a loved one, disagreements with important persons in one's life, life changes which disrupt close attachments) are intrinsic and universal elements of the human condition. The current findings, on both the acceptability and efficacy of IPT with rural Ugandans, suggest that the depressogenic effects of these universal conditions, as well as the efficacy of IPT, extend beyond the confines of Western culture.

Naturally, replication of current findings in many other developing countries is required before their universality can be persuasively argued. These attempted replications should also clarify the links between these universal problem areas and depression as well as the source of the psychotherapeutic efficacy of IPT in these other cultures that are profoundly different from Western society and from each other.

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