

Local Perceptions of the Impact of Group Interpersonal Psychotherapy in Rural Uganda

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Abstract

This study investigated local perceptions of changes stemming from a long-standing Group Interpersonal Psychotherapy (*IPT-G*) program for the treatment of depression in rural Uganda. The study was conducted in a low-income, severely HIV/AIDS affected area where in 2001 the prevalence of depression was estimated at 21% among adults. Data were collected between May 10 and May 31, 2010, using free-listing and key informant qualitative interviewing techniques. A convenience sample of sixty free-list respondents was selected from among adults who had participated in *IPT-G*, their family members, and other community members, from 10 villages representing a range of sizes and geographical locations. Twenty-two key informants were also selected from these villages, based on their knowledge about changes reported by free-list respondents. Interviews were analyzed using content analysis and response frequency tallied. *IPT-G* facilitators were also interviewed about the reported changes. Free-list respondents identified 5 primary categories of change in the community related to the *IPT-G* program: 1) Improved school attendance for children; 2) Improved productivity; 3) Improved sanitation in communities; 4) Greater cohesion among community members; and 5) Reduced conflict in families. Key informant interviews with community members and *IPT-G* facilitators suggested that as depression remitted, *IPT-G* participants became more hopeful and motivated and resumed productive pursuits. Greater cohesion between group members and other affected community members led to increases in collaborative farming and building efforts, and to ongoing mutual emotional support and peer counseling. Changes reported in this study cannot uniquely be attributed to the *IPT-G* program as other development programs in the area, related to farming, sanitation, and education, may also have contributed. Nevertheless, results suggest that providing treatment for depression in communities where it is prevalent may lead to positive changes in a range of non-mental health areas that are perceived to be connected the depression services.

Keywords: Depression; Low and middle-income countries; Uganda; Group interpersonal psychotherapy; Rapid ethnographic assessment; Community impact; Community; Education

Introduction

Recently, greater attention and resources have been devoted to improving mental health care in low and middle income countries (LMIC), though this support has not matched efforts in other areas of health and development [1-4]. Mental health, however, is an essential component in efforts to achieve major health and development goals [2,4,5]. Depression, for example, is a leading cause of disability [6,7], associated with negative economic and health outcomes including reduced productivity and role functioning [8-12], poor prognosis and treatment adherence in HIV/AIDS [13,14], and poor outcomes in children of depressed mothers, such as low birthweight, undernutrition, reduced vaccination and well-child visits, and mental disorders [15-18].

These associations suggest that increasing availability and access to depression treatments may have broad health and development benefits but there remains little evidence that treatment translates into such improvements [19-21]. The current study, therefore, explored the range of changes, beyond the reduction of symptoms and improved functioning, that local people in rural Uganda perceived to have resulted from a Group Interpersonal Psychotherapy (*IPT-G*) depression treatment program in their community.

IPT-G in Uganda

In 2002, researchers from Johns Hopkins University and Columbia University were invited by the non-governmental humanitarian organization World Vision International to adapt and evaluate the group format of IPT, a manualized treatment for depression [22], in the rural Ugandan districts of Masaka and Rakai. World Vision speculated that unidentified factors related to the HIV/AIDS epidemic, possibly mental health problems, were impeding the uptake and success of their development programming [23]. A qualitative assessment identified two depression-like illnesses, *Yo'Kewkyawa* (self-hatred) and *Okwekubagiza* (self-pity) that were seen by local people as important problems related to HIV/AIDS [24,25], and led to the development

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Received July 03, 2015; Accepted August 18, 2015; Published August 21, 2015

Citation: Lewandowski E, Verdelli L, Feighery A, Bass J, Hamba C, et al. (2015) Local Perceptions of the Impact of Group Interpersonal Psychotherapy in Rural Uganda. J Depress Anxiety 4: 198. doi:10.4198/2167-1044.1000198

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of an intervention program to address these identified mental health problems, from which World Vision could see improved uptake and outcomes of other programs among those affected.

In a 2002 randomized controlled trial of *IPT-G* [24], delivered by trained lay people from the local communities using a locally adapted version of *IPT-G* [26], people who received *IPT-G* showed greater symptom reduction and were less likely to be depressed following treatment compared to people who were in the wait-listed control condition. These intervention effects were maintained at a 6-month follow up [27]. Between 2002 and 2004, the *IPT-G* facilitators that provided treatment in this trial continued to lead *IPT-G* groups as volunteers under the supervision of World Vision. In 2004, the facilitators were hired by World Vision and this treatment, *IPT-G*, became the centerpiece of the Masaka-Rakai Psychosocial Project (MRPP), part of World Vision's formal psychosocial programming for the region.

In the MRPP, *IPT-G* was supplemented with an Income Generating Activity (IGA), which included a 3-day entrepreneurial training and supervised preparation of a business plan and financial grant application. The IGA was provided several weeks after the end of the 16-week *IPT-G* treatment. In 2007, due to high local demand for *IPT-G*, World Vision trained 40 local volunteers to deliver *IPT-G* treatment under regular supervision from World Vision staff facilitators. At this time, an HIV education component was added to the initial phase of the treatment and all IGA activities were discarded, except for the entrepreneurial training, which took place approximately one month after treatment for those who desired it.

As before, people were invited to join the *IPT-G* treatment program only if they met the locally validated criteria for depression, as assessed by screening and a standard diagnostic interview. After the 16-week *IPT-G* treatment, many groups continued to meet as peer-led support groups, some for years. At the time of this study (May 10 – 31, 2010), the MRPP consisted only of the *IPT-G* treatment and the entrepreneurial training, the HIV education component having been discontinued. The MRPP concluded in July 2010 with the end of World Vision's 15-year funding cycle for operations in the region. From the introduction of *IPT-G* in Masaka and Rakai in 2002 to the end of the MRPP, it was estimated that over 5900 individuals received *IPT-G* treatment for depression (Ndogoni, personal communication, July 27, 2012). In this study, former *IPT-G* participants, their family members, and members of the community at large were asked, in qualitative interviews, to report from their perspective what changes resulted from the *IPT-G* program for them and their community.

Method

This study employed a rapid qualitative research methodology that included free-listing and key informant interviews [25]. A qualitative methodology was selected so that local respondents could report any changes they perceived. Interviews were conducted in Uganda, the local language, by 10 local university-educated Ugandan interviewers who could speak and write English. Interviewers completed three days of training in qualitative interviewing techniques provided by the first author (REL), which focused on accurate recording of participants' responses and the use of non-leading questions and probes. Interviewers wrote down responses verbatim. Interviewers read a consent form, written in Luganda, out loud to all respondents, and obtained verbal consent for their participation. Respondents were assured during the consent process that neither their decision to participate or not, nor the answers responses they provided, would affect their access to support

from World Vision and other organizations. Interviewers did not record participants' names or other identifying information. No one approached to be a respondent in this study refused to participate.

A convenience sample of 10 villages representing different geographical locations and population size was chosen from among those in which the MRPP was currently active. There was no reliable record of how long *IPT-G* groups had been run in each of these communities. Due to logistical challenges and resource limitations it was not possible to return to any of the villages where the 2002 *IPT-G* evaluation had been conducted. The institutional review board at Teachers College, Columbia University approved this study.

Free-listing interviews

Free-listing interviews were used to identify a range of changes resulting from the *IPT-G* groups as perceived by the local population. A convenience sample of 60 free-list respondents was selected (six per village), representing both sexes and a range of adult ages. Respondents were individuals who had participated in the *IPT-G* program, members of their households (spouses or other relatives, including young adults who were children at the time when a caregiver participated in the *IPT-G* program), and members of the community at large (Table 1 for a distribution of the Free List respondents). Each respondent was asked four questions: 1) What has changed for people who took part in the *IPT-G* groups?; 2) What has changed for families of people who took part in the *IPT-G* groups?; 3) What has changed for children in families of people who took part in the *IPT-G* groups?; 4) What has changed in the whole community because of the *IPT-G* groups? Respondents were asked to list all of the changes they could think of. Interviewers asked for a brief description of each response and probed exhaustively for additional responses.

Key informant interviews

To gather greater depth of information, five categories of changes most frequently reported in free-listing interviews were explored further in key informant interviews, in the following format: "Last week, people in this community said (insert reported change based on results of free-listing) because of the *IPT-G* groups. Can you tell me more about this change?" Key informants were 22 community members (13 men; 9 women; 2 or 3 per village) ranging in age from 28 to 63, who were identified by free-list respondents as knowledgeable about specific changes reported. Interviewers used open-ended, non-leading probes to encourage respondents to talk in depth about areas of interest.

IPT-G facilitator interviews

Interviews were conducted with a convenience sample of six current volunteer *IPT-G* facilitators (3 female; 3 male) representing 15% of the total number of facilitators practicing at the time, selected to represent the range of geographical locations within the program area. Interviews with *IPT-G* facilitators aimed to triangulate responses given by *IPT-G* participants, family members, and community members, and to learn more about their perceptions of the mechanisms underlying the changes reported. Facilitators were asked the following question,

Respondent type	Male	Female	Total
<i>IPT-G</i> participant	16	10	26
Family member	5	17	22
Adult child	6	0	6
Community member	7	0	7
(Age range: 18 – 64)			n = 60

Table 1: Distribution of respondents in free-list interviews.

which was developed during the fieldwork in response to information gathered during free-list interviewing: “Community members who participated in this study mentioned things such as cash rounds, trainings, and improvements in productivity as being related to the *IPT-G* groups. Can you tell me about this?” Cash rounds are a common method of raising money in which group members contribute a small sum to a pot that is then given to a different member each week to pay for large expenses like school fees or funeral arrangements. They are not a prescribed component of *IPT-G* but are a common practice in development programs, church meetings, and other informal gatherings, which predated the arrival of *IPT-G* in the region. “Trainings,” refers to other development related information and programming delivered by World Vision and other organizations.

The lead author conducted all facilitator interviews with assistance from an experienced translator. English translations of facilitator responses were recorded verbatim by the interviewer.

Data analysis

Data from free list interviews were coded collaboratively by interviewers, working in pairs to achieve consensus, and supervised by two authors to ensure fidelity to coding procedures. Responses were summarized into lists that included every discrete response and the number of times that response was mentioned. All interviewers and two authors reviewed these lists to obtain consensus for responses that expressed the same concept even though the wording was different. Conceptually equivalent items were combined into a single item and the number of responses summated. Interviewers and authors then sorted the responses into categories of changes, which became the focus of key informant interviews. Key informant interviews and facilitator interviews were analyzed in the same way, summing the frequency with which individual and conceptually equivalent responses were given.

Results

Free-list respondents reported five general categories of changes that happened because of the *IPT-G* program: 1) School attendance for children improved; 2) Productivity increased in agriculture and animal husbandry; 3) Sanitation in communities improved; 4) Togetherness and unity improved; and 5) Conflict in families was reduced. Responses grouped in each category are described in sections below. Descriptions

are based on data from both free-listing and key informant interviews. Responses were included in the following sections if they were given by at least 20% of free-list respondents (N=12 minimum) or key informants (N=5 minimum).

School attendance for children improved

The most frequent response given in free-list interviews was that because of the *IPT-G* treatment program, children go to school more because people now pay school fees (34 of 60 respondents; Table 2). Eleven of 22 key informants reported that children are now encouraged to work hard with their parents to increase family income in order to afford school fees, and 10 explained that parents now prioritize saving money to pay school fees. Six key informants stated that group members help each other to provide school fees and supplies so that children can go to school. Five key informants also stated that group members advised each other about various means of acquiring money to pay for school fees. Four key informants reported that *IPT-G* groups helped members “to put worries aside” and to concentrate on paying school fees for their children.

Nineteen free-list respondents mentioned that children now go to school because of changed attitudes of parents and increased motivation in children. The most frequent response of key informants, given by 12 of the 22, was that *IPT-G* groups “opened people’s eyes” and helped them to realize the value of sending their children to school. These key informants elaborated that before participating in the *IPT-G* groups, parents “never minded about children because of their problems” and that children did not go to school “because of *Okwekubagiza*” (self-pity). One key informant, expressing a concept representative of what was reported by others, explained that a community member might have thought “why should we send children to school since we will soon be dead and it doesn’t matter?” This key informant elaborated that group members came to recognize that even though they themselves may soon die, their children would continue to live and must be prepared for their future through education.

Other key informants reported that parents now ensure that their children to go to school. Five key informants stated that parents now “speak with children in friendship,” which has enabled them to persuade their children to attend school again. Four key informants explained that *IPT-G* has enabled group members to inspire parents to take their

Change in community (60 respondents):	Number of respondents who mentioned change:
People pay school fees for children to go to school	34
People are active in agriculture and animal husbandry	33
Cleanliness in families has improved	28
We get enough food from farming	26
People are working harder	21
We received knowledge and skills in modern farming, agriculture and animal husbandry	21
Cleanliness in the community has improved	20
Children now go to school due to changed attitudes and motivation in children	19
Parents learn to behave well and respect other family members	18
Behaviors in homes have improved	16
We get counseling and advice concerning our problems from fellow group members	16
People behave well, as society expects	14
There is peace in families	13
We still lack some support	13
We give each other advice about animal and crop husbandry and how to overcome problems	13
There is unity and cooperation	12

Note: (Primary Free List Question: What are all the changes that have happened for people who participated in the *IPT-G* groups?)

Table 2: Summary of all changes reported in free-list interviewing, mentioned by more than one person.

children to school and, as one key informant stated, to “instill the spirit and zeal” in those children who did not have it. Four key informants explained that parents now participate in meetings at school to ensure their children are doing well. Finally, four key informants indicated that children miss school less often due to illness because their parents no longer “stay sleeping” and seek medical assistance when needed. A dramatic example of *IPT-G* members’ renewed commitment to education was a group of women who had lost their spouses and children to AIDS. At the completion of their 16-week *IPT-G* treatment this group began to care for orphans and child-headed households in their community. The women also founded a school for children in the community, and monitored local families to ensure that children attended.

Productivity increased in agriculture and animal husbandry

Four of the six most frequently reported free-listing responses related to increased productivity (Table 2). Free-list respondents stated that because of the *IPT-G* groups: participants are active in agriculture and animal husbandry (33 of 60 respondents); families now produce sufficient food through farming (26 respondents); participants are working harder (21 respondents); and members have received knowledge in modern farming, agriculture and animal husbandry (21 respondents). Other changes related to productivity reported by free-list respondents included: “We give each other advice about animals and crop husbandry and how to overcome problems” (13 respondents).

Key informant interviews suggested that increased productivity is attributable to three factors stemming from the *IPT-G* groups: 1) Improved knowledge and skills in modern farming methods; 2) Increased cooperation and social support around farming; 3) Increased emotional strength and hopefulness. The most frequent response, given by 19 of 22 key informants, was that group members learned improved agriculture practices. The four next most frequent key informant responses highlight the sharing of farming information between group members that stems from “togetherness among people.”

The sixth most frequent key informant response (6 respondents), which was the most frequent response that did not refer directly to farming practices, was that group participants had been “restored” by the counseling in the groups and were able to work well. These key informants explained, for example, that before *IPT-G* groups, many community members were “lazy and reluctant” and “not able to do anything” because they were “thinking too much and worrying about problems.” They elaborated that previously members believed it served nothing to work hard because their land was too small to be productive.

Sanitation in communities improved

The third most frequent free-list response was “Cleanliness in families has improved (28 of 60 respondents). Similarly, 20 free-list respondents reported that “Cleanliness in the community has improved because there are better sanitation facilities and practices” (Table 2). Key informants reported that sanitation improved because people build toilets and kitchens and construct racks for dishes and utensils (17 of 22 key informants), clear rubbish from the family compound (12 respondents) and practice better hygiene such as hand washing, and boiling drinking water (11 respondents).

Key informants reported that *IPT-G* group members now visit each other and discuss cleanliness and monitor sanitation and hygiene (8 respondents). Five key informants reported that group members make an effort to assist each other in communal work to improve sanitation, for example by helping to build toilets.

Togetherness and unity improved

Free-list respondents reported that because of the *IPT-G* groups people have learned to give and receive counseling and advice about their problems (16 respondents; Table 2). Respondents stated that there is greater unity and cooperation because of the *IPT-G* groups (12 respondents). Almost all key informants reported that group members learned to support each other in their problems, and care about each other as before they had not (20 respondents) Eight key informants reported that members now advise each other on how to overcome problems (8 respondents). Key informants reported that community members now “work together” and do not segregate along lines of wealth, religion, and tribe (11 respondents), and that they have been taught to work together as a group to grow crops and rear animals (9 respondents). Key informants further reported that they have been able to resolve conflict, remove jealousy, and see each other as equals (7 respondents). Seven key informants stated that “hatred has stopped.” Finally, key informants reported that “visiting and knowing each other” has increased (7 respondents), and that members now trust each other because they vowed not to spread problems to outsiders (5 respondents).

Conflict in families was reduced

Free-list respondents reported that “parents learned to behave well and respect other family members” (18 of 60 respondents; Table 2) and that “behaviors in homes” have improved (16 respondents). Thirteen free-list respondents reported that there is “peace in families.” Key informants reported that members now advise each other in groups on how to resolve family conflicts (12 of 22 respondents) and are encouraged to maintain peace and love in their families and to respect all family members (6 respondents). Additionally, key informants reported that group members learned to work hard and were too busy for family arguments (10 respondents). Seven key informants stated that group members advised themselves to change and “leave bad behaviors.”

IPT-G facilitator interviews

Facilitator-reported changes due to participation in *IPT-G* treatment: All six *IPT-G* facilitators reported that *IPT-G* group members “were happy.” Five of six facilitators reported that “now members work.” In many cases, facilitators’ responses suggest that being “happy” was directly related to being able to resume working. Three facilitators reported that “members’ problems have been resolved by the group suggestions.” Three facilitators also stated that formerly depressed group members resumed socializing. Two facilitators stated that husbands and wives now “work together” and that this was associated with increased productivity and increased happiness. Facilitators also referred to material gains stemming from *IPT-G* participation. For example, two facilitators reported that members were able to “buy land and livestock” and that members now “have food” and “food to feed their children” as a result of farming. Two facilitators reported that members have resumed their business, for example selling pancakes or baskets. Responses that members “have money,” and “built a house,” or have “improved production” were given by one facilitator each.

Interrelation of *IPT-G*, development-related trainings, and cash rounds: Three of six facilitators stated that development-related information, for example, about modern farming techniques, sanitation, and the idea to start cash rounds, were introduced by group members themselves near the end of treatment. Facilitators stated that members drew on their own expertise and shared information among

themselves about raising animals. Three facilitators emphasized that focusing on weekly and long-term goals in the treatment led to these other ideas, and two explained that the focus on long-term non-mental health related goals, like planting seeds to grow fruit and vegetables, began in the middle phase of treatment. Two facilitators indicated that at times they made suggestions based on their experience leading other trainings, including in farming methods. Two other facilitators reported that their groups focused only on treating depression, while another two stated that other ideas and practical goals were introduced but that this occurred as group members' depression began to remit, and they started "to look for what to do." In her description, one facilitator explained: "Before treating depression, treating the mind, they couldn't do the others and they were even fearing. It was after going through treatment for the mind, after opening up...and getting suggestions and starting working, they started to get other ideas." Another added, "When people were still depressed, [development trainings] would come and people would say 'this cannot help me' and they ignored it. Before they didn't want to have it because they were depressed."

Discussion

The *IPT-G* depression treatment program was reported by respondents to have led to a range of changes in general quality of life and local development. Two of these changes in particular, increased school attendance and increased productivity in farming, align with major international development priorities, articulated by the United Nations in the Millennium Development Goals, to achieve universal primary education, and eradicate extreme poverty and hunger [28]. Free-list and key informant interviews suggested two interrelated mechanisms underlying the reported changes: i) increased social support and strengthened social bonds, ii) the treatment and remission of depression. Also, the communication of farming and sanitation information appeared to be an important contributor to reported improvements in productivity and cleanliness

The impact of increased support and social ties among *IPT-G* participants and between participants and other family and community members, which was itself a main category of change, was intertwined in the other categories of change as well. For the category "school attendance has improved," key informants stated that group members inspired each other to take children to school and supported each other in helping children to have the necessities for school. For the category "productivity has increased," responses indicated that togetherness brought new farming practices and that people visited each other, learned new farming techniques, and helped with "digging." For the category "sanitation has improved," changes were linked to increased cooperation and sense of responsibility for others.

Similarly, apparent reductions in depression symptoms were highlighted in explanations of multiple categories of reported changes. For example, key informants reported that *IPT-G* group members who "never minded about children because of their problems," learned to put "worries aside and concentrate on paying school fees." Agricultural productivity improved because people who previously could "not do anything" and "had no interesting digging" because of "thinking too much" and "worrying about their problems," were "counseled and... restored" and could "work well" at farming. A number of other free list and key informant respondents gave answers consistent with this mechanism, though not with enough frequency to meet the cut-off for inclusion in the results. For example, five free list respondents reported having "more strength" to work and being "motivated and encouraged."

Three key informants reported that counseling eased family conflict by renewing hope and restoring people to their "normal senses." Two others reported that sanitation and hygiene improved because "people stopped thinking a lot," and no longer "felt sorry for themselves." Free list respondents also mentioned mental health specific outcomes related to the *IPT-G* program, such as "There is no more depression," and "Now we are happy," which also were not reported frequently enough to include in the results. Finally, three or fewer free list respondents reported negative changes due to the *IPT-G* program, including husbands or wives of participants fearing their partners will find other men or women as a result of treatment, and jealousy among community members who did not participate in the *IPT-G* groups.

During the lifespan of the *IPT-G* program in Masaka and Rakai, World Vision and other organizations led concurrent initiatives to improve education, farming, and sanitation that may have contributed to the reported changes, though it was not possible to determine precisely which other programs had been received by specific respondents or communities. The description of apparent mechanisms underlying the reported changes does however support the specific contribution of the *IPT-G* program. World Vision staff also reported anecdotally that numerous development programs operated in the area long before *IPT-G* was introduced but were not successful, explaining that it was the added influence of the *IPT-G* program that helped participants benefit from other programs. *IPT-G* facilitator responses about the interplay between *IPT-G* and other development programs clearly reflected this concept. *IPT-G* facilitator responses also suggested that information from other programs did not alter the *IPT-G* group focus on the treatment of depression.

Limitations

Results of this study must be interpreted cautiously for several reasons, in particular, the challenge of isolating *IPT-G* program effects from those of other programs operating in the area. Additionally, the entrepreneurial training offered as part of the MRPP may have contributed to reported changes, although most reported changes were not entrepreneurial in nature. Whenever possible interviewers selected free-list respondents that had completed the 16-week *IPT-G* treatment but had not yet participated in the entrepreneurial training, so that their responses could be more confidently attributed to the *IPT-G* component of the program.

The sampling approach may also have introduced a positive response bias. For logistical reasons, *IPT-G* facilitators helped to identify respondents. Those respondents who were former *IPT-G* participants may have reported more positive changes out of a sense of loyalty or obligation to the facilitator. Respondents were assured during the consent process that the research team equally valued positive and negative responses, and that respondents' access to support from World Vision and other organizations would not be affected by the answers they gave. According to World Vision staff, respondents in this study were aware of the impending termination of the *IPT-G* treatment program in Masaka and Rakai and may have emphasized positive changes to persuade World Vision to continue the *IPT-G* program.

The sampling approach also limits the generalizability of the results. Most respondents were *IPT-G* participants and their family members, thus it is uncertain when responses referred to participants and their families or to the community as a whole. In small communities, where many community members participated in *IPT-G* treatment, or had a family member participate, the changes reported by participants and family members may in fact be representative of changes perceived in

the community as a whole. In larger communities, not all community members may recognize the changes reported by participants and their families.

Finally, *IPT-G* facilitator responses highlighted questions about *IPT* fidelity. Volunteer facilitators appeared still to be guided the *IPT* treatment model, in which therapy focuses on problem solving in one of four areas (grief, role transitions, role disputes, interpersonal deficits) though the extent to which they faithfully employed *IPT* treatment techniques was less clear. Facilitators emphasized general group therapy facilitation techniques, which are also practiced in *IPT-G*, including drawing on group members for suggestions for each others' problems and refraining from "giving answers" to the members. Two senior volunteer *IPT-G* facilitators who had more education than the facilitators that were formally interviewed described anecdotally, in detail, specific *IPT* techniques that they employ. There was likely variability among volunteer facilitators in fidelity to *IPT* techniques; nevertheless, all facilitators reported that *IPT-G* retained a primary focus on depression treatment, rather than on farming, or other topics related to material gain,

Conclusion

This study indicated that the *IPT-G* depression treatment program was perceived by respondents to have led to positive changes in quality of life and development for people who received treatment, their family members, and for communities. Two of the reported changes are consistent with Millennium Development Goals to achieve universal primary education and eradicate extreme poverty and hunger, suggesting that treating depression in developing countries may have a positive impact on development efforts. Because multiple programs operated simultaneously in the *IPT-G* program area, it may be most appropriate to consider the reported changes as stemming from the combined impact of the *IPT-G* treatment and other programs: a picture of what might be expected to result over time from a sustained, coordinated aid effort that includes a treatment response for depression-like illness.

Acknowledgements

The authors thank the field staff of World Vision Uganda for their assistance with data collection for this study, as well as Alison Shafer of World Vision Australia, Stefan Germann of World Vision International, and Bill Forbes of World Vision USA for their support and assistance in securing financial and organizational support.

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