ıal Psychotherapy for Depression in Rural UgandaA Randomized Controlled Trial

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Abstract:

Context Despite the importance of mental illness in Africa, few controlled intervention trials related to this problem have been published. Objectives To test the efficacy of group interpersonal psychotherapy in alleviating depression and dysfunction and to evaluate the feasibility of conducting controlled trials in Africa. Design, Setting, and Participants For this cluster randomized, controlled clinical trial (February-June 2002), 30 villages in the Masaka and Rakai districts of rural Uganda were selected using a random procedure; 15 were then randomly assigned for studying men and 15 for women. In each village, adult men or women believed by themselves and other villagers to have depressionlike illness were interviewed using a locally adapted Hopkins Symptom Checklist and an instrument assessing function. Based on these interviews, lists were created for each village totaling 341 men and women who met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for major depression or subsyndromal depression. Interviewers revisited them in order of decreasing symptom severity until they had 8 to 12 persons per village, totaling 284. Of these, 248 agreed to be in the trial and 9 refused; the remainder died or relocated. A total of 108 men and 116 women completed the study and were reinterviewed. Intervention Eight of the 15 male villages and 7 of the 15 female villages were randomly assigned to the intervention arm and the remainder to the control arm. The intervention villages received group interpersonal psychotherapy for depression as weekly 90-minute sessions for 16 weeks. Main Outcome Measures Depression and dysfunction severity scores on scales adapted and validated for local use; proportion of persons meeting DSM-IV major depression diagnostic criteria. Results Mean reduction in depression severity was 17.47 points for intervention groups and 3.55 points for controls (P<.001). Mean reduction in dysfunction was 8.08 and 3.76 points, respectively (P<.001). After intervention, 6.5% and 54.7% of the intervention and control groups, respectively, met the criteria for major depression (P<.001) compared with 86% and 94%, respectively, prior to intervention (P = .04). The odds of postintervention depression among controls was 17.31 (95% confidence interval, 7.63-39.27) compared with the odds among intervention groups. Results from intention-to-treat analyses remained statistically significant. Conclusions Group interpersonal psychotherapy was highly efficacious in reducing depression and dysfunction. A clinical trial proved feasible in the local setting. Both findings should encourage similar trials in similar settings in Africa and beyond. Depression is a leading cause of disability in both developed and developing regions of the world, including Africa.1- 2 In 2000, we conducted a community-based survey in an impoverished part of southwest Uganda that has been severely affected by the human immunodeficiency virus (HIV) epidemic. Using Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) major depression criteria, we found a current depression

ied data, 2000), consistent with previous research e and bereavement in depressive symptoms. World Vision International, a nongovernmental humanitarian organization, was interested in addressing this substantial mental health burden in Uganda. Both antidepressants and psychotherapy have been shown to be efficacious in numerous controlled trials in developed countries, including evidence of equivalence in reducing the symptoms of acute depression.3 However, use of antidepressants is not feasible in this region because of high cost and limited supply infrastructure. Psychotherapy was therefore the preferred option, although its use raised other issues. While there is substantial evidence for the efficacy of "talking therapies,"4 these have been developed in industrialized nations in the Western Hemisphere. The extent to which the concepts and therapeutic strategies they use are appropriate among other populations is unknown. In sub-Saharan Africa, conditions are very different from those in which psychotherapy was developed, in ways that could reduce effectiveness. For example, many populations are reluctant to communicate directly about sensitive issues; others live in conditions of extreme chronic deprivation that are rare in developed countries. The need to test the local effectiveness of psychotherapy raised an additional problem. Such testing has been hampered in Africa by a lack of field methods for cross-cultural adaptation and validation of assessment instruments. The lack of these methods, as well as perceived logistic and ethical difficulties, have led some to believe that clinical trials of psychotherapy are not feasible in Africa. We therefore began by developing a field method that has since been successfully tested in 2 sitesð Rwanda and the same villages in Uganda as in the current study.5- 6 In both settings, we created or modified and then validated measures of depressive symptoms and social functioning. These instruments were then used in community-based prevalence surveys. The instruments developed in Uganda form the basis of the current study. The intervention we studied is a group-based interpersonal psychotherapy (IPT) for depression. Extensive evidence for its efficacy and effectiveness comes from randomized controlled clinical trials in which treatment was time-limited and specified in a procedural manual.4 "Time-limited" means that treatment is not open-ended but that the number, frequency, and duration of sessions are specified at treatment outset. Selection of this intervention allowed us to more accurately budget the intervention and also made it cost-effective compared with open-ended therapies. The IPT manual (available by e-mail from the authors at mmw3@columbia.edu or kfclougherty@aol.com)7 was essential for accurate provision of IPT to this population. Prior experience also suggested that the focus of IPT on interpersonal relationships was compatible with Ugandan culture. The full rationale behind the development of IPT, its adaptation for use in Uganda, and the training of local care providers is described elsewhere.4,7 This article reports the results of a controlled clinical trial of group IPT. The study was conducted in the same Ugandan villages surveyed in 2000. Screening and baseline assessments were conducted in February 2002. The IPT took place from March through June 2002 (all groups began and finished within a week of each other), and the follow-up assessment was conducted within 2 weeks of IPT completion. Our purposes were (1) to test the efficacy of group IPT for Uganda (IPT-G-U) in relieving depressive symptoms and improving functioning and (2) to evaluate the feasibility of such studies in sub-Saharan Africa. To our knowledge, this is the first published controlled clinical trial of a psychological intervention in resource-poor sub-Saharan Africa.