Journal of Affective Disorders 163 (2014) 10–17

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Developing a culturally sensitive group support intervention for depression among HIV infected and non-infected Ugandan adults: A qualitative study

Etheldreda Nakimuli-Mpungu [a,b,*], Kizito Wamala [c], James Okello [b,d], Stephen Alderman [b], Raymond Odokonyero [a,b], Seggane Musisi [a,b], Ramin Mojtabai [e]

[a] Makerere University, College of Health Sciences, Kampala, Uganda
[b] Peter C. Alderman Foundation, NewYork, USA
[c] African Center for Tortured Victims, Kampala, Uganda
[d] Gulu University, Department of Psychiatry, Gulu, Uganda
[e] Johns Hopkins School of Public Health, Department of Mental Health, Baltimore, United States

ARTICLE INFO

Article history:
Received 16 November 2013
Received in revised form
22 March 2014
Accepted 24 March 2014
Available online 1 April 2014

Keywords:
Depression
Culture
HIV/AIDS
Group support psychotherapy
Social support
Northern Uganda

ABSTRACT

Background: Depression is ranked first among neuropsychiatric diseases that contribute to the burden of disease in low- and middle-income countries. However, access to antidepressants is limited and there is a dearth of locally developed psychotherapeutic interventions targeted to treat depression.
Aim: We aimed to obtain information on the cultural understanding of depression symptoms, complications and treatment methods used in post-conflict communities in northern Uganda in order to inform the development of an indigenous group support intervention to treat depression.
Methods: Focus group discussions (FGDs) were conducted with a total of 110 men and women aged 19–68 years. FDGs took place in a private space, lasted about 2–3 h and were conducted in the local language for patients and their caregivers and in English for health workers. Interview transcripts from the FGDs were reviewed for accuracy, translated into English and transcribed. QRS Nvivo 10 qualitative data analysis software was used for coding and thematic analysis.
Results: Our study revealed community misperceptions about etiology, presentation and treatment of depression. Regardless of HIV status, most FGD participants who were not health workers linked depression symptoms to HIV infection. Although there were concerns about confidentiality of issues disclosed, many FGD participants were supportive of a group support intervention, tailored to their gender and age, that would not only focus on treating depression but also provided them with skills to improve their livelihoods. Simple CBT techniques were deemed culturally appropriate and acceptable.
Limitation: Generalizability of study findings may be limited given that the sample was primarily of Luo ethnicity yet there are different ethnic populations in the region.
Conclusion: Local communities can directly inform intervention content. The participants' preferences confirmed the need for a gender-specific intervention for depression that extends beyond medications and empowers them emotionally, socially and economically.

1. Introduction

Depression is ranked first among neuropsychiatric diseases that contribute to the burden of disease in low- and middle-income countries (LMIC) (Mathers and Loncar, 2006). War-related violence, chronic diseases such as HIV/AIDS and socio-economic disadvantage including poverty and low education have been found to be major risk factors for depression in these countries (Patel and Thornicroft, 2009). Indeed, high prevalence rates of depression symptoms have been reported in the northern region of Uganda which suffered two decades of brutal civil wars, with estimates ranging from 45% to 70% (Roberts et al., 2008; Vinck et al., 2007).

Depression is associated with low energy level and feelings of inefficacy which results in an inability to care for self, and adhere to medical, behavioral or economic interventions. Indeed, several studies have reported that depression affects an individual's work productivity and subsequently the economic productivity of an

* Corresponding author at: Makerere University College of Health Sciences, School of Medicine, Department of Psychiatry, P.O. BOX 7072, Kampala, Uganda. Tel.: +256 715105276.
E-mail address: ethelmpungu@yahoo.com (E. Nakimuli-Mpungu).

http://dx.doi.org/10.1016/j.jad.2014.03.042
0165-0327/

entire nation (Wedegaertner et al., 2013). For these reasons, there is urgent need of culturally appropriate interventions for depression especially in low resource settings.

The World Health Organization (World Health Organization, 2010) recommends treating depression with basic psychosocial support combined with antidepressant medication or psychotherapy, such as cognitive behavior therapy (CBT). However, these treatments are limited in low resource settings like northern Uganda (Patel et al., 2007). Further, recent studies (Fournier et al., 2010; Kirsch et al., 2008; Khan et al., 2002) have found that antidepressants are superior to placebo only in cases of moderate-severe depression and may present no advantage over placebo in treatment of mild or sub-threshold depression which is more common in low resource settings like northern Uganda (Nakimuli-Mpungu et al., 2013a, 2013b; Roberts et al., 2008). Psychotherapeutic intervention may provide safer alternatives to medications in such cases. There is substantial evidence to support the use of CBT in the treatment of depression (Cuijpers et al., 2013), and psychological therapies are recommended by WHO as first line treatments for cases of mild or sub-threshold depression (WHO, 2010).

Although most research on development of psychotherapeutic interventions for depression has been concentrated in developed countries (Huntley et al., 2012), studies in Indonesia (Bass et al., 2012), Uganda (Bolton et al., 2007) Congo (Bass et al., 2013), and South Africa and Tanzania (Kaaya et al., 2013) indicate that both adapted western psychotherapeutic interventions and locally developed psychotherapeutic interventions can be efficacious in alleviating symptoms of depression. Provision of these therapies in group format can help to maximize the use of scare resources and thus improve access to the therapy for those who need it and decrease costs associated with providing psychological therapies.

In northern Uganda, there is urgent need to develop culturally sensitive interventions for depression. The development of culturally appropriate psychotherapeutic interventions for depression requires an understanding of the target population perceptions of the etiology, presentation and community care pathways. By integrating population-specific beliefs about depression with the CBT, it is possible to develop a theoretically grounded intervention that is tailored to the needs of this population (Jemmott, 2012). Moreover, because mental health problems and help-seeking behavior are found to be interlinked with gender roles, it is important to take gender into consideration when developing intervention models (Danielsson et al., 2011; Wiklund et al., 2010). Studies indicate that stressors such as sexual or domestic violence are closely linked to women's experiences of distress and impaired mental health (Devries et al., 2013).

This paper reports the results of a qualitative study in which we aimed to obtain information on the cultural understanding of depression symptoms, complications and treatment methods used in post-conflict communities in northern Uganda in order to inform the development of an indigenous group support intervention to treat depression. The paper also describes the features of the developed group support intervention.

2. Methods

2.1. The process of developing the group support intervention

The group support intervention was developed collaboratively and iteratively over a one year period (June2012–May 2013). Initially, study investigators reviewed the literature on psychotherapeutic interventions for depression and found that more evidence exists for the effectiveness of CBT than for other psychotherapeutic interventions (Hofmann et al., 2012). We also learned that in cultural adaptations of CBT for ethnic minorities which have been described in developed countries (Interian et al.;2008), focus group discussions were used to obtain in-depth information about what it was about the therapy that worked in the "original" CBT. However, in our target community, no one had the experience of participating in the "original" CBT sessions and no health worker had the experience of having facilitated these CBT sessions. Through our work in the PCAF trauma clinics, we knew that depression exists in our target community and this community had specific ways of expressing their depression symptoms as well as indigenous ways of dealing with individuals with depression. Also, our PCAF staff had experience in providing a group counseling intervention in which they actively listened to personal problems and trauma stories, conducted psych-education talks, taught positive coping skills and discussed negative coping skills. These group counseling sessions appeared to be effective in reducing depression symptoms (Nakimuli-Mpungu et al., 2013a, 2013b) but, given the low uptake of this intervention, we were not certain as to whether this counseling was addressing all psychological and social issues that the community associates with depression and whether the mode of delivery of this group counseling was culturally appropriate and acceptable.

These issues were discussed through emails and face-to-face meetings with faculty in the department of Psychiatry, Makerere University, Peter C. Alderman Foundation (PCAF) staff who were involved in group counseling, community members, local government district officials and non-governmental organization workers, particularly those working with HIV infected and affected individuals. A decision was made to conduct focus group discussions to obtain information on the cultural understanding of depression symptoms, complications and treatment methods used in the local community to inform the further development of the counseling intervention that is provided to individuals attending PCAF trauma clinics in northern Uganda. A research proposal for this qualitative study was submitted to and approved by both the Makerere University College of Health Sciences Research Ethics Committee and the Uganda National Council of Science and Technology (UNSCT). All study participants provided written informed consent. Light refreshments were served during the discussions and each participant received an equivalent of $2–$5 US dollars to defray transport costs.

2.2. Setting and participant recruitment

Focus groups of HIV infected and affected men and women were convened at the Gulu and Kitgum PCAF trauma clinics and their rural outreach centers – Mucwini health center III and Namukora health center IV. The two trauma clinics are situated in the Gulu and Kitgum districts, have the same ethnic population and form part of the post-conflict northern region of Uganda that endured more than two decades of brutal civil wars. The PCAF trauma clinics have a functioning infrastructure, culturally adapted monitoring and evaluation tools, and an established relationship with the community, thus providing a logistically sound and cost-effective platform for this qualitative study (Nakimuli-Mpungu et al., 2013a, 2013b).

Over a two-month period (February–March 2013), PCAF staff identified patients receiving treatment for depression either during regular clinic visits, or by clinic electronic database, and contacted them with information about the study. If the potential participant was interested, the participant and their caregiver were given an appointment to confirm eligibility, obtain informed written consent, and collect baseline socio-demographic information. Eligible participants for focus group discussions (FGDs) were individuals who were currently receiving treatment for a depressive episode or had experienced a depressive episode in the past and their caregivers.

Also, FGDs were held with mental health workers, general health workers and individuals working with non-governmental