

# Group Interpersonal Psychotherapy for Depressed Youth in IDP Camps in Northern Uganda: Adaptation and Training

Helen Verdeli, PhD<sup>a,b,c,\*</sup>,  
Kathleen Clougherty, MSW<sup>b,c</sup>, Grace Onyango, MA<sup>d</sup>,  
Eric Lewandowski, MSc<sup>a</sup>, Liesbeth Speelman, MA<sup>e</sup>,  
Teresa S. Betancourt, ScD<sup>f</sup>,  
Richard Neugebauer, PhD<sup>b,c</sup>, Traci R. Stein, MPH<sup>a</sup>,  
Paul Bolton, MBBS<sup>g</sup>

<sup>a</sup>Teachers College, Columbia University, Box 102, 525 West 120th Street, New York, NY 10027, USA

<sup>b</sup>New York State Psychiatric Institute, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032, USA

<sup>c</sup>College of Physicians and Surgeons, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032, USA

<sup>d</sup>World Vision Uganda, P.O. Box 5319, Plot 15B, Nakasero Road, Kampala, Uganda

<sup>e</sup>War Child Holland, Gulu, Uganda

<sup>f</sup>Harvard University School of Public Health, 651 Huntington Avenue, 7th floor, Boston, MA 02115, USA

<sup>g</sup>Johns Hopkins Bloomberg School of Public Health, 615 N Wolfe Street, Room E8646, Baltimore, MD 21205, USA

This article reviews the use of interpersonal therapy in a specific population of displaced children, and describes and discusses the methods used to adapt interpersonal therapy for this population. Armed conflicts expose children to prolonged and repeated stressors that can have severe immediate and long-term psychologic consequences, including posttraumatic stress (PTSD), depression, and behavioral and conduct problems [1–3]. Additionally, the emotional and cognitive development of young children may be

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\* Corresponding author. Teachers College, Columbia University, Box 102, 525 west 120th street, New York, NY 10027.

E-mail address: hv2009@columbia.edu (H. Verdeli).

affected by constant fear; severe losses or disruptions in relationships with caregivers, family, and community members; limited access to formal education; exposure to malnutrition and infections; and pressure to prematurely assume adult family roles [4,5].

Among a sample of 61 Tibetan child and adolescent refugees living in India, 11.5% were found to meet DSM-IV criteria for PTSD and 11.5% for major depressive disorder [6]. A well-known longitudinal study of 40 Cambodian refugees resettled in the United States found a 50% prevalence of PTSD and 56% prevalence of depression 4 years after leaving refugee camps in their home country [7]. Nine years after the first study, depression rates were 14% and PTSD rates were 35% [8].

In a sample of 229 Palestinian children and adolescents exposed to violence since the start of the Second Uprising, almost 70% were identified as having PTSD and 40% as having moderate to severe depression. Additionally, 70% showed poor coping responses [9]. Other studies that did not report on posttraumatic stress symptoms have identified depression and internalizing behaviors in children in response to war-related trauma. For example, exposure to war stress was related to internalizing symptoms in 121 children from Gaza aged 6 to 16 years [10].

A study of Bosnian children and adolescents showed the highest rates of depressive symptoms in children whose father had disappeared during the war and whose current whereabouts were unknown. These children exhibited even more depression than those whose fathers had disappeared and were eventually confirmed dead [11]. Despite variability in the relative prevalence of depression and PTSD and differences in their duration after exposure to war stress, both seem highly prevalent adverse mental health outcomes in children and adolescents exposed to war and dislocation.

An exponential growth in studies of youth afflicted by war and violence occurred over the past 2 decades, indicating the increased attention devoted to mental health problems by the international humanitarian community. However, most of these studies use Western instruments to measure mental health outcomes in non-Western resource-poor communities without first validating these instruments locally. Similarly, mental health interventions for humanitarian emergencies have been increasingly included in the global health agenda, resulting in the fielding of various treatment programs. These interventions have been developed mostly in Western countries, based on Western assumptions about human relationships, communication, and coping.

Although the value of some interventions has been rigorously tested in Europe or the United States, assessments in other settings are rare. Thus, discrimination among helpful, ineffective, and harmful interventions for resource-poor areas in non-Western countries is exceedingly difficult given the paucity of evidence on their efficacy in these settings [12]. The lack of scientific evidence on programs addressing the psychologic needs of war-affected adolescents is especially pronounced [13].

To fill this scientific and programmatic gap, a research collaboration among three groups was formed in 2004: Bolton and colleagues from Boston University (BU); two Interpersonal Psychotherapy experts from Teachers College and the New York State Psychiatric Institute, College of Physicians and Surgeons, Columbia University; and two non-governmental organizations (NGOs): World Vision and War Child Holland (WCH). This two-step research program had the goal of selecting mental health problems in the youth important for the local population and potentially amenable to interventions; and assessing in a randomized clinical trial (RCT) the impact of the mental health interventions on these problems [14,15].

Previously, the three collaborating groups conducted a RCT with depressed adults in Southern Uganda. In that study, group interpersonal psychotherapy (IPT-G) showed efficacy for treating depression with some anxiety symptoms in adults. Compared with an assessment-only control group, IPT-G led to significantly higher symptom and functional improvement, with results persisting in the 6-month follow-up [16,17]. However, because the control condition included no intervention, the question remained whether the specific IPT-G skills or a more general nonspecific group-support effect was operative.

A second condition, a form of creative play therapy developed by WCH was included. IPT-G and creative play therapy were compared with a wait-list control group.

The Awer and Unyama camps in the northern province of Gulu were selected for study because they represent the service catchment area of the two NGO partners. Awer camp is located southwest from Gulu town, with a population of approximately 27,000. The camp has little legal economic activity, such as shops or businesses. Unyama camp, with a population of 20,000, is closer to Gulu and somewhat more economically active than Awer. Residents of Awer and Unyama have attempted small-scale farming near the camps, because it is considered too dangerous to farm farther afield (Paul Bolton, MBBS, and colleagues, World Vision Internal Report, 2006).

### **Armed conflict in Northern Uganda**

The 20-year-old armed conflict in Northern Uganda between the rebel Lord's Resistance Army (LRA) and the Ugandan government is among the deadliest humanitarian emergencies in the world. The LRA has committed countless atrocities against Ugandan civilians from the northern Acholi ethnic group, including rape, mutilation, and murder.

One of the LRA's most notorious crimes against humanity involves the abduction of more than 25,000 children to serve as soldiers and labor/sex slaves. Abductees habitually witnessed and were victims of horrific acts of violence, such as severe beatings, marching until exhaustion, rape, and mutilation. Captive children were occasionally forced to kill others, including relatives and friends [18].

## **Internally displaced persons camps in Northern Uganda**

This conflict has displaced 1.8 million Ugandans to internally displaced persons (IDP) camps guarded by the Ugandan military. Most of this population has been exposed to significant psychologic trauma. A survey among adults at an IDP camp in Pader found that 79% of respondents had witnessed torture and 40% a killing. Of respondents, 63% reported the disappearance/abduction of a family member and 58% had lost a family member to violence.

This survey also found that men and women experienced the local syndrome “par,” which shares many symptoms with major depressive disorder, including low mood, sadness, poor appetite, sleep disruption, social withdrawal, and thoughts of suicide. Women were considerably more likely to experience Par than men. Suicidal thoughts in the week before the survey were reported by 63% of women and 13% of men. All respondents could identify one person who had attempted suicide in the past month. Men and women also reported current symptoms of traumatic stress [19].

In these camps, the normal fabric of society has been eroded by dislocation, fear, and death from violence and disease. Traditional social structures have been disrupted and the routines of life and education of youth suspended. Women fear rape and abduction and bear the burden of caring for their family without the traditional support of kin and community elders. Men have lost their traditional role as the family provider. Because finding work is difficult and dangerous, camp residents are often idle and become dependent on humanitarian programs. Fear and hopelessness contributes to high rates of alcohol abuse and domestic violence, and hunger drives women of all ages to prostitute themselves. Little is known specifically about the impact of the conflict on the mental health of children and adolescents (Paul Bolton, MBBS, and colleagues, World Vision Internal Report, 2006) [20].

## **Preintervention assessment**

In July 2004, the BU team initiated a two-step assessment process, a qualitative followed by a quantitative study. The assessment was conducted in Luo, the local language. The qualitative study identified (1) major mental health and psychosocial issues affecting the camp youth, as experienced and perceived by the local community; and (2) youth tasks and activities that the community considered important, such as the ability to perform gender-specific chores, attend school, interact with peers, and fulfill family and community roles. This information was then used to inform the design of quantitative instruments of mental health problems and associated dysfunction. These instruments were then used to assess the impact of candidate mental health interventions in the RCT [14,15].

The results of this assessment have been described in detail elsewhere [14]. In summary, the qualitative study yielded seven locally described syndromes. Two states of mind—a legitimate fear of LRA attacks and “cen,” an agitated

posttraumatic stress reaction experienced by local people as attack by evil spirits seeking revenge—were determined by the BU and NGO research team as unlikely to be amenable to psychosocial intervention with available resources.

Three of the remaining local syndromes (two *tam*, *par*, and *kumu*) were local depression-like problems with mixed depression and anxiety symptoms. The fourth (*ma lwor*) was an anxiety-like local syndrome, and the fifth (*kwo maraco*) involved a combination of conduct problems. Alcohol abuse and sexual violence were part of several of these syndromes [14,15].

A locally derived quantitative instrument was developed, the Acholi Psychosocial Assessment Instrument (APAI), to incorporate the symptoms of the five major syndromes and a measure of functional limitations experienced during the past week. The APAI depression scale contained all symptoms of the depression-like syndromes. A cut-off score on the APAI depression scale was determined based on discrimination of cases versus noncases. Reliability and validity are discussed in works by Bolton and colleagues [14] and Betancourt [15].

## **Randomized clinical trial**

### *Participants*

The RCT by Bolton and colleagues [14] screened 667 youth, with 314 adolescents aged 14 to 17 years meeting inclusion criteria. Study inclusion criteria included residence in the camps in the month preceding the screening interview, depression-like symptoms for at least 1 month and currently exceeding the predetermined cutoff score, functional impairment, and assent (adolescents) and consent (caregivers).

Exclusion criteria were severe cognitive or physical disability that would impair ability to answer questions in Luo, and active/persistent suicidal ideation/behavior. Posttraumatic and other anxiety symptoms and substance use problems were not exclusionary criteria. A total of 304 participants who met inclusion criteria agreed to take part in the study; 57% were girls and 42% had been previously abducted by the LRA [14]. The study was sanctioned by local community leaders.

### *Interventions*

The results of the qualitative and quantitative study showed that depression-like syndromes were both prominent and debilitating in adolescents in these camps; among those assessed, 45% were met inclusion criteria. However, the local depression-like syndromes contained a high number of anxiety symptoms. Comorbid anxiety in depressed adolescents is routinely encountered in Western countries (rates ranging from 15%–60%) [21,22] and, given the degree of danger and trauma in the lives of the camp population, was expected to be at least as high in the current sample.

When making decisions about candidate interventions addressing depression or trauma/anxiety, the authors decided to include IPT-G for several reasons. First, during the qualitative study, youth and caregivers reported that their main concerns revolved around daily life in the camps, including struggles for survival and access to food and education. Negotiation of space (given the overcrowding in the camps), the readjustment of abducted youth to the camp life, and dealing with the burden of caretaking of members of their family of origin and new family were some prominent issues for adolescents. Adult caregivers also complained that the adolescents were disrespectful and unmotivated.

Furthermore, United States studies indicate that IPT for depressed adolescents who had comorbid anxiety had positive effects on depression and comorbid anxiety. Among 48 adolescents aged 12 to 18 years diagnosed with major depression, those who participated in IPT treatment experienced greater reductions in depressive symptoms and more improvement in social and global functioning than those who underwent clinical monitoring [23].

A study of adolescents aged 12 to 17 years experiencing various depressive disorders found that IPT was significantly more effective in reducing symptoms of depression than usual treatment. This study also showed that the presence of comorbid anxiety symptoms did not diminish the effectiveness of IPT-A, which continued to be superior to usual treatment, and was in fact associated with a near-significant increase in the effectiveness of IPT-A relative to usual treatment [24].

Lastly, IPT-G has shown efficacy for treating depression with some anxiety symptoms in adults in South Uganda. Compared with an assessment-only control group in an RCT, IPT-G led to significantly higher symptom and functional improvement, with results persisting in the 6-month follow-up [16,17].

The partner NGO World Vision and local communities adopted and disseminated the treatment, which is still practiced by the original clinicians and has been administered to approximately 2500 community members (Grace Onyango, MA, personal communication, 2007). A main reason for selecting IPT-G for South Uganda was its compatibility with the cultural attitude of experiencing self as an integral part of a social and ethnic group. This attitude also characterizes the Acholi population in Northern Uganda.

### **Interpersonal psychotherapy for groups**

IPT was originally developed in the United States as an individual treatment for unipolar nonpsychotic depression [25]. In treating depression, IPT targets the connection between onset of symptoms and current interpersonal problems. IPT therapists begin with a systematic diagnostic assessment, explain the diagnosis, and work with the patient to identify the problem areas associated with the onset of current symptoms.

Difficulties in four interpersonal areas are considered triggers of depressive episodes and become the focus of treatment: (1) grief (from death of a loved one), (2) interpersonal disputes (disagreements with important people in one's life), (3) role transitions (negative and positive changes in life circumstances), and (4) deficits (persistent problems in initiating or sustaining relationships) [26].

IPT is specified in a manual, has been tested in numerous open and randomized clinical trials, and is efficacious for several mood and non-mood disorders among adolescent, adult, and geriatric outpatient populations [26]. The feasibility and efficacy of individual IPT for treating symptoms of depression in adolescents in clinical settings has been tested in open, randomized, controlled clinical trials [23,27]. Its effectiveness in treating depression in adolescents recruited and treated in school-based clinics by community mental health professionals was subsequently established [28]. IPT for depressed adolescents (IPT-A) typically consists of 12 weekly sessions and has the goal of decreasing depressive symptoms and improving interpersonal functioning. As with IPT for adults, IPT-A conceptualizes interpersonal difficulties as fitting into one or more of the four problem areas mentioned earlier [23].

IPT was adapted for groups (IPT-G) and was found to be efficacious in treating binge-eating disorder [29], postpartum depression [30], and depressed adults in communities in South Uganda [16,31]. IPT-A has also been adapted for use as a 12-session group intervention [32]. A group therapy context can provide adolescents with additional peer support and opportunities to practice interpersonal skills.

The adaptation of IPT-G for South Uganda specified one or two pre-group meetings, which are individual meetings between the leader and each group member followed by 16 weekly group meetings lasting 90 minutes (Kathleen Clougherty, MSW, and colleagues, unpublished manual, 2002).

In IPT-G, members are encouraged to practice new communication and interpersonal problem-solving skills in the group. They inform each other about progress in their weekly goals. Therapists also make supportive and cohesion-building process remarks.

Termination is the fourth phase of treatment, with particular emphasis on enhancing each patient's independent functioning and developing strategies for relapse prevention. It usually lasts 2 to 4 sessions in IPT and IPT-G clinical trials.

### **Creative play**

Creative play was developed by WCH to promote social skills, self-esteem, and self-expression for war-affected children [33]. It typically lasts 12 weeks and is provided to children aged 6 to 14 years in their communities, and is based on the premise that their coping will be strengthened by verbal

and nonverbal expression of thoughts and feelings through age-appropriate creative activities, such as singing, art, role-playing, and music. [33]. The content of the group meetings is not fixed and is usually organized around themes relevant to the children's circumstances. For example, if the goal is to build trust among peers, then facilitators might encourage a collaborative game in which each child leans on the others with eyes closed, supported entirely by the rest of the children.

For the RCT, creative play was used with children aged 14 to 17 years diagnosed with depression-like illnesses, and extended to 16 weekly sessions of 1.5 to 2 hours. The games and exercises were adapted for this age group. The groups of 11 to 25 adolescents were of mixed gender, and were facilitated by two WCH social workers (one man and one woman). Its adaptation for Northern Uganda focused on integrating formerly abducted and nonabducted children, thus facilitating social cohesion.

Activities drawn from the WCH manuals were adapted for developmental level by the local facilitators and supervisors, and included games, drama, songs, art, and debates. Weekly sessions began with warm-up exercises followed by focused group activities. Groups ended with a closing activity, such as a game and an opportunity for participants to provide feedback on how they felt about that day's activities.

Although some WCH programs have incorporated therapy-based elements into their postactivity discussions, this study declined to use this strategy to more clearly delineate the contrast between the IPT-G and creative play. Although participants in crisis could discuss problems with creative play facilitators after group meetings, this was not typical and only occurred on a few occasions (eg, with a young woman whose baby had just died, and a formerly abducted boy who was overwhelmed by memories of his life with the rebels). The two facilitators were supervised on a weekly or bimonthly basis by the WCH Psychosocial Specialist, who discussed the program and shared reports regularly with the BU staff through email and weekly phone conversations.

Creative play had several features that rendered it an ideal comparison group to IPT-G. The group format controlled for nonspecific group effects, such as hope, group member support, attention by members and facilitator, reduction of social isolation, and structure of time (an important element in the IDP camps). In addition, some important antidepressant skills, common to effective treatments of depression [34], were operative in creative play, such as behavioral activation (increase in pleasurable and mastery activities) and social skills building.

Creative play also had significant credibility in the community because its facilitators had strong ties with the camp youth and had earned the confidence and respect of the community. Finally, from the beginning of the study, the facilitators believed that creative play would lead to significant clinical and functional improvement, paralleling the IPT-G facilitator expectations.

### **Wait-list controls**

During the study period, participants in the control group received no intervention. However, they could access services and programs not linked to the study. The adolescents who were assigned to the control condition, along with their caregivers, were informed at the beginning of the study that if they agreed to participate, they would be first to receive either (or both) CP or IPT-G intervention, which were shown to be effective at reducing the depression-like symptoms that were the target of the RCT.

### **Development of group interpersonal psychotherapy for depression in Northern Uganda**

Two IPT experts of the research group undertook the manual adaptation for this project and the training and supervision of the group leaders. Before the visit to the site they prepared a draft of the manual based on the IPT-G manual from Southern Uganda, and hypothesized that some basic assumptions of the IPT-G model would at least be somewhat relevant to the Northern Ugandan youth [31].

The first of these assumptions was that three of the four interpersonal problem areas of IPT (grief, interpersonal disputes, and role transitions) would be triggers of depression in the camp youth, similar to those in Southern Uganda. The authors were unsure whether the fourth IPT problem area, interpersonal deficits, would be a relevant trigger for depression. To determine if it would be pertinent in communities, they planned to ask the trainees open-ended nonleading questions about what made local youth depressed, and then judge whether their responses corresponded to the four problem area.

The second assumption was that strengthening interpersonal skills would improve depression. Offering an opportunity to mourn losses while receiving group support; building skills to contain grief; improving communication and decision-making regarding relationships, roles, and readjustments; and assisting youth to support each other would result in symptomatic improvement. Evidence for this has been shown in several clinical trials in Western countries and in the RCT in Southern Uganda. However, the authors had misgivings about whether the skills that IPT-G offered were potent enough to protect the adolescents against these extreme adversities.

### **Adapting the manual**

In May 2005, the IPT trainer traveled to the Gulu district to train prospective group leaders who were fluent in English and Luo; training was conducted in English. The main source of information about the local culture was the trainee group members, because they lived in the districts

participating in the study. In addition, Bolton and colleagues, who had conducted the qualitative study, consulted with the team on a regular basis. The Southern Uganda IPT-G manual was adapted on-site for cultural relevance (Kathleen Clougherty, MSW, and colleagues, unpublished manual, 2002). Its language was free of jargon (ie, grief was called *death of a loved one*; disputes were *disagreements*; transitions were *changes*; and interpersonal deficits were *loneliness and shyness*) and included detailed scripts in simple language with numerous clinical examples. This section discusses adaptations made in consultation with trainee group leaders.

### *Developmental adaptations*

Developmental issues characteristic of adolescence were considered in this adaptation. The first was the necessity for involvement of caregivers in the therapy. The leader met separately with a caregiver in at least the initial pre-group sessions and for a termination session either with or without the adolescent. The second were the frequent and abrupt changes of mental status and high reactivity among adolescents. The leaders were instructed to monitor very closely symptom changes and emergence of suicidality, which was rampant in the camps.

Finally, the adaptation considered the multiple roles and issues these adolescents had, some typical of adolescence (eg, disagreements with caregivers about going out with friends, disrespectful behavior), and some characteristic of young adults (eg, caring for other children, either their own or siblings; taking financial responsibility for themselves and often the family; having to pay for secondary school education).

### *Diagnosing depression*

In IPT, diagnosis of depression occurs during the initial meeting between the group leader and each group member individually. Therapists begin by diagnosing depression and clarifying its triggers and treatment. During training, the trainees were asked to describe adolescents with the three depression-like syndromes and discuss the behavior and community reaction. It was emphasized that the group leader had to convey to the adolescents that they are not “mad,” and offer hope by saying that this condition is treatable.

The assignment of the “sick role” presented a challenge, because lowering expectations about optimal performance and functioning when these adolescents were struggling for survival was frequently unrealistic; not fetching clean water or being late for food distribution had serious life-or-death consequences. The facilitators believed that educating adolescents and caregivers about the impact of depression on functioning, offering hope and support, and removing the guilt and blame about suboptimal performance had important impacts on adolescents. However, the trainees supported the right of the caregivers to insist on being respected.

### *Explaining the treatment contract*

#### *Role of the leader*

During the initial pre-group meeting, the leader's task was to explain to the adolescent and caregiver and how the group would proceed. Like in Southern Uganda, the leaders emphasized to the adolescents repeatedly during the group meetings that they would not provide material goods (the community was used to World Vision and other NGOs providing financial and health-related benefits). Instead, leaders explained that they and the group members would be supporting each other to determine what situations contribute to depression and what can be done about the situations to feel better. The leaders also explained that they could all work together to find 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.

#### *Confidentiality and trust*

The group members were asked not to disclose the content of the group meetings to people outside the group. Although no major instances of breach of confidentiality were raised, the leaders reported to their supervisors another, deeper problem during the trial: they felt that initially, the adolescents showed a significant lack of trust, and frequently refrained from revealing specifics about their life circumstances (either not giving an accurate account or withholding information). It was not unusual for adolescents to open up during the second half of the treatment (after session 8).

For example, one girl who had been living with her "uncle" eventually revealed in the ninth session that he was a man with whom she had eloped. A boy eventually revealed that the death of his brother was not caused by a snake bite but from suicide. Through supervision and self-reflection, the leaders understood these reactions as the adolescents' need for self-protection, and supported and celebrated with the rest of the group each adolescent's decision to open up.

One technique that many leaders found useful was to talk in the beginning of the session about general issues that that camp adolescents frequently confronted (eg, pregnancy, substance use, suicidality, domestic violence, abductions) without referring to specific individuals, and discuss what IPT skills might help manage these issues. Leaders found this helped adolescents reveal more personal material. For example, one leader knew that a young woman was not discussing her unwanted pregnancy. When arriving early for a session once, the leader found many used condoms strewn about an area in the camp. She took this opportunity to discuss sexual behavior and condom use. A large outdoor celebration had occurred the previous night, and as the group talked about what happens at these parties, the adolescent who had previously avoided group discussions opened up and began sharing with the group.

### *Flexibility*

Sixteen weekly sessions at a specific place within the camps (eg, community center, church, open space) were initially planned. However, the trainees cautioned that significant flexibility had to be built into the structure to make the project viable. For example, adolescents frequently came late or skipped sessions during planting season, food distribution, hospitalization of self or family member, and major camp events.

For safety reasons, leaders could only work in the camps during the day, which made it difficult to find a weekday time for the groups to meet because many adolescents attended school. Most group meetings were switched to meet on Saturdays. In the first couple of sessions, several adolescents did not attend the session, either because of work or shyness. The leaders sought them out and reported that by the third session the adolescents started attending regularly. Sometimes the leaders needed to ease the way for adolescents to attend the group by asking parents and caregivers to allow their children to perform chores at other times.

### *Problem areas*

When asked about triggers of depression in these communities, the trainees identified interpersonal problems that corresponded with all four IPT problem areas (death of a loved one, disagreements, life changes, and social isolation). Contrary to the trainees in South Uganda, these felt that social isolation was not just an epiphenomenon of a life change, but a problem on its own. The facilitators in this project found that several adolescents, mostly abductees, had significant gaps in their interpersonal skills because they spent critical periods of their development in the bush. For instance, the use of language was minimal in captivity because whistling and clapping formed the bush vocabulary. These gaps resulted in isolation and social deficits when the children returned to the IDP community. The following examples, presented during supervision, were characteristic illustrations of problem areas and peculiarities in their presentations because of camp circumstances.

#### *Death of a loved one*

Adolescents often encountered the death of a family member or friend from violence (which adolescents occasionally witnessed either first-hand or second-hand through its impact on the dead in the aftermath) or illness, including AIDS, malnutrition, accidents. As in South Uganda, when dealing with traumatic loss, facilitators asked the adolescents for details about what was witnessed, addressing the last time the adolescent saw the loved one alive and what happened during that time; helped adolescents to remember and mourn the relationship with the deceased; and supported the adolescent's new ties to other people. Adolescents were then asked what they wished they had said or done at that time. The grieving adolescents were invited to bring items that reminded them of the loved ones.

Those frequently overwhelmed by thoughts about the deceased were instructed to put some time aside during the day to think about their loved ones, while trying to retain focus on other activities during the rest of the day. Occasionally, family members had been abducted and the adolescent did not know whether they were dead or alive. The leaders conceptualized these incidents as transition problems, helping adolescents focus on how hope or despair affects them, helping them refocus their energy on self-improvement and -care and care of other loved ones.

### *Disagreements*

Adolescents argued with caregivers about issues such as the latter's expectation for the adolescents, including being more involved in the household, contributing to the family income, protecting the family honor, and being more respectful. Many disagreements (overt or covert, such as silent marginalization) occurred with relatives other than parents who had to care for the adolescent after parental death. These caregivers often had different expectations about the role the adolescent would play in their lives. Rampant substance use by the adults and occasionally the youth fuelled these arguments.

Sometimes the disagreements occurred among children; for example, siblings or neighbors fighting about access to resources. As with IPT in South Uganda, the authors helped adolescents develop communication skills, focusing on how to convey a point without necessarily being direct, because Western-like directness would often cause worse problems for the adolescent.

Using culturally appropriate options when resolving a dispute was an important goal. Some options considered useful and adaptive in that culture would not be considered as such in the West. For instance, the group frequently suggested that, when fighting with caregivers, adolescents not answer back and ignore them, which worked surprisingly well. Another strategy was to find powerful advocates who could influence the other person. For example, a boy whose father disagreed with his decision to go to school was encouraged by the group to talk to his uncle, who had influence over the father and could make him change his mind. Furthermore, a girl who had disagreements with her father because he would not let her practice traditional dance talked to the father's relatives who persuaded him to be more lenient.

### *Life changes*

Life changes included returning to the camp after being abducted, having a new family (numerous adolescents considered themselves married, and some had or were expecting children), taking care of the family of origin (usually because of parental death), becoming sick with AIDS and other illnesses, and being unable to find work to pay school fees. The challenge was to identify and focus on the elements that the individual could control and work on skill-building and identification of options.

Facilitators noted that depression makes individuals feel more powerless than they are in reality, and helping them explore various options is worthwhile instead of assuming a priori that these are unrealistic or will be unsuccessful. For example, a boy who was significantly burdened because he had to care for his infant sister after their parents' death was encouraged to identify relatives who could care for her.

Another powerful tool incorporated into the work was helping adolescents find advocates with power who could assist them, while also learning skills to communicate effectively with that person. The group members happily exchanged information about matters such as how to apply for school fees and identify NGOs and other resources to improve their condition.

Although the groups were usually very supportive of members, especially to abducted boys who opened up about their experiences, occasionally they were less accepting of particular life transitions. Some girls complained that when they were abducted life was easier for them. One 15-year-old girl who was a rebel commander's wife during her abduction described the beautiful clothes her husband brought her and how she was never hungry then. When she lamented her loss of privilege, the group was restrained and numb in their responses to her.

### *Social isolation*

The authors found only four cases of social isolation, always as a secondary problem area to a life change or death of a loved one. Emphasis was placed on building skills for the life change while helping the individuals break the social isolation. For example, a 17-year-old girl who cried frequently in the group was very lonely after the death of her parents, with whom she was close. She had trouble hearing, and other children teased her "because (she) looked like a boy." The leader and group helped her mourn, supported her, and discussed ways to respond to those who teased her and seek out more understanding companions.

### **Case example**

*A* is a 16-year-old depressed girl living in an IDP camp in northern Uganda. She is an orphan with no history of abduction whose parents were killed by the rebels 5 years ago. At the time of the group, *A* was living with her grandmother. Her problem areas, which were determined during the two pre-group meetings, included life change because of her current pregnancy and frequent disagreements with her abusive, blind grandmother who felt that *A* no longer listened or helped at home. *A*'s long-term goals were to find a way to earn a living so that she could take care of herself and her baby, and to reduce the arguments with and abuse by her grandmother.

*A* was active during the initial phase of the group, discussing her disagreements with her grandmother and her need to prepare for her baby's arrival. The group was helpful in suggesting how she could cope better with her

grandmother (eg, ignore and avoid) and supporting her ideas for earning a living. However, approximately halfway through the treatment, *A* disclosed that the father of her baby abandoned her on discovering she was pregnant. By the end of the group, *A* was earning a living through farming and selling her produce, and had worked out many problems with her grandmother through a combination of doing more of what her grandmother wanted and following the group's suggestion to ignore the grandmother and avoid engaging in arguments.

When these methods were not possible, the group suggested that she cook bad food for her grandmother. As a result, the grandmother became alarmed by the change in *A*'s behavior and questioned her. *A* told her grandmother how the beatings made her feel, and the grandmother was able to admit her fear that *A* would abandon her. At a follow-up visit, the therapist learned that *A* had delivered a healthy baby, whom her grandmother caring for while *A* worked. Disagreements at home were significantly reduced and *A*'s mood had significantly improved.

### *Special clinical issues during the trial*

The following clinical vignettes show the importance of careful monitoring and planning to manage adverse events when conducting trials of this nature.

#### *Cen*

*G* was a 17-year-old boy randomized to the IPT-G condition who had been abducted by LRA rebels twice and forced to kill people, including his brother-in-law's brother. *G* had previously experienced episodes of cen ("being haunted by the spirits of those that one killed") before participating in the trial. During the middle phase of IPT-G, his cen attacks re-emerged. During treatment, his wife was expecting a child and he heard that the wife of the man he had killed intended to bring her 5 children to him so he could care for them.

While *G* was participating actively and opening up in the IPT-G treatment group, on two successive occasions he experienced blackouts or a period of brief psychosis or dissociation, and injured himself. He described being outside with friends when a "spirit" attacked him. He started shouting and friends brought him to his house and locked the door, after which he started hitting the walls. He hit the walls of his hut hard enough to break bones in his hands and hit his knees with a hammer, causing swelling. A similar event occurred a few days later.

These two episodes occurred around the time he began to talk in the IPT group about his history of being abducted as a child soldier and forced to kill others. Per the IRB plan, this young man was assessed by the lead psychosocial advisor for the NGO War Child Holland in North Uganda.

The clinician who evaluated *G* did not believe that his living environment in the camp was safe enough to contain his symptoms at that time. He was

placed at the World Vision Rehabilitation center (one of the two NGO partners involved in the study) for formerly abducted children to be stabilized. Because he was a formerly abducted child, the NGO World Vision paid for his hand surgery (from the injuries sustained during his blackout), and the hospital fees for his wife's delivery. He was suspended from group participation for three sessions during his surgery. Given his connection to the IPT-G group, both *G* and his facilitator (who saw him as a leader in the group) were upset by the suspension and viewed it as punishment. The authors had to conduct additional individual supervision with the group facilitator, who had come to lean heavily on *G* in the group given his comfort with disclosing his experiences and his ability to provide support to others in the group. The facilitator had several anxieties that his group would be unsuccessful without *G* involved.

Once it was evident that *G* was more stable and was receiving support from individual and family counseling in the interim care center, he was allowed to return to the group. *G* was able to attend the last IPT-G sessions, but he and many others in his group lamented the period he had been away.

### *Suicidal group*

The group of six suicidal adolescents who were excluded from the study met weekly, a male and female facilitator were assigned to lead the group, and the facilitators were encouraged to make mid-week individual visits to anyone deemed to require more clinical monitoring. Except for closer monitoring, the flow of the suicidal group mirrored that of the traditional IPT groups. At termination the group members improved significantly and no suicide attempts were made during the trial.

*M* is an example of a typical adolescent from this group. She reported that the trigger for her grief was the recent death of her husband, who had been killed in an ambush by the LRA. Through the first eight sessions, she used the group to mourn the loss of her husband. In session nine she finally revealed that her grief was caused by the multiple deaths in her immediate family and the death of her husband by suicide, not murder.

She described in detail her husband's suicidal ideations, his behavior on the day of his death, his method of suicide, and the events after his death, including the burial. The group comforted *M*, told her that she was not alone, and suggested she be strong for her young sick child. The facilitators observed that *M*'s mood had improved. Her hygiene also improved and she became more talkative, reported feeling better, and concluded that the group was a place where people would listen to her. After the group, *M* started attending literacy classes.

### *Training*

IPT-G training took place on-site in northern Uganda over 13 days. Twelve trainees (six men and six women) attended. All were familiar with

the camps and lived in nearby communities. Each trainee either had or was working toward a college degree and had work experience with children (eg, teaching, youth team leadership). Training was conducted in English, and all trainees were proficient in English and Luo.

The training was developed by two senior Columbia IPT consultants and was implemented on-site by one of these consultants and three World Vision staff, two of whom were clinicians in the original IPT-G southwest Uganda trial and the third was an experienced psychosocial trainer. The authors used a combination of didactics and experiential methods to teach basic IPT group principles and techniques. They treated the training group as an experiential group to show the trainees the development of group dynamics and processes.

The first goal of the training was to make the trainees comfortable working in a group. The trainers began by talking about themselves and their work, and sharing some personal information. The trainees were then asked to do the same. When this activity was completed, the trainees were asked to reflect on how it felt to talk about themselves among strangers. Some described feeling embarrassed, anxious, and worried about being judged. One trainee disclosed a personal history of abduction. Their experiences of the activity were used to explore what group members might feel when they first join an IPT group.

Next the training was divided into four phases to reflect the pre-group, initial, middle, and termination phases of group IPT. IPT-G skills characteristic of the pre-group phase include learning to talk to group members, forming a therapeutic alliance, expressing empathy, assessing depression symptoms, taking a relevant history, conducting the interpersonal inventory, establishing the problem area and setting related goals, psychoeducation about depression, explaining IPT-G treatment (including confidentiality), and obtaining consent from the patient to join the group. The authors expanded the knowledge the trainees had from earlier work with adolescents to establish basic guidelines on how to communicate with that age group. Next, pre-group tasks were broken down as outlined earlier and each component systematically taught.

In this type of training, trainers demonstrate IPT concepts in front of the class, followed by break-out groups of initially two and then three trainees. The practice occurs first in English so the trainers can listen and know what the trainees have learned, and then in Luo so the trainees become comfortable with what they will actually say when they are with the adolescents. This approach, including repetition in both languages, is key to training inexperienced or less-experienced clinicians in a brief timeframe.

The authors asked trainees to practice each section of IPT pre-group in the evening, because the amount of work that could be done in the evenings was limited as the trainees lived at home during these 2 weeks. The authors' recommendation for future trainings is that all participants stay together for

the training period. The goal is always to have trainees become familiar enough with the concepts and scripts that they do not need to rely on notes.

To learn the phases of IPT-G, the trainees needed to learn to conduct group therapy and understand the IPT concepts and techniques. During these phases, the trainees learned to assess patient mood and symptoms during a group; encourage members to disclose within a group; link mood change to events; mobilize the group members to support each other and make suggestions; and encourage members to try out new approaches for improving their interpersonal problems.

The final phase of training is intended to mirror the termination phase of IPT-G. Trainees were taught the tasks they needed to learn during this phase, and were encouraged to draw from their experience in ending their training to understand a group's potential feelings about finishing IPT-G.

### **Results of the clinical trial**

Results, presented in detail by Bolton and colleagues [14], showed that although all three groups (IPT-G, CP, and WLC) showed decline in mean depression symptom scores between baseline and termination, mean depression symptom scores in the IPT-G were significantly lower than in the WLC group. Among girls, IPT-G was superior to WLC in reducing depression symptom scores. Boys' results, although in the expected direction, were not statistically significant. Creative play showed no effect on depression severity scores. Neither IPT-G nor creative play was associated with significant improvement in anxiety or conduct-like syndrome scores in the total sample. Also, neither treatment group showed improvement in functioning or conduct problems.

Preliminary analyses showed that a history of abduction was associated with higher baseline depression scores, although this factor did not affect the change within any of the three study groups at termination.

### **Summary**

The authors adapted IPT-G for this population knowing that IPT was a good fit for depressed Ugandan adults. However, they questioned whether it would be effective for depressed Ugandan adolescents dealing with extreme adversity. Research findings from Southern Uganda and two subsequent years of IPT groups in that region showed the usefulness and transportability of this Western psychotherapy. The four IPT problem areas resonated with this population as triggers for depression: death of a loved one, life changes, disagreements with important persons, and, to a lesser degree, loneliness and social isolation. The "here and now" focus was appropriate in this adolescent population, for whom solving current problems

was often essential to survival, and relying on others for support and help was culturally compatible.

The authors understand that they are far from proclaiming that this approach “cured” depression and its associated disability in this population. Although IPT-G significantly lowered depression in girls, it did not significantly impact depression in boys, nor did it affect the functioning of both boys and girls. Speculations about its lack of effectiveness in those targets and suggestions for improvement have been presented elsewhere [14].

In the scope of this article, IPT-G proved to be feasible in its training and implementation, was accepted as a treatment option by the community, and, to an important extent, reduced depression significantly for several adolescents. The control group has been treated with IPT-G, as promised, and the group leaders are currently treating depressed adolescents in eight IDP camps in Northern Uganda, showing the sustainability and adoptability of the IPT-G program (Grace Onyango, MA, personal communication, 2007).

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