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Interpersonal Psychotherapy Group in Senegal

First Steps and Future Plans

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BACKGROUND

Senegal, the "gateway to Africa," is an ethnically and ecologically diverse sub-Saharan country on the western side of the continent.[1] Its capital, Dakar, houses many of the country's medical and research facilities, including the Fann National University Hospital Center (FNUHC), home to the oldest psychiatric department in the country and the site of our work. It was there, in 2019, and in the context of a research project by the West Africa International Epidemiological Databases to Evaluate AIDS that interpersonal psychotherapy (IPT) was first introduced to Senegal to treat depression in people living with HIV (PLHIV).

Depression is the most common psychiatric disorder[2] in sub-Saharan Africa (SSA) and is highly prevalent[3] among PLHIV on antiretroviral therapy (ART). It has been associated with suboptimal HIV treatment outcomes (i.e., decreased adherence to ART, rapid progression to AIDS stage, and slow increase in CD4 count)[4–6] and negative consequences for quality of life.[2] Yet, depression remains underdiagnosed and undertreated in SSA.[2,6,7] Also, a large mental health care gap continues to be observed in resource-limited countries,[8] such as Senegal (e.g., shortage in mental health specialists[8]), where only 46 psychiatrists provided care in 2018 according to the Ministry of Health and Social Action.[9] Most services were in Dakar, to the detriment of other areas. Accessibility and affordability of care are further limited with the exclusion of mental health from primary health

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care, compelling patients to seek alternate ways of healing in traditional and religious practices.[9]

In the face of resource scarcity, the World Health Organization (WHO) recommends "task shifting"—a practice that involves the training of nonspecialists to provide mental health care under the guidance of specialists.[10,11] Further, it recommends group interpersonal therapy (IPT-G) to treat depression in low- and middle-income countries. However, the acceptability and feasibility of IPT-G was never evaluated in Senegal, let alone with a task-shifting approach. Thus, the present authors sought to test it out, with PLHIV as target population.

The project, conducted jointly by the psychiatry and outpatient departments at FNUHC, involved the IPT-G training of hospital staff (i.e., 4 social and community workers). Participating PLHIV were predominantly middle-aged women (50%) and men who had been screened for depression with the Patient Health Questionnaire-9 (PHQ-9) by the referring doctor on the project, with confirmatory diagnosis by a psychiatrist for any score of 5 or greater. Some were recently diagnosed with HIV, whereas others had been living with HIV for years. Exclusion criteria included hospitalization or medical emergency; diagnosis with a psychiatric illness other than depression; vision or hearing impairment that would seriously hinder group interaction; and imminent suicide risk. None of the participants were prescribed antidepressants at time of diagnosis, during, or following IPT-G implementation, in neither the training phase nor the study phase of the project, which involved 13 groups over the span of 2 years.

GENERAL IPT ADAPTATIONS

Interpersonal psychotherapy adaptation centered on treatment modality, protocol, language, and training. Context and population informed the choice of modality and protocol. Previous work with PLHIV in Uganda had shown group IPT-G to be effective in treating depression[12,13] and the group modality lined up with Senegal's collectivistic culture. The adoption of a brief 8-session IPT-G protocol developed by WHO placed less burden on patients and the resource-strapped system. IPT's multiphasic structure (i.e., pregroup, initial, middle, termination) was preserved. However, groups were limited to same-sex members (including facilitators) in line with Senegalese norms and previous practice. Also, the age range was extended within groups, given the shortage in patients needed to form similar-age groups.

Following authorization by WHO, the treatment manual was translated from English to French,[14] Senegal's official language. This was critical for Senegalese staff who were French educated, though they belonged to the Wolof ethnic majority and often spoke Wolof with hospital patients. The use of Wolof arguably enhanced cultural relevance. Yet, it potentially challenged staff-patient communication around key terms in the manual, including signs and symptoms of depression. For this reason, these terms were discussed with staff psychiatrists for

accurate use in Wolof throughout the training. The expression *naxaru xol* (literally, "loss of taste for doing things" in Wolof) was chosen to refer to depression.

Training nonspecialists in the context of task shifting also informed IPT adaptation in terms of implementation. Given the scarcity of mental health specialists, and in line of recommendations by WHO on task shifting, 3 social workers and 1 community health worker were tasked with group facilitation, though they had no prior experience with therapy. Budgetary constraints and previous experimentation with individual IPT confirmed IPT-G as the modality of choice, largely because of its cost-effectiveness.

ADAPTATIONS TO TRAINING AND SUPERVISION

Training in IPT-G was undertaken in the context of a feasibility and acceptability study.[15,16] The plan consisted of a 5-day intensive training followed by 6–8 months of supervised practice. The primary objective was to build competency in IPT-G so that its effectiveness could be tested. The benchmark was successful facilitation of 2 patient groups (6 patients each). By design, the first IPT group was led by 2 trainees; the second, by 1. Cofacilitation was intended to reduce the work burden of the trainees and enable them to assist one another in their first group. Two additional incentives helped cement this model: (1) parsimony (e.g., fewer patients needed) and (2) operational cost reduction. Feedback from trainees supported the usefulness of this training model.

Group facilitators were paired to form 2 supervision groups led by an IPT master trainer (S. Z.) from the United States. Trainees who cofacilitated the same group were supervised together. Supervision consisted of weekly online sessions (90 minutes each) conducted in French. On completion of their first group, trainees went on to facilitate a second group, this time by themselves. In this round, supervision was provided per IPT group, and each facilitator received a full hour of weekly supervision.

Contextual limitations called for additional adaptation. First, case identification to form groups depended on diagnostic confirmation by busy psychiatrists. This meant (1) longer wait time for patients to join a group and for facilitators to start training and (2) longer study duration. Therefore, group size was limited to 6. Second, work demands on trainees in the context of task shifting called for schedule flexibility with supervision to ensure attendance. On a more global level, the COVID-19 pandemic that hit Senegal in the study phase brought all group and supervision activities to a halt, thus forcing a reality of its own and raising a global question about how IPT-G can work in similar conditions.

A retrospective examination of adaptation, in the context of training, identified some areas for improvement. For one, the WHO manual (used in training) could be better adapted to the local context with Senegalese case examples and minor revisions to IPT strategies. Here, follow some illustrations in the context of grief, dispute, and transition.

In classic grief work, tears are expected and perhaps encouraged as patients "mourn their loss." However, in predominantly Muslim Senegal (95%), the approach needed to be adapted since crying in this context produces "burning tears that hurt the deceased." Praying for the beloved would be more appropriate. The same goes for items used to facilitate grieving. Jewelry and clothes, inherited or gifted, are more laden with significance in Senegalese culture than photographs. And, given cultural expectations to speak well of the dead, caution is advised when helping patients "reconstruct" their relationship with the dead person. The focus should be on validating the loss and honoring the memory of the deceased.

In the area of "disputes," the collectivistic and hierarchical nature of Senegalese society lends itself nicely to mediation as a primary strategy for resolving conflict. People traditionally live with their extended family in dwellings governed by social hierarchy and specific expectations, such as "centrality of family" and "filial duty." Polygamy, widely practiced in Senegal, adds some complexity to marital relationships and often requires some change in patient expectation or a "give-to-receive" approach. Role disputes can generally be resolved with the help of a respected elder (e.g., uncle; imam).

As regards role transitions, IPT-G strategies seem straightforward and appropriate for the Senegalese context overall. Nonetheless, specific challenges need to be addressed when working with PLHIV. These include stigma and poor understanding of the condition. Patients avoid help lest they be discovered. Therefore, offering IPT-G in a setting associated with HIV (i.e., infectious diseases treatment facility) was not ideal for our PLHIV participants. Yet, there were no viable alternatives at the time.

While relocation wasn't feasible, forming same-sex groups was. Participants were informed their groups would be entirely composed of same-sex PHLIV. Sharing one's HIV status is difficult enough in Senegalese society and more so with the opposite sex. PLHIV live with their "secret" for years, not only due to stigma but also because they perceive it as a condition that cannot be helped. Deep social isolation and despair ensue. Therefore, in training IPT-G providers, special attention was given to education about HIV, hope instillation, and breaking social isolation.

The IPT techniques of role play, communication analysis, and decision analysis were well received by our trainees. The same was true of group facilitation skills and IPT-G-specific techniques, such as "harnessing the power of the group" and the "interpersonal lab."[17] Trainees were especially moved by the power of the group (e.g., sharing experiences and supporting one another, which resonated nicely with local culture).

IMPLEMENTATION CHALLENGES

Challenges to IPT-G implementation were primarily organizational in nature and nonspecific to the intervention itself. They included patient identification, service integration, and treatment accessibility. The IPT-G feasibility and acceptability study required a confirmed diagnosis of depression for participation. This had two

implications. It increased the burden on psychiatrists and restricted the pool of PLHIV to those with diagnosable depression. Given the stigmatization of mental health and HIV in Senegal, case identification thus became more problematic. Further, IPT service integration into a preexisting operational system increased work demands on staff tasked with implementation, in not only amount but also coordination. Adverse consequences such as worker dissatisfaction, burnout, and attrition constituted a potential threat.

Other challenges involved service recipients and were mainly associated with treatment burden and accessibility. Though the adoption of an 8-session treatment protocol significantly reduced the intervention's burden, some patients still voiced concern over weekly attendance. For a couple, it was employment with a changing schedule; for a few, stigma; for most, transportation. Participants got a flat fare from the IPT-G program, but those who lived far found it insufficient.

A different form of patient accessibility pertained to Senegal's ethnic and linguistic diversity. It had to do with language spoken in session. Group facilitators routinely spoke Wolof, which is widely spoken in Senegal as *lingua Franca*; however, in a couple of groups, participants had to intermittently use French or another local language to keep a nonfluent ethnic minority member in the loop. This is quite normal in polylinguistic Senegal and may indicate group cohesiveness. Nonetheless, the point is raised in the interest of broader inclusion and accessibility.

To address the above challenges, we propose that future training include providers from diverse backgrounds and more trainees to counter attrition. Further, shifting focus from a diagnosis-based to a symptom-based identification process would enable more depressed PLHIV to be included and decrease the system's dependence on psychiatrists. Also, because depressed PLHIV carry a double stigma that makes them difficult to identify and treat, awareness-raising and destigmatizing education campaigns targeting HIV and mental illness would be in order.

IMPLEMENTATION FACILITATORS

Group IPT was well implemented overall.[15,16] At the organizational level, direct support by the department head (M. S.) secured the resources needed for running groups; supervisory oversight and team management (C. B.) smoothed operational activities. Service delivery was optimized with ongoing competence building through training and clinical supervision (S. Z.). Despite hard work time pressure, group facilitators enjoyed several satisfiers, including professional growth and opportunity for achievement. They were enthusiastically engaged in training and practiced professionally. Their social work background and related interpersonal competencies helped them implement IPT-G with no prior therapy experience.

Contextually, IPT-G implementation benefited from cultural relevance. All group facilitators were Senegalese and observed cultural norms in their practice.

Punctuality was encouraged but not strictly enforced. Members who came on time completed their PHQ-9 and chatted while waiting for the rest to arrive. On average, groups began within 30 minutes of scheduled time. Similarly, it was normal for group members to exchange phone numbers, socialize, and support one another outside of group. Following termination, members stayed in touch. Many continued to meet, months after their group ended.

Some IPT-G features contributed to its successful implementation. The group modality resonated well with the collectivistic nature of Senegalese society, with its relational and storytelling culture. In effect, focused discussions with facilitators identified experience sharing as a primary strength of IPT-G. Group processes and techniques proved potent and made sense to Senegalese participants. Further, the very constitution of PLHIV groups was helpful, inasmuch as it broke individual isolation and accessed support.

FUTURE PLANS AND RECOMMENDATIONS

The IPT-G feasibility and acceptability study laid the grounds for future work in Senegal. One future direction is upscaling service delivery. The country's health settings are adequate in number but not in distribution. Most are concentrated in Dakar, making them less accessible to out-of-area patients.[18] Further, given the study's geographic bounds (limiting its generalizability), program replication in a less centralized context seems warranted. In this vein, two facilities outside the capital will be used to evaluate IPT-G in different contexts of care.

The upcoming project wouldn't be possible without trained personnel. To this end, our IPT-G providers in Dakar are presently cosupervising new providers following a training-of-trainers model. The plan is to create a self-sustaining training system—perhaps in collaboration with the national School of Social Work, where IPT-G would be studied. Such a move would considerably facilitate the dissemination of interpersonal therapy in Senegal and beyond.

Additional future plans include (1) systemic screening at health facilities to help with case identification; (2) a stepped-care model with newly diagnosed PLHIV, with interpersonal counseling as a first step; (3) use of specific nonclinical indicators of improvement (e.g., social and economic impact) to broaden treatment outcome assessment; and (4) application of IPT to more disorders (e.g., anxiety, distress, and trauma).

In terms of recommendations, context and organization stand out. IPT-G implementation requires more than good training. And, though supervision can increase trainee satisfaction, it cannot resolve organizational and contextual issues. Systemic support (e.g., by leadership) is primary and should be accompanied by procedural and structural reform. Personnel management, critical to service sustainability (e.g., staff retention) and quality, may be optimized with improved "conditions of service" (e.g., professional advancement). Therefore, we recommend systemic integration for successful implementation. As regards patients, PLHIV may especially benefit from health education outreach programs targeting

depression and HIV. In the era of COVID-19, we also need alternate forms of service delivery (e.g., online; satellite service units).

CASE EXAMPLE

Amadou was a 53-year-old man who returned with his family to his native Senegal from Mali following a serious decline in his wife's health. Traditional healers told him that his wife had been "marabouted by family members." Hospital medical tests, on the other hand, showed Amadou's family (except 2 of his 5 children) to be HIV+, information he kept to himself.

Amadou's wife eventually died, following a long hospitalization, leaving him with 3 young children, all seropositive. Depression set in, as he grieved the death of "the woman he loved so enormously" and felt trapped with his HIV+ secret and hospital bills. Leaving Mali had left him with no income, and, with his wife gone, he was at loss about "how to care for his young children." In the intake session, he reported deep sadness, depressed mood, and disturbed sleep and was visibly upset and overwhelmed.

In group, Amadou was no longer alone. He opened up and shared his experience with loss and HIV. As he successfully grieved, he began to engage socially, build friendships, and take steps to get medical care for himself and his children. In the sixth session, he took the leap to share his HIV status with his eldest son. This opened a major support pathway for Amadou. It brought him closer with his son, who, in turn, stood by him and helped with child care. By the termination session, Amadou was gainfully employed, capably caring for himself and children, and depression free (PHQ-9 = 2).

The above case illustrates a typical PLHIV case, with "role transition" as primary problem area exacerbated by stigma. It also showcases other challenges PLHIV face, such as loss of loved ones and HIV care burden. The following discussion nuances the case in a Senegalese context.

Amadou's case reflects a characteristic feature in PLHIV presentation: multiple problem areas. This, combined with the brevity of an 8-session treatment protocol, dictates prioritization. In Amadou's case, grief seemed a good place to start inasmuch as he couldn't get past the death of the woman he loved so much. Strategies for grief were straightforward, except for a minor adaptation in the context of Amadou's faith (i.e., Islam): honoring his wife's memory through prayer (vs. shedding tears), remembrance, and being a good father. The group supported Amadou's efforts to draw on his faith—which valued steadfastness and patience in the face of hardship and gave meaning to his "trials," thus enabling him to work through grief.

Absent from Amadou's case, the problem area of "dispute" was nonetheless present in numerous PLHIV cases seen in Senegal (along with "transition"). Some were HIV related (e.g., being shunned by family due to HIV), but others occurred in different contexts, such as preferential treatment in polygamous marriages. In Amadou's case, an interpersonal dispute could have erupted in the context of the

"curse" placed on his wife by members of his own family. Arguably, it didn't because none were specifically identified.

With his wife passing, Amadou was catapulted into a double role transition as widow and PLHIV. Without a spouse by his side, he became the sole caretaker of three seropositive children. Jobless, he couldn't afford medical care or sustenance. Social stigma stood between him and others, including his adult children, further deepening his loneliness and isolation. The group, however, proved a powerful antidote in both support and composition. Knowing that all members were PLHIV, Amadou related well and found it easier to share. This practice would subsequently prove useful in reaching out to the adult son. Given the centrality of the family in Senegalese culture, Amadou's talk with his son was critical to his recovery. It not only reduced his isolation and got him help, but also "put him together" in terms of collective identity.

PUBLICATIONS

Since its introduction to Senegal in March 2019, IPT-G has incrementally shown promise. The first results of the project are to be published in 2 articles (in preparation) that focus on quantitative and qualitative findings, respectively. Preliminary results were presented in 3 congresses, in the form of 1 oral presentation[19] and 3 posters.[15,16,20] Related publications include the French translation of the treatment manual, available online through the WHO web page.[14]

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