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Views on Depression From Traditional Healing and Psychiatry Clinics in Uganda: Perspectives From Patients and Their Providers

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Abstract

In Uganda, depression is a growing concern, yet mental health professionals are in short supply, and help is often sought from traditional healers. To develop an integrated system of care, we must understand sociocultural aspects of depression including beliefs about help seeking and treatment. In a mixed methods study, we used semi-structured interviews and self-report measures to assess depressed patients (N = 30) seeking treatment in traditional healing (n = 15) and psychiatry clinics (n = 15) near Kampala, Uganda. We assessed demographics, symptoms, treatment characteristics, and explanatory models (EMs) of depression (e.g., labeling the problem, cause, impact on life, best type of treatment). We predicted differences across treatment settings. To further explore EMs, we assessed differences in EMs of patients and their providers by interviewing patient–provider dyads (n = 8 dyads). Patients in both settings were similar in demographics, symptoms, perceived cause, seriousness, and impact of depression. However, patients at traditional clinics were more likely to desire herbal remedies, while those in psychiatry clinics were more likely to desire modern medication. Patient–provider dyads also had different treatment beliefs, with patients desiring financial assistance, social support, and medication, and providers more likely to suggest counseling or advice. The study highlights the need to understand diverse beliefs and treatment trajectories in a multicultural context.

Keywords

traditional healing, explanatory model, Uganda, depression, mixed methods

Depression is recognized internationally by health service providers as a mood disorder that negatively affects people around the world, contributing immensely to the burden of global illness (World Health Organization [WHO], 2009). Although depression is relevant in cultures and nations across the globe (WHO, 2009), we have yet to fully appreciate its diverse concepts,

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meanings, approaches to treatment, and implications for service delivery (Kleinman, 2004). Epidemiological studies show high rates of depression in Uganda (Bolton, Wilks, & Ndogoni, 2004), attributable in part to poverty, disease, sociocultural change, and ethnic and civil conflict (Kibanja, Kajumba, & Johnson, 2012; Vinck, Pham, Stover, & Weinstein, 2007).

Although depression is a growing public health concern, Uganda is under-resourced in mental health services to treat depression within the formal health care sector (Kigozi, Ssebunnya, Kizza, & Ndyanabangi, 2010). However, traditional healers are present in approximately 80% of communities, whether urban or rural (Ndyanabangi, Basangwa, Lutakome, & Mubiru, 2004). Most Ugandans rely on traditional healers when they do seek mental health care, and the important role for traditional healers has been acknowledged in Uganda's mental health policy (Ovuga et al., 2001). However, accessibility is only one contributor to the help seeking and treatment pathway. To develop an integrated system of care, we must understand how depression is experienced, explained, and responded to by those experiencing it (Kleinman, 1980, 2004).

Depression in Uganda

Cross-cultural research indicates that "depression" in some form exists in nearly all societies and that the core features (sadness or low mood and loss of interest/pleasure) are evident in many (Draguns, 2000). Yet, considerable cultural variation exists in how symptoms are experienced and communicated, patterns of distress, social and personal meanings, help seeking, and treatments (Kleinman, 2004). Research on depression in Uganda, using different methods and samples, suggests that depression as defined by Western-based nosological systems (WHO, 1997, 2009) is both similar to and different from "universal" patterns in terms of its rates, help seeking, and lived experience. Epidemiological studies in Uganda show high rates, with estimates of 14% to 22% in most studies (Bolton et al., 2003, Bolton et al., 2004; Ovuga et al., 2001) and as high as 44% in the war-affected northern areas (Vinck et al., 2007). A sampling of almost 5,000 people from 14 districts yielded a rate close to 30%, ranging from low (7.7%) in Bushenyi to high (49.6%) in Moyo (Kinyanda et al., 2011).

While these rates are cause for concern, rates may be even higher when considering possible cases that were "masked," appearing in a more somaticized or social form (Ovuga, 1986), lacking sufficient symptom severity or classic features (i.e., low mood or sadness). In Uganda, studies have shown little support for a specific term, local idiom or colloquial use that would be directly comparable with depression. Instead, a number of different terms are used across a number of different languages. For example, among the Luganda-speaking people, the terms used to describe depression presented in a vignette included sad/sadness ("obunakuwavu"), excessive sadness or sorrow ("enyike"), thoughts, to think a lot ("ebirowoozo" or "okulowooza"), worry ("okwelalikilira), and loneliness ("ekiwubaalo"), (Johnson, Mayanja, Bangirana, & Kizito, 2009). Lay persons in this study often used vague terms such as "general hardships" or "problems in living," and these were linked to poverty, HIV, or interpersonal conflict. Okello and Ekblad (2006) also found that unipolar depression was associated with an "illness of thoughts" (often due to social problem or illness), while psychotic depression was labeled as a clan illness "ebye kika." Among lay women in a primary care setting in Wakiso, Uganda, Tugamisirize (2007) found other key Luganda phrases used to describe depression such as to be fed up ("okwetamwa"), to feel self-pity ("okwekubagiza"), to cause or to be sad ("okwenyamira"), and angst ("enyiike").

Treating Depression

Arguably, many Ugandans with depression will not seek formal treatment, relying on social or religious supports in their communities. However, in a study using a vignette of depression that

asked what type of treatment would be helpful, an array of sources was suggested by lay persons and professionals. Hospitals/health clinics, traditional clinics, mental clinics, non-government organizations, and social supports were identified by participants (Johnson et al., 2009). Thus, Ugandans may seek out more than one type of care, either sequentially or simultaneously (Ovuga, Boardman, & Wasserman, 2007).

Traditional Healing Approach

As in many African nations, traditional, indigenous approaches to viewing the world and to treating mental illness are well-rooted in Uganda, with traditional healers available in nearly every community. Healers are wide ranging in their trainings, theories, and approach to treatment (Ovuga, Boardman, & Oluka, 1999), with herbalists, spiritualists, diviners, pastors/sheiks, faith healers, and midwives included in the category. While some rely on a single approach, many employ a range of methods, such as herbal medications, counseling, conflict resolution, monetary support, employment or housing assistance, and spiritual or cultural rituals (Johnson et al., 2009). Okello and Ekblad (2006) found that talking about problems in an individual or group format was a common recommendation for depression among traditional healers. Likewise, Johnson et al. (2009) found that "counseling" accounted for 23% of healers' suggested treatments for depression. Many healers involve the patient's family in the treatment process, and some extend the focus of their treatment to include the larger, community environment, such as through HIV education or supporting schools (Johnson et al., 2009). Despite diversity among healers, some commonalities include use of local languages, accessibility of services (usually within communities they serve), flexible means of payment (such as donations, barter, or payment upon improvement), and a shared understanding of spiritual and cultural beliefs and entities (e.g., Luganda spirits and ancestral ties). These common features of traditional healing enhance their accessibility, acceptability, and affordability compared with more "modern" approaches (Johnson, Drescher, & Bordieri, in press).

Psychiatric Approach

In contrast to the traditional approach, the Western psychiatric approach arose from a biomedical perspective with a focus on the individual patient, reduction of symptoms, and/or control of behavioral disturbances. The mental health system had been slowly rebuilding in Uganda since the early 1990s with development of postgraduate programs in clinical, community, and school psychology at Makerere University (Johnson, 2007); the development of a formal mental health policy emphasizing decentralization; and a community sensitization to increase awareness and decrease stigma of mental illness (Kigozi et al., 2010). Despite some successes, mental health legislation is outdated and services are underfunded, with only 1% of health expenditures going to mental health (Kigozi et al., 2010). Uganda is under-resourced, with just 32 psychiatrists per almost 39 million people and only a handful of psychologists employed by the government (Hall et al., 2004). Services remain available largely in urban areas (Kigozi et al., 2010). Only about 28 outpatient facilities are available, and so information on treatment approaches and effectiveness is rare. A few treatment studies utilizing interpersonal, group therapy (e.g., Bolton et al., 2003) have shown good results for adapted interpersonal therapy for depression. Yet these treatments are usually limited to intervention studies and are unavailable to most Ugandans.

Explanatory Models (EMs)

The concept of patient's EMs was introduced by Kleinman (1980) to account for the phenomenological experience of a physical or mental disorder. EMs are multifaceted and are construed of several, more or less interrelated, components, including the nature of the illness, perceived

cause, severity, stigma, expected course, impact, fears related to the disorder, help seeking and treatment sought, and desired outcomes. The study of EMs has been taken up by an array of researchers and providers in the health professions, focusing on a diverse range of disorders, including depression (Karasz, 2005).

Although we often refer to EMs of patients, Kleinman (1980) highlighted that EMs are held by professionals as well. Professional EMs are expected to differ from patients and from each other based on different education and training experiences, theories, epistemologies, practice models, and the context of diagnosis and treatment (Johnson & Sandhu, 2010). When opposing conceptualizations are held between different types of providers and/or between patients and providers, patients and their families can feel "caught" between systems. This can result in confusion and a reduced expectation for benefit in the treatment. Consequently, the EM framework can be valuable in preventing early attrition, poor treatment adherence, or reduced benefit (Chrisman & Johnson, 1996) and enhancing programming or individual treatment (Johnson & Sandhu, 2010; Karasz, 2005).

The study of EMs of depression in Uganda can yield information needed to develop a culturally competent system of care that utilizes available resources, such as traditional healers, and recognizes important contextual factors (Ovuga et al., 2007). For example, Uganda has a diversity of languages, ethnic groups, and cultures, with three main ethnic groups (Bantu, Nilotic, and Nilo-Hamitic) and roughly 40 different languages and tribes, the largest being the Baganda, from the Bantu group. Ethnic and religious divisions were sharpened under colonial rule and remain a tool of political polarization, resulting in civil conflict around the country (Kibanja et al., 2012). Uganda continues to undergo rapid changes related to urbanization, migration, and industrialization. Poverty, population increases, high rates of disease, political oppression, and environmental degradation are among the problems that breakdown traditional supports (Kibanja et al., 2012). Efforts to advance service delivery in such a changing context will benefit from understanding different conceptions and approaches to the treatment of depression (Kleinman, 2004).

Study Goals and Hypotheses

In countries such as Uganda that are developing their mental health infrastructure, understanding the diversity of EMs may contribute to a comprehensive and contextually appropriate system of care. For this study, we reasoned that if different symptoms and beliefs about depression are associated with differential help seeking, we would expect differences among patients with depression who are seeking care from different sources (Baingana, 1990). We aimed to identify patients in traditional and psychiatric settings meeting criteria for depression and then assess EMs, demographics, depression profiles, and treatment characteristics using interviews and measures. Although largely exploratory, we expected differences to emerge based on location (traditional or psychiatric). We also expected differences to emerge between patients and their providers. Based on previous findings, specific predictions of the types of differences expected included the following:

1. Regarding sociodemographics, we expected those in traditional clinics to be more likely to complete the interview in Luganda because a previous study indicated that formal therapy and modern medicine were suggested less by Luganda-speaking community members (Johnson et al., 2009). We expected that individuals with higher education and income would be more likely to seek help from a psychiatry clinic.
2. In symptom profiles, we expected patients in psychiatry clinics to have more severe depressive symptoms, as studies have indicated psychiatric formal help may only be sought when individuals become disruptive (e.g., suicidality, impaired social functioning) or other treatments have failed (Baingana, 1990; Okello & Neema, 2006).
3. In help seeking and treatment, we expected patients in psychiatric clinics to have sought out help from traditional healers before consulting psychiatric services, given the

accessibility of healers and that psychiatric help may be seen as a more drastic step (Nsereko et al., 2011). We assumed that patients in traditional clinics would report more traditional treatments (e.g., herbal remedies, ritualized bathing, smoking pipes) compared with patients in psychiatric clinics (Johnson et al., 2009).

4. EMs of patients in traditional clinics were expected to include more spiritual and cultural aspects across the EM components. For example, we expected patients in tradtitional clinics to mention more beliefs about ancestors, cultural taboos, and traditional herbal remedies compared to those in psychiatric clinics (Johnson et al., 2009).
5. Finally, we expected EM differences between patients and their providers in our patient–practitioner dyads regardless of treatment setting (Kleinman, 1980). We further expected that patient–traditional healer EMs would be more closely aligned with each other due to shared cultural knowledge. Previous studies found that traditional healers and their clients held "traditional models" of mental illness, suggesting potentially more congruence between healers and patients than between patients and other mental health providers (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, & Flisher, 2010).

Method

Participant Referral and Selection

Ethics review and permission to conduct the study were granted from The Ugandan National Council of Science and Technology (UNCST), the Ugandan Ministry of Health, the Mukono Traditional Healer's Association, and the Jubilee Park Healers' Association. Participants were 30 Ugandan adult patients at traditional healing and psychiatry clinics and eight patient–provider dyads. Patients were referred by staff based on a chart diagnosis of unipolar depression (in psychiatric settings) or reported symptoms that were akin to depression, such as sadness, low mood, and so forth (in traditional healing clinics that do not utilize Western nomenclature or diagnostic procedures). Treatment histories were obtained from healers and, if available, from records. If the referred patients met criteria for a major depressive episode and did not endorse manic episodes or psychosis, they were included in the study. Those meeting inclusion criteria were invited to participate, with 15 from traditional and 15 from psychiatric settings ($N = 30$) participating. Treatment providers of patients, when available, were invited to participate after referring their patient to the study. For eight patients, we were able to interview their treatment provider for a specific case ($n = 8$ patient–provider dyads). Professional providers (five from psychiatry and three from traditional clinics) participated in interviews to elicit their EM of their patient so that we could compare and contrast EMs in patient–provider dyads. All providers completed the interview independently of the patient interview.

Patient Characteristics

A sociodemographic measure was taken from a previous questionnaire used in Kampala (Baingana, 1990). It assessed background information such as education, income, employment, standard of living, gender, age, ethnicity, religion, occupation, employment status, and housing conditions. Participants were most likely to be women (58%), single (42%), Catholic (36%), and Baganda (49%), which is the largest ethnic group and the dominant tribe in the study's urban location. It is common in Uganda to not know one's exact age, so we used age brackets to allow estimation. Fifteen patients were younger than 30 years (but above 18), eight participants were 30 to 39 years of age, four participants were 40 to 49 years, and the remaining three were older than 50 years. The majority of participants (67%) reported attending school at least beyond Primary 7 (similar to seventh grade in the United States) and working full time (42%) or unemployed (36%). The modal

monthly income category was the US$6 to US$30 bracket, with 71% earning less than the estimated average monthly household income in Uganda (i.e., US $60 per month). The majority reported having electricity in their homes, but only 31% had running water.

Assessment Measures

Depression. For assessing depression, we used two measures based on Uganda psychiatrists' recommendations. The Primary Care Checklist (PCC-10; Appendix A) contains a series of questions and checklists for mental disorders, including depression. It was developed as a brief semi-structured interview to be used as a screening tool in low-income countries, and it confers with the tenth version of the International Classification of Diseases (ICD-10; WHO, 1997). To provide convergent support for the diagnosis, we used an oral administration of English or Luganda versions of the revised Beck Depression Inventory (BDI; Beck & Steer, 1987), a self-report questionnaire that had been previously translated into Luganda (although we used the same translation procedures with all measures for consistency in this study; see section "Translation of Measures"). Each item on the BDI is scored on a four-point scale from 0 to 3 (higher scores indicating higher severity), with the total score obtained by summing the scores (range = 0-61). Scores and psychometrics are in the "Results" section.

Explanatory models. To assess EMs, we used Kleinman's open-ended questions as the basis for the interview, reworded slightly in English to reflect the terms used in translation (Kleinman, 1980). Numerous studies have used some or all of these questions as the basis for open-ended or semi-structured EM interviews (e.g., Johnson et al., 2009; Okello & Ekblad, 2006; Weiss, 1997). The main questions used to describe our patients' EMs and as the basis for analysis in this study were as follows: (a) What do you call your condition, what name does it have? (Name/Label) (b) What do you think caused it? Why do you think it started when it did? (Cause/Etiology) (c) To what extent does the condition affect you, is it much cause for fear or worry? (Seriousness) What are the problems your condition has caused for you? How has it affected your life? (Impact) (d) What treatment are you getting now? (Current Treatment) What type of treatment is best for this problem? (Best Treatment) (e) What are the most important changes or benefits you hope to get from treatment? (Treatment Expectations). Providers were asked similar questions albeit they were based on "the patient's condition." Answers were audio taped and transcribed. Coding and reliability are presented in the section "Data Reduction and Analyses."

Translation of measures. Interview questions and consent forms were translated into Luganda, blind back-translated, and cross-evaluated for conceptual equivalence (Van de Vijver & Leung, 1997). Bilingual graduate students in a Ugandan psychology program and a medical sociologist instructor at the Makerere Institute for Social Science Research (MISR) conducted the translations and blind back-translations of the PCC-10, BDI, and EM interview. The two versions were reviewed and evaluated for conceptual equivalence by an independent team of graduate students, a British psychiatrist, a U.S. psychologist, and a medical sociologist. Areas of discrepancy were identified and revised based on consensus. For example, rather than saying "losing or gaining weight," the terms *fattening* and *slimming* were used; for decreased sexual interest, we used "decreased feminine or male energy/love affair contact" due to sensitivities.

Procedures

Authors of this study (four interviewers in total) conducted 38 face-to-face EM interviews. At the outset of the study, each interviewer was fluent in English and/or Luganda and familiar with diagnostic interviewing through coursework and practical experiences in a clinical psychology

program. The interviewers had experience working with the population of interest and had the skills to elicit EM-related information from patients and providers. Use of English or Luganda in interviews was based on participant's preference. The interviews were practiced and observed via observations and audiotape. The diagnostic interview (Appendix A) was administered first with the PCC-10 checklist and BDI. This interview lasted 30 minutes to 1 hour with each patient, including informed consent. After the diagnostic interview, the EM interview (Appendix B) was administered. Given the open nature, interviews ranged from 30 minutes to 2 hours. In all cases, patients and providers agreed to the interview and elaborated as much as desired. They were informed that they could discontinue at any time.

Data Reduction and Analyses

Data analysis combined qualitative and quantitative methods, including content analysis of interview transcripts, coding transcripts, and exploring predictions of differences with parametric and nonparametric statistics. To compare patients' demographics, symptoms, and treatment features, we used chi-square analyses, Fisher's exact tests (FETs), and *t* tests. Cramer's *V* values were reported as a measure of effect size for chi-square and FET analyses (small effect size = .10, medium effect size = .30, large effect size = .50; Cohen, 1988). Cohen's *d* values were reported as a measure of effect size for *t* tests (small effect size = .20, medium effect size = .50, large effect size = .80; Cohen, 1988).

To get an overall picture of the patient EM, we coded responses and calculated frequencies. Several categories were developed under each EM domain (i.e., name, cause, impact, treatment). Most were established a priori based on previous research on EMs in sub-Saharan Africa (Johnson et al., 2009; Patel, Musara, Butau, Maramba, & Fuyane, 1995). However, some code labels, such as financial help as a "treatment" for depression, arose from the patients themselves. Codes were expanded and collapsed to account for the data. The categories used for each EM domain can be seen in Tables 2 to 5. Measures of inter-rater reliability on the EM coding system were assessed as part of a previous, larger study with more participants (Johnson et al., 2009). Kappa statistics were as follows: labeling the problem (six categories, .88), causation (six categories, .98), seriousness (three categories, .79), impact (six categories, .95), best type of help (six categories, .95), and treatment expectations (five categories, .81). Measures of intra-rater reliability based on a 2-week interval suggested 100% agreement for each coder. To examine expectations for differences in EMs, we conducted chi-square analyses, or in cases of low frequencies, FETs.

To examine EM differences in patient–provider dyads, we used Kleinman's method to calculate cognitive difference scores. For each dyad, a measure of "cognitive difference" between EMs was calculated (Cohen, Tripp-Reimer, Smith, Sorofman, & Lively, 1994) for each EM domain. Answers were scored "0" (no difference), "1" (partial difference), or "2" (complete difference) based on their level of agreement. For example, if a provider believed symptoms stemmed from a psychological cause but the patient believed that symptoms stemmed from a physical cause, a cognitive difference score of "2" was assigned. If a provider believed that symptoms stemmed from spiritual and social causes, while the patient believed that symptoms stemmed psychological and social causes, a cognitive difference score of "1" was assigned. EM components that were in complete agreement with one another were scored "0."

Results

First, we present results for patient sociodemographics, symptom profiles, and treatment characteristics. Next, we present findings for each EM area assessed (labeling the problem, cause, seriousness/course and impact, best type of help/treatment, treatment expectations). Finally, we present results of the matched patient–provider dyads.

Patient Demographics

Surprisingly, patients in both settings were quite similar. The age distribution, for instance, was not markedly different (FET, $p = .38$): More than half of patients at both locations were in the youngest category (below 30). In addition, there was no difference in sex distribution, $\chi^2(1) = .14$, $p = .71$, marital status (FET, $p = .27$), employment status (FET, $p = .22$), or income (FET, $p = .61$). There was a marginally significant difference between groups based on the language of the interview (FET, $p = .05$, Cramer's $V = .41$), with 86% ($n = 12$) of those at traditional clinics speaking in Luganda, compared with 47% ($n = 7$) in psychiatric clinics. We saw a difference in religion (FET, $p = .04$, Cramer's $V = .56$) with 87% ($n = 13$) at traditional clinics more likely to be Catholic or Moslem, compared with 33% ($n = 5$) in psychiatric clinics.

Clinical Features

On the PCC-10, most patients endorsed both screening questions: low mood or sadness (94%) and loss of interest or pleasure (77%). The most frequent symptoms were fatigue or a lack of energy (94%), sleep problems (80%), loss of appetite or weight (77%), and concentration difficulty (73%). Suicidal ideation was lowest (30%, $n = 9$). On the BDI (Cronbach's $\alpha = .87$), 40% of participants scored in the severe range, 33% in the moderate range, 10% in the mild range, and 7% within normal limits. The average score was 28.96 ($SD = 11.62$). Patients were least likely to endorse the items on suicidal thinking and attempts ($M = 0.56$, $SD = 0.85$). Results did not indicate marked differences in depression characteristics. The difference on BDI scores between clinics was not significant, with most patients in both locations in the severe score range. Similarly, the difference on number of endorsed symptoms on the PCC-10 was not significant. We examined differences in the specific symptoms because those may be related to help seeking. No significant differences in BDI items were found. However, patients in traditional clinics were more likely to endorse "low confidence" compared with patients in psychiatric clinics on the PCC-10, $\chi^2(1) = 7.03$, $p = .01$, Cramer's $V = .49$.

History of Help Seeking and Treatment

The majority of patients (67%) reported a history of seeking help for their condition. There was no difference in where previous help was sought, with eight patients from each group seeking prior treatment from health clinics/hospitals. The most common form (53%) was modern medicine, usually "tablets." Informal help in the form of social support, financial aid, and environmental change accounted for 17% of responses. Two patients sought prior religious help (e.g., "getting saved"), and one from traditional sources (smoking and sniffing herbs). Both groups had similar ratings of perceived benefits regarding previous treatments with most (43%) saying they had benefitted only partially, followed by a third (27%) claiming no improvement, and the smallest percentage (10%) said they had improved a good deal. Ratings of patient satisfaction corresponded to perceived benefits with the majority not satisfied or partially satisfied (67%) with previous treatment and a minority (10%) very satisfied.

Current Treatment Characteristics

All patients reported between 1 and 11 visits to the provider in their current treatment period, which ranged from less than 1 week to 5 years. Most (80%) were receiving outpatient treatment. Independent t tests between patients at psychiatric and traditional clinics revealed no significant differences in length of the current treatment period, while a difference did emerge in the number of visits, $t(22) = -2.189$, $p = .04$, $d = 0.89$, with those at traditional healers having nearly three

times as many visits. Differences based on current treatment were found with 86% of patients in traditional clinics receiving herbal/traditional treatments, while the majority in psychiatric clinics were receiving modern medicine ("tablets" and injections, 67%) or therapy (27%). The largest percentage (48%) said they had improved very much, followed by 45% reporting partial improvement. Patients in both settings reported similar levels of improvement and satisfaction—with most participants saying they were very satisfied (47%) or partially satisfied (47%).

Patients' EMs

In this section, we present descriptive information from the content analysis of EMs for each area assessed, including (a) problem label; (b) cause; (c) seriousness, course, and impact; (d) best type of help/treatment; and (e) treatment expectations. We include the results from our comparisons across settings.

Labeling the problem. When asked, "what is the name of your condition?" patients provided a wide range of names (Table 1). More than one third (n = 13) gave names that were mental or psychological in origin, with the majority related to depressive affect (sad, not happy, no hope, bunakuwavu), followed by cognitive processes, such as worry (birowoozo) and thinking too much (kwelalikilira). Fisher's exact tests revealed no differences for the name of the condition based on location.

Table 1. *Names / Labels used by Patients to Describe their Condition* (N = 30).

		Percent (n)		
EM category	Content	Psychiatric Clinic	Traditional Clinic	Total
Psychological	Sadness (obunakuwavu), ('I am hurt'), depression, bi-polar depression, being sorrowful and not happy, having no hope, took poison due to too much thinking, thoughts (ebirowoozo), worry, worry about family and money, mental distortion, psychological torture, and others	60% (9)	27% (4)	43% (13)
Don't Know	Don't know, uncertain, can't give it a name, I don't know it's name, I can't tell	20% (3)	33% (5)	27% (8)
Biomedical	Lack of energy, body weakness ('I am weak'), sick/ illness, ulcers, serious headache, high blood pressure due to divorce, diabetes	20% (3)	13% (2)	17% (5)
Social	*('Dr. told me it was kiawabulo'), (worry from loss and loneliness)*	0% (0)	7% (1)	3% (1)
Other	*Poverty, have problems, it occurred through the presidential campaigns*	0% (0)	13% (2)	7% (2)
Cultural	*Neglecting ancestors, "talo" ('I was bewitched')*	0% (0)	7% (1)	3% (1)

Note. Fisher's exact tests revealed no significant difference between name/labels used by patients to describe their condition across treatment settings (FET, p = .23). Content that is italicized indicates information obtained from traditional healer clinic only.

Causation. As illustrated in Table 2, social problems were cited most often as the cause of the problem. We found no significant difference for cause based on location. Family pressure, isolation, and rejection by the community were specific precipitating events mentioned by patients.

Table 2. *Patients' Causal Models of Depression* (*N* = 30).

EM category	Content	Percent (*n*)		
		Psychiatric Clinic	Traditional Clinic	Total
Social	Separation/divorce, loss/death of family member ('my parents died'), family conflict ('leaving home and friends as a result of conflict with step-brother'), pressure from family, loneliness ('not being loved the way you are loving somebody')	27% (4)	27% (4)	27% (8)
Psychological	Too much thinking, worry ('worry about my children's future was the main reason'), wanting to kill myself, thoughts ('it comes from overthinking about my future and job')	40% (6)	7% (1)	23% (7)
Financial	Poverty, debt ('I had a debt that I could not clear'), no job, financial problems, ('someone stole my money', 'money disappeared'), no help ('not having anyone to help you leaving you with no job and helpless')	13% (2)	33% (5)	23% (7)
Biomedical	Diagnosed with HIV, AIDS, ulcers, illness, not eating food, Pains in body ('It was due to the illness I was suffering from, it was physical pains in the legs, stomach, neck and back…')	20% (3)	13% (2)	17% (5)
Other	*Discontinued studies ('I think it was discontinuation of my studies, out of the blue I started feeling like a failure in life'), presidential election ('I had so many enemies before the campaign, they threatened me'), don't know*	0% (0)	13% (2)	7% (2)
Traditional	*Bewitching, neglecting ancestral spirits ('neglecting ancestral spirits and bewitching by husband because of separating from him')*	0% (0)	7% (1)	3% (1)

Note. Fisher's exact tests revealed no significant difference between causal models of depression across treatment settings (FET, p = .15). Content that is italicized indicate information was obtained from traditional healer clinic only.

Psychological, financial, and biomedical problems followed social problems in terms of frequency. Specific examples and counts are provided in Table 2.

Seriousness, course and impact. There were no location differences in beliefs about the seriousness of their problem (FET, p = .33) or its expected course (FET, p = .65). The majority of patients (80%) believed their condition was serious or very serious. There were no differences among patients in the impact of depression on their lives (FET, p = .60). Notably, patients gave more responses about the impact than any other question (see Table 3). Most common were psychological effects (27%, n = 8) and most of these were related to depressed mood, such as feeling sad and unhappy.

Best type of help/treatment. As seen in Table 4, herbal medicines, modern medicine, and financial help accounted for the largest percentage of responses. Although many believed financial help would be best, only one received financial assistance. Not surprisingly, we saw a significant difference in the type of treatment deemed most beneficial based on location (FET, p = .001, Cramer's V = .74). Nearly half at psychiatric clinics believed medications were best, while more than half in traditional clinics believed herbal medicine was best.

Treatment hopes and expectations. Responses (see Table 5) were general, such as feeling better (37%) and health and physical well-being (33%). Patients reported general and health benefits

Table 3. *Impact for Depression* (*N* = 30).

EM categories	Content	Percent (*n*)		
		Psychiatric	Traditional	Total
Psychological	Sad ('I am always sad and not happy because of this condition'), ('sometimes I cry'), unhappy, useless, feeling of a hanging heart, lost hope, low motivation, *worry about bewitching*, children, or illness	13% (2)	40% (6)	27% (8)
Physical Health	Feel weak, problems eating, lost weight, sleep disruptions ('sometimes I can't sleep'), ulcers, ('pressure'), no energy	27% (4)	27% (4)	27% (8)
Social	Don't fit into society, dating problems, lost friends, ('people accuse me and I argue'), feel inferior ('I can't relate to others and have to look down')	27% (4)	20% (3)	23% (7)
Performance	('I cannot carry out my normal duties thoroughly well'), forgetting, ('my work is not done'), failure to concentrate	20% (3)	7% (1)	13% (4)
Financial	No money for treatment, poverty	7% (1)	0% (0)	3% (1)
Others	No problems	7% (1)	7% (1)	7% (2)

Note. Fisher's exact tests revealed no significant difference between treatment settings and impact of depression (FET = p = .60). Content that is italicized indicates information from traditional healer clinic only.

Table 4. *Patient Beliefs about the Best Treatment for their Condition* (*N* = 30).

EM Category	Content	Percent (*n*)		
		Psychiatric Clinic	Traditional Clinic	Total
Modern Medicine	Tablets, medicine, antidepressants, help from hospitals/clinics ('seeing a psychiatrist and not a psychologist, I want antidepressant and antianxiety drugs'), injection ('medicine because I don't get so worried')	47% (7)	0% (0)	23% (7)
Traditional	*Local medicine (if thoughts disturb you they reduce), herbal medicine, smoking a pipe (when I smoke it I get what I want, if I want a man I get a man, If I want a job I get a job', Spiritual ritual ('lubale' to satisfy ancestors)', 'demanding some things from my family to be put some where so that at least they also (those ancient ancestors) become happy.*'	0% (0)	53% (8)	27% (8)
Financial	Job, financial assistance ('someone to help me stand on my feet, if someone bought me a bike I could do anything…') Money for children to study, financial assistance ('money for food, transport, everything takes money')	20% (3)	20% (3)	20% (6)
Other	Going back to school, don't know, 'something to keep me busy', leave here	13% (2)	20% (3)	17% (5)
Counseling	Counseling ('Counseling b/c I would get solutions'), advice, talking ('advising me to stop thinking the way I did')	13% (2)	7% (1)	10% (3)
Social	Consolation, company of friends, care from relatives	7% (1)	0% (0)	3% (1)

Note. Fisher's exact tests revealed a significant difference in beliefs about best treatment for depression across treatment settings (FET, p = .001, Cramer's V = .74). Content that is italicized indicates information from traditional healer clinic only.

Table 5. *Treatment Hopes and Expectations for Treatment for Depression* (*N* = 30).

EM category	Content	Percent (*n*)		
		Psychiatric	Traditional	Total
Physical	Reduced heart pounding, increased energy, can eat/drink, recover from physical symptoms, will be healthy, improved weight, rest	53% (8)	31% (2)	33% (10)
Psychological	No longer be sad ('My happiness will come back'), regain confidence and getting out of fear, stop thinking and worrying ('I will run a normal life and not be haunted')	13% (2)	7% (2)	13% (4)
Social	('Stop thinking about what they do to me'), ('wife will return')	7% (1)	7% (1)	7% (2)
Performance	*Increased ability to perform ('I have to get a job; will prosper in my work; able to work')*	0% (0)	27% (4)	13% (4)
Other	Don't know, ('they just give me medication'), nothing, get back to normal, *feel better, helped to recover and settle, anything, feel okay*	27% (4)	47% (7)	37% (11)

Note. Fisher's exact tests revealed a significant difference for treatment hopes and expectations across treatment settings (FET, $p = .04$, Cramer's $V = .54$). Content that is italicized indicates information from traditional healer clinic.

(see Table 6). Notably they differed by location (FET, $p = .04$, Cramer's $V = .54$), with half at psychiatric clinics expecting health benefits, while almost half at traditional clinics indicated other benefits such as "feel better" and improvements at work or school.

EM Differences in Patient–Provider Dyads

In patient–provider dyads, there was some agreement in the overall conceptualizations (EMs), with an average cognitive difference score of 0.93 (on a 0-2 scale, with 0 being no difference and 2 the greatest), suggesting agreement on about 50% of the EM total model. If we look at both minor and major discrepancies (scores of "1" or "2"), the dyads had slightly more discrepancies (56) than agreements (41). The largest areas of discrepancy were type of treatment needed (with an average cognitive difference score of 1.63, on a 0-2 scale), cause (1.50), best treatment (1.50), and patient' biggest fear about their problem (1.30). Areas of least difference were seriousness (0.00), type of current treatment received (0.25), and treatment results obtained (0.25). In identifying best treatments, patients were more likely to say that they needed financial assistance, social supports, and medications than were their providers. Providers, however, were more likely to think that their patients needed counseling, advice, or psychotherapy. The hypothesis that EM congruence would vary according to provider type was not supported. The average cognitive difference score for dyads was similar, with 12.30 for healers and 11.60 for psychiatric providers (0 [no discrepancies] to 24 [major discrepancies] is the range of possible scores).

Discussion

The experience of depression presented by these patients was multifaceted and diverse, yet remarkably similar across treatment settings, lending support to the notion of universal features and also to cultural variation in depression (Draguns, 2000; Karasz, 2005).

The majority of patients conceptualized their problem as an emotional or mental state, which included sadness and "depression." This confirms reports that sadness is a relevant and common

feature in the experience of depression in Uganda, though it may not be spontaneously reported (Ovuga, 1986). In comparison with other findings (Okello & Ekblad, 2006; Okello & Neema, 2006) that depression was conceptualized primarily as "illness of thoughts," we also found evidence for an anxiety-stress-related conceptualization, which included worry and overthinking. However, our patients provided twice as many names related to core affective features. These results are similar to findings in a larger, community-based study in which a vignette of depression was most often labeled "sadness" or "unhappy" followed by worry and overthinking (Johnson et al., 2009). Somatic and anxiety-related features throughout the conceptualization suggest a possible "category fallacy" in which symptoms of discrete disorders, such as depression and anxiety, may be viewed as one illness in different cultural contexts (Patel, 1995). Our sample was small, yet it is possible that a subtype of depression with mixed symptoms of worry and overthinking is commonly conceptualized and experienced among Ugandans (e.g., illness of thoughts; Okello & Ekblad, 2006). Similarly, Patel and colleagues reported "kungfugisisa" (illness of thoughts) as a possible subtype of mental illness similar to a "neurotic disorder" among the Shona in Zimbabwe (Patel, Gwanzura, Simunyu, Lloyd, & Mann, 1995).

Consistent with other studies (Johnson et al., 2009; Okello & Neema, 2006), our results confirm the social embeddedness of depression in Uganda, as patients emphasized the role of relational problems and social concerns as contributing to their condition (e.g., divorce, death of loved one, loss, conflict) and also being a negative outcome of their depression (e.g., no partner, can't take care of children). As noted earlier, traditional healers often address social issues through methods such as family conflict resolution, community participation, affirmation of cultural beliefs and values, and even managing disruptions in patients' relationships with ancestors, spirits, and the cosmos. Traditional treatments, such as smoking the pipe, were said to bring jobs, money, and even relationships. The need for money to be able to support oneself and family loomed large for patients and seemed a top concern and a route by which other problems would be solved. As one patient noted, "if someone could just buy me a bike, I could do anything," and another, "getting a job is the most important thing because every problem a person has such as paying school fees, dressing and eating take money."

Constraints in the current system may result in psychiatrists and mental health professionals focusing on medications rather than work with patients' social relations or circumstantial concerns. However, results suggest that environmental and social factors should be addressed in treatment. Given the number of Ugandans suffering from depression who will continue to rely on social supports alone, it is important to strengthen existing social support systems and pay attention to factors that weaken those supports, such as poverty and social upheaval (Kibanja et al., 2012). Relational treatment approaches such as interpersonal, group, and family therapies may prove to be helpful in this aspect (Bolton et al., 2003).

Related to the wide variation in EMs seen in this study, there was also significant variation in suggested treatments. Medications, money, and herbal treatments were identified as best treatments. Patients in both settings expressed a desire for a comprehensive approach. As such, clinicians should be prepared to offer a range of therapeutic services. For patients who do need medication, medications with less severe side effects should be made available. Brief forms of therapy, such as cognitive-behavioral therapy, solution-focused treatment, family sessions, and interpersonal therapy could be helpful (Bolton et al., 2003). "Wellness" models may be appropriate in both preventing and treating depression in Uganda, as they are multifaceted, address somatic issues, and reduce stigma.

Traditional clinics in Uganda will continue to serve patients with depression. As one psychiatric clinical officer stated, "If I had the condition, I would go where the majority of people go, to the traditional healer." In fact, in recruiting patients, cases of unipolar depression were difficult to identify at inpatient and outpatient mental health clinics at Mulago and Butabika. However, these cases were relatively easy to identify at traditional clinics. Numerous patients were

socializing with one another and partaking in various herbal remedies. Some healers involve the patient's family in the treatment process, and some extend the focus of their treatment to the larger community, contributing to schools and community development projects (Johnson et al., 2009). Thus, the widespread use of traditional healers may be attributed to a number of factors, including the wider variety of interventions available in traditional settings, a lack of psychiatrists in Uganda (Ndyanabangi et al., 2004; Ovuga et al., 2005), and/or ease of language (i.e., Luganda or other tribal language).

The path to appropriate treatment, however, is not as direct as it should be, as the majority of patients sought previous help from health clinics and described these efforts as ineffective and unsatisfactory. Health-related aspects were prevalent throughout the EM, and thus, communication of distress may be at least partially somatic, driving individuals with depression to interface with primary health clinics (Pereira et al., 2007). This reiterates primary care as a likely entry point, and underscores the need for a health service setting model of mental health care. For instance, screenings could be readily incorporated into existing programs such as antenatal and postnatal clinics. The English and Luganda versions of the PCC-10 screening tool appear appropriate. However, based on our results and others, we suggest measures assess for fatigue, loss of energy, body weakness, body pain, worry and overthinking, loneliness, illness of thoughts, bewitching, and stressful family situations (Okello & Neema, 2006; Ovuga et al., 2007). Similarly, universal self-report measures (such as the BDI) may be able to capture common features of depression across diverse populations (e.g., sadness) but may leave out important symptoms specific to the context of Uganda. Active elicitation and incorporation of the patient's reported symptoms (via EMs) can enable a clinician to achieve a better sense of the patient's experience of symptoms.

In a rapidly changing context such as Uganda, one's understanding of depression is likely more nuanced and more dynamic than simply having a "Western" or "traditional" understanding. In our study, for instance, the majority of participants (regardless of location) cited social causes for their condition, while those in traditional clinics believed traditional treatments were best and those in psychiatric clinics believed medication was best. Indeed, as found in other EM studies (Williams & Healy, 2001), EMs are not necessarily congruent with one another and patients actively shape their view. Providers are encouraged to use EMs as an illuminative tool to explore a range of possible beliefs with patients throughout the duration of patient care and not rely on the universal scales. This is highlighted by results that show EM differences between patients and providers in both settings. It has been suggested that providers explicitly communicate their professional EM with patients and work to negotiate a cooperative treatment approach (Kleinman, 2004). This was long the intention of Kleinman and would be a movement in the direction of cultural competence, not just in Uganda but in a global, multicultural society (Johnson et al., in press). The feasibility of such an approach in both settings is another issue altogether. Anecdotally, one of our traditional healers wanted to learn alternate conceptual models, methods of assessment, and ways to alter treatment to better meet certain patients' needs. On a positive note, despite some disagreement, most patients reported improvements and satisfaction with their current treatment, suggesting they can get their needs met at either treatment setting. It is clear that improving treatment for depression in Uganda will depend on collaboration between providers and integration of services within an overall approach to care.

Limitations

This study relied on the translation of many psychological concepts. Although appropriate procedures for translation were followed, the process of achieving conceptual equivalence for such intricate concepts posed a challenge. Even if the measures were accurate in establishing a major depressive episode, patients may have had additional disorders. Moreover, it may have been

illogical for them to distinguish between various constellations of symptoms. In addition, responses to open-ended questions may have been influenced by factors such as social desirability and the context of the diagnostic interview. Respondents may have been less inclined to report traditional, spiritual, or cultural models if they believed that the researchers held a non-cultural model. A self-selection bias should also be considered, as those volunteering may have been more educated or acculturated to Western beliefs. In addition, because all data were collected from sites around Kampala, the variability in EMs may have been restricted. Although our sample had representation of tribes from other regions, it was predominately Baganda and representative of a more urban and educated group in Uganda (Kibanja et al., 2012). Pastoralist tribes in other areas such as the Ankole in the north, Karamojong in the northeast, and farmers in the west and southwest represent a more rural, under-resourced group—which is consistent with reports of higher rates of depression in these regions. More support for psychological services and treatment development research is needed.

Conclusion

In this study of depressed patients and corresponding providers in Uganda, we heard a diversity of beliefs about depression. Patients in traditional and psychiatric settings reported similar demographics, depression profiles, history of help seeking, labels used to describe the condition, perceived cause, seriousness of the condition, impact of condition, and satisfaction with their current treatment. They expressed differences in their current treatments and beliefs about treatment. Beliefs about the best treatment were the greatest area of difference between patients in each setting and in patient–provider dyads. Advancing treatment for depression in Uganda within the formal mental health sector will depend on understanding the diversity of EMs, increasing availability and accessibility of services, and working toward systems of care that integrate traditional paradigms and resources into existing models of service delivery.

Appendix A

Diagnostic Interview for Patients

In the past month, have you experienced any of the following symptoms, most of the time for not less than two weeks. *(Check the box for positive responses)*

I. Low mood (for example feeling sad, unhappy, down, or depressed) ☐

II. Loss of interest or pleasure (loss of interest in previously enjoyed activities or failure to derive enjoyment from these activities) ☐

If yes to I. or II. continue

1. Sleep disturbance, such as difficulty falling asleep, waking up too early, unsatisfying sleep ☐
2. Loss of appetite or increase in appetite or significant weight gain (fattening) or weight loss (slimming) ☐
3. Difficulty concentrating (i.e. staying mentally focused on what you are doing) ☐
4. Lack of energy (fatigue, feeling very tired or exhausted) ☐
5. Psychomotor retardation (feeling slowed down in your thinking and/or body movements) ☐

6. Decreased desire for sex (love affair contact) ☐
7. Loss of confidence or guilt (decreased confidence in your ability to do things, feeling worthless, or blaming yourself for things, even if you have done nothing wrong) ☐
8. Helplessness or Hopelessness (feeling as if you can't do things yourself or feeling a lack of hope for the future) ☐
9. Thoughts of death or suicide (thinking about death or about hurting or killing yourself) ☐

Total Number of Symptoms: _____ (*need at least four symptoms for 2 weeks or more).*

Note. Diagnostic Interview also contains section that assesses functional impairment in terms of self-care, academic/work, and social domains.

Appendix B

Explanatory Model Interview for Patients

Now, I am going to ask you a few questions about your condition. There are no right or wrong answers. We just want to know your own thoughts and opinions.

1. What do you call your condition, what name does it have?
2. What do you think caused it? , What is the most important cause?
3. Why do you think your problem started when it did?
4. To what extent does the condition affect you, is it much cause for fear or worry? (How severe/serious is it)
5. Do you think it will take a long or short time to recovery from this condition? (Will it have a short or long course?) How long?
6. What are the main problems your condition has caused for you? How has it affected your life?
7. What is the biggest or most important problem?
8. What do you fear most about your condition?
9. What kind treatment do you think you need?
10. How long did you experience the problem before seeking help?
11. What are the most important changes or benefits you hope to get from treatment?
12. Did you seek other help before coming here? (*Probe-location, type of practitioner*)
13. What type of treatment did you receive? *(If traditional healer, Probe for specific procedure, etc.)*
14. Did that treatment lead to any improvement ? *(None, some/partial, much)*
15. How satisfied were you with that (previous) treatment ? *(Not at all, partly satisfied, satisfied, very satisfied)*
16. What type of treatment have you received here?
17. Has it led to improvement ? *(None, some/partial, much)* What improvements?

18. How satisfied are you with the treatment here? *(Not at all, partly satisfied, satisfied, very satisfied)*
19. What type of help do you think is the best for this problem? Why?
20. What are the benefits you hope to gain from treatment, what is the hoped for outcome?

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