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Get Happy, Get Rich

The Relationship Between Depression and Poverty

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The world's poor, whether they live in dangerous urban slums or in the remote countryside, are often in dire need of food, clean water, and basic medications. So it might appear misguided to argue that mental health should be a primary rather than secondary concern in developing countries. But the reality is that mental health is not just a First World problem: disorders such as depression are pervasive in developing countries. Depression of course exacts a heavy psychological toll, but it also has economic costs because it impairs individuals' ability to function in everyday life. Accordingly, treating depression in developing countries has been shown to boost economic productivity, particularly among the most disadvantaged. A study in Uganda, for example, found that interpersonal group therapy for women with depression improved their ability to undertake economic activities, while treatment in India increased the number of productive workdays for patients.

Depression, which the World Health Organization **calls** ^[1] "the leading cause of disability worldwide," affects 350 million, but it strikes the poor the hardest. A meta-analysis of 56 epidemiologic studies by **researchers** ^[2] at the Catholic University of Louvain in Belgium found that those who fell in the lowest socioeconomic group within any given population were several times more likely to suffer from major depression than those in the highest group. In developing countries, depression and mental illness are exacerbated by conflict, extreme poverty, and other calamities. For example, in Uganda, a country disproportionately affected by civil unrest and the HIV epidemic, **rates of depression** ^[3] hover between 21 percent and 25 percent. Globally, depression affects 10 percent of the population.

Sadly, the vast majority of the mentally ill do not receive any care—**over 80 percent** ^[4] are left untreated in developing countries. There are two problems when it comes to treatment. First, mental illness manifests itself differently across cultures, which means that addressing it will require a different methodology in Kampala, Uganda, from what is practiced in, say, Princeton, New Jersey. The second looming issue is the extreme

shortage of mental health professionals in developing countries. High-income countries have **10.5 psychiatrists** ^[5] per 100,000 people; the average among low-income countries is **0.06** ^[6]. Rwanda, for example, has only **six psychiatrists** ^[7] throughout the entire country (for a population of almost 12 million), and Ghana has only **12 nationwide** ^[8] (for a population of almost 26 million). Even fewer psychiatrists work in the public sector or in rural areas.

The good news is that in recent years, mental health researchers around the world have begun to design care packages that tackle these two challenges in delivering treatment in developing countries: making remedies culturally appropriate and operating in low-resource environments.

Just as doctors craft a personalized treatment plan for each of their patients, mental health researchers are now tailoring their screening tools and evidence-based therapies to specific cultural contexts and socioeconomic risk factors. For instance, a program called the Friendship Bench in Zimbabwe treats *Kufungisisa*, which means “thinking too much” in the Shona language, a condition that in the West would be considered depression. Through six sessions of therapy, health workers help patients generate solutions to their psychosocial and financial problems, develop coping skills to reduce anxiety, and engage in activities that will assist them in recovering.

Those suffering from *Kufungisisa* differ from patients in the West in that they rarely present emotional symptoms but rather exhibit somatic ones (such as fatigue and headache) and often attribute their symptoms to supernatural factors as well as social and economic stressors. Such cultural concepts have been incorporated into a symptom questionnaire for patients in Zimbabwe, enabling health practitioners to more accurately detect depression in clinical settings. For example, between 2002 and 2003, a team of health-care providers and interdisciplinary researchers from Columbia University and Johns Hopkins University conducted extensive ethnographic research in Uganda on the manifestations of depressive symptoms. They sought to build a foundation for adapting and testing evidence-based therapy for mental health and conducted one of the first treatment trials in a developing country. They found that depressive symptoms were described locally as *y’okwetchawa* and *okwekubaziga*, akin to “self-loathing” and “self-pity” in the local language of Luganda.

Their research revealed that particular triggers of depression in these communities involved interpersonal problems, especially ones related to the HIV epidemic—losing loved ones to AIDS, losing social support from friends and family, and losing a job. Patients noted that the most problematic consequences of depressive symptoms revolved around their inability to engage with their community and in economic activities, as well as care for others. The research team decided accordingly to adapt and implement therapy that addresses interpersonal issues, as opposed to cognitive behavioral therapy, which focuses on altering negative thinking and habits. In this way, health-care workers could directly address the local understandings, triggers, and consequences of mental illness. Relying on Western diagnostic criteria alone would result in overlooking or dismissing many of these patients in Uganda.

In addition to culture, mental health treatment programs must consider local risk factors. Through decades of extensive research in Zimbabwe, researchers have **found** ^[9] that patients experiencing financial insecurity and hunger are not only more likely to develop depression, but to experience it more persistently. Furthermore, many *Kufungisisa* patients

also have HIV/AIDS, which adds another level of social and economic stressors to their depression. The research team that developed the Friendship Bench program thus enhanced treatment with a “behavioral activation activity” that enables HIV-positive female patients to participate in an **income-generating project** ^[10], such as manufacturing and selling handbags. This therapeutic component serves the dual purpose of reducing financial stressors that may prevent recovery and of providing an empowering and uplifting activity to reinforce the cognitive elements of recovery. This program is but one example of a new, rigorous, thoughtful, and multidisciplinary approach to treating mental disorders in developing countries—one that is designed by mental health professionals with the help of public health practitioners, anthropologists, and other social scientists.

When it comes to delivering care in resource-poor settings, however, the challenge is finding enough practitioners to counsel and treat patients. Twelve psychiatrists in Ghana cannot possibly provide adequate care for a country of nearly 26 million. The answer to the problem may lie in using well-trained laymen. A **number of studies** ^[11] show that this approach works. In practice, specialist and nonspecialist health workers “task share” and are assigned a portion of the treatment based on their specific knowledge and skill set; for example, anyone can be trained in basic counseling, although drugs can be prescribed only by licensed professionals.

A number of randomized controlled trials have now proven the effectiveness of this multitiered approach to the delivery of mental health care in developing countries. In fact, the Friendship Bench program is primarily implemented by peer health workers, although it is overseen by psychiatrists and/or psychologists. Friendship Bench is based upon the success of the programs evaluated in the MANAS trial in India. MANAS was one of the largest mental health trials in a low-income country to date. This study evaluated a treatment program where lay health workers were trained to manage cases and educate patients about anxiety, depression, and psychotherapy while primary care physicians and mental health specialists focused on diagnosis and drug prescription, particularly in patients with more severe illness. The study revealed that the intervention was effective both in treating depression and, notably, in increasing productivity: patients in the treatment group suffered four to five fewer “disability days” per month or days of work lost because of their illness. Another program in Uganda, **StrongMinds** ^[12], uses lay health workers to deliver therapy in groups and has produced striking results, including increased self-employment, lower unemployment, and increases in savings.

Currently, a majority of the developing world remains woefully underserved in mental health care. Thus, the next step is to determine how to rapidly scale up these services to reach not thousands but millions of people. In addition to employing lay health workers in the clinical setting, many community-based solutions hold promise. For example, StrongMinds ultimately intends to teach laypeople to then teach others in basic counseling techniques. In this way, the program empowers communities by giving them the skills to address their own needs. Such treatment models do not suggest that mental health professionals are superfluous—they are sorely needed, especially in the poorest parts of the world—but this model can expand their reach.

Whether mental illness is tackled through community-based approaches or more formalized health-care systems, prioritizing mental health care in developing countries promises to reap large returns: improving individual well-being and socioeconomic outcomes. Given the large returns to treating mental illness, it is not just a humanitarian issue but also a crucial factor when it comes to boosting a country’s economic

development.

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- [4] <http://europepmc.org/abstract/med/15173149>
- [5] <https://books.google.com/books?id=5YgHCAAQBAJ&pg=PA245&pg=PA245&dq=10.5+psychiatrists+per+100,000+people&source=bl&ots=OKtp50pGWR&sig=l3Kwb6UIVBtZVaQEA4RWL4van1M&hl=en&sa=X&ei=DX82VYvMAYXdsATZ4oDgBg&ved=0CCUQ6AEwAQ#v=onepage&q=10.5%20psychiatrists%20per%20100%2C000%20people&f=false>
- [6] http://www.gulbenkianmhplatform.com/conteudos/00/83/00/01/Global-Mental-Health-4_6116.pdf
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- [12] <http://strongminds.org/our-impact/>