Triggering Hope: Motivating for Change in an Environment of Dependency, Disincentives and Despair

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Why are some people "adopters" and others not?
Fixed or Material/Environmental Reasons for Lack of Response to Opportunities

- **Households and individuals often respond differently to the same messages and inputs:**
  - *Example:* An organization provides **loans** to poor households in a district, but only **some people step forward to take a loan**
- **Fixed or Material disincentives**
- Shepherd, A. (2007) found that some of the most common reasons for chronic poverty are: **exposure to natural disasters, breakdowns in law and order, exposure to market fragmentation, health shocks, and economic collapse.**
- **Other reasons for lack of response:**
  - Not having **time or money** to attend group meeting or participate in training
  - Not having to **land** or **tools** needed to take advantage or improved seeds
  - Not having enough **education** to feel comfortable participating in training with others

More Fixed or Material/Environmental Reasons for Lack of Response to Opportunities

- **Discrimination:** Not being accepted **socially** because of one's tribal or ethnic background, gender, HIV status, etc.
- **Lack of power at a household level:** Men own and make decisions about assets and income use – women only gain access through men, may be subject to abuse
- **Lack of voice or power at a community level:** People may lack the sense that they have a voice in decisions at the level of their community:
  - **Power over public goods lies elsewhere:** the government, traditional leaders
  - **Decisions about development lie elsewhere:** government ministries, development agents, NGOs, donors or investors
  - **Lack of power to negotiate access to resources:** decisions made by others, inability for those competing for access to negotiate a peaceful solution
- **Presence of perverse incentives (or *dis*incentive effects)**

Why are some people "adopters" and others not?
Non-material / Changeable Reasons for Lack of Response to Opportunities

- **Some Non-Material / Changeable Reasons:**
  - **Aspirations:** degree to which people want to move out of their present situation
  - **Perceived Self-Efficacy** or **"Agency":** beliefs about ability to *do what is necessary* to respond to opportunities; and degree to which people are *invited* to participate in opportunities
  - **Fatalism, "Learned Helplessness":** beliefs about the degree to which peoples own actions and agency can and will change their adverse situation; internal vs. external **"Locus of Control"**

More Non-material / Changeable Reasons for Lack of Response to Opportunities

- **More Non-Material / Changeable Reasons:**
  - **"Perceived action efficacy":** people's beliefs about the degree to which taking the promoted action will improve their lot.
  - **Sense of having a say: "Voice"** over community affairs, access to resources, and ability to negotiate with other groups.
  - **Mental health:** degree to which a person has **depression or anxiety**, or other mental illness that affects their overall response to adversity and opportunities

Focus of this Session: Non-material and changeable causes for non-adoption / Lack of response to opportunities

- Important to keep in mind that there are many reasons why some people sink into poverty and are less resilient to shocks than others
- Focus of this session: causes related to beliefs about the world and people's situations (sometimes called *"worldview" or "mindset"*)

Increasing Hope/Optimism vs. Fatalism / Learned Helplessness

- **Fatalism**: "1. The belief that all events are predetermined and therefore inevitable. 2. A submissive attitude to events, resulting from such a belief." But that sort of fatalism does not always lead to despair (ex: Predestination and Presbyterians).
- But what we *usually* mean by fatalism (in a development context) is a *larger collection of beliefs* that can lead to *despair* (in both Africa and the U.S).
- Science based on "Learned Helplessness" and "Learned Optimism" research by Martin Seligman:
  - Two out of three animals and humans became helpless following inescapable shock / negative events.
  - Further, when placed in a new situation with a different annoying element, they would make no attempt from the beginning.
  - One in three would shrug off situations and continue acting to improve their lot regardless. (We can learn from this group.)

Increasing Hope/Optimism vs. Fatalism / Learned Helplessness

- Despair / Depression associated with having a *pessimistic explanatory style,* seeing the causes of bad events as *permanent*, *pervasive*, and *personal*.
- Sweeney et al. (1986) conducted a meta-analysis on the relationship between explanatory style and depression (104 studies, n~15,000). People who attributed negative events to **personal**, **permanent**, and **pervasive** causes were more likely to be depressed. People who attributed either positive or negative events to their own **luck** were also more likely to be depressed.

When Bad Things Happen

- Optimism ≠"thinking positive thoughts," but instead having an *optimistic explanatory style*. The way that people think about the causes of **both success and failures** is what matters most in attributional style, and hence in depression.
- ***When something bad happens, you are <u>more likely</u> to become depressed when you believe:***
  - It's **personal**: it's due to something you <u>did</u> or something about the way that you <u>are</u>;
  - It's **pervasive**: the cause is something that not only affects this particular situation but <u>many</u> others that you face.
  - It's **permanent**: you believe it <u>cannot</u> be changed.

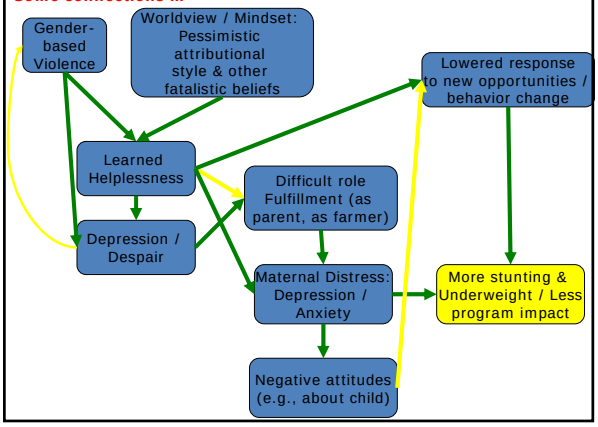
When Bad Things Happen

- For example…
  - You **<u>lose</u>** a game of *Mankala* (a.k.a., Gabata, Sadeqa), and you think: "**I am *never* good at things that require competition.**" [Personal, permanent ("never good at"), pervasive ("things that require competition").]
  - Another choice would be to say: "**I've been so tired lately. I was not thinking very clearly when I played *Mankala* tonight.**" [Personal, but not permanent or pervasive – limited to tonight's game.]

When Bad Things Happen

- Another example…
  - A farmer has a poor harvest when rainfall is sparse, and thinks: "**I will always be poor. I am not a very good father to my children.**" [Personal, permanent ("always be"), pervasive – not just reflective of his farming, but being a father.]
  - Another choice would be to say: "**There seems to be less and less rain. I need to do something different so my crops need less rain**." [Personal, but not permanent or pervasive, and action oriented.]

Some connections …



Why focus on Depression?

- **Maternal depression is high** in communities where we work:
  - Depression incidence in developing countries varies from 15-57%.
  - Marsabit, Kenya: 39% of the women were depressed on half of the days of the week or more.
  - Sofala Province, Mozambique: 37% of mothers were depressed on half the days of the week or more.
  - Bolivia (n=15):
    - 73.3% of women were depressed on half the days of the week or more;
    - 79% of women mentioned one or more times that they had been physically abused in the last year; High correlation coefficient (0.65) between depression and abuse.
    - (Women exposed to GBV have a higher incidence of depressive and anxiety symptoms, PTSD and thoughts of suicide.)

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PREVALENCE IN LAMI COUNTRIES

- Africa and Asia (*Husain, Creed, & Tomenson, 2000*)
  - **15%-28%**
- Pakistan *(Kazi et al., 2006)*
  - **28%-57%**
- Latin America *(Wolf, DeAndraca, & Lozoff, 2002)*
  - **35%-50%**
- WHO estimates that by 2020 depression will be the second largest cause of DALYs [third now].

Wachs, et al, *child development perspectives*, 2009

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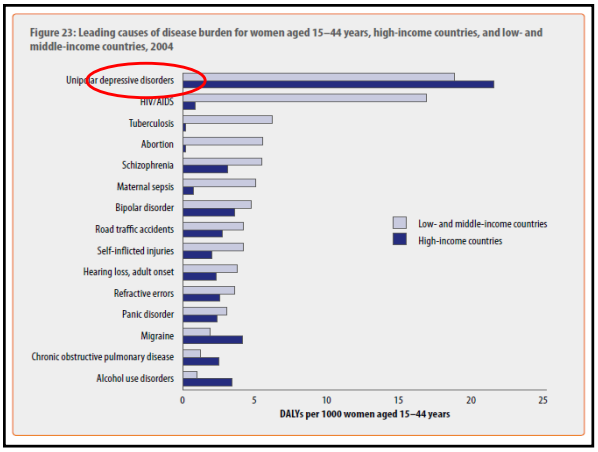
RISK FACTORS ASSOCIATED WITH MATERNAL DEPRESSION IN LAMI COUNTRIES

- Poverty/ Economic Stress (6)
- Low social support (7)
- Domestic violence (1)
- Maternal anemia (2)
- Lack of mental health resources/services (2)
- Social stigma (1)
- Families with large #'s of young children (3)
- Having preterm or LBW infant (1)
- Having a child with developmental disabilities (1)
- Having unplanned or unwanted infant (1)
- Female child in culture with strong preference for male (2)
- Lack of control over resources & reproductive health (1)

Wachs et al, *child development perspectives*, 2009



Depression and Food Security: Effect of Depression on the Mother

- In the **mother**, maternal depression is associated with:
  - Impaired parenting/caregiving
  - Problems in breastfeeding and comp. feeding
  - Child perceived as having a difficult temperament
  - Lower ability to give maternal stimulation to infant
  - Less positive interaction and less affective behavior
  - More variable behavior (e.g., anxiety, fatigue, insomnia, decreased appetite, substance abuse)
  - Poor treatment compliance (e.g., ARTs)

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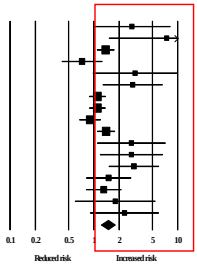
Depression and Food Security: Effect of Depression on the Child

- In the **child**, maternal depression is associated with:
  - Behavioral problems
  - Childhood depression
  - Motor delay and low academic achievement
  - Diarrhea
  - Undernutrition
- Meta-analysis of 17 studies[1] looking at stunting and underweight and depression -- Africa (4), South America/Caribbean (6), Asia (7) -- found that depression in women may be a risk factor for poor growth in young children (WHO, 2011)

[1] Surkan et al. *Bull WHO* 287:607-615D, 2011

[Maternal Depression &] Underweight: Results from 17 studies

Study	Location	Time point	Odds ratio	Lower limit	Upper limit	p-Value
Adewuya et al. 2008	Nigeria	9 months	2.840	0.979	8.235	0.055
Anoop et al. 2004	India	6-12 months	7.400	1.509	36.300	0.014
Baker-Henningham et al. 2003	Jamaica	9-30 months	1.385	1.081	1.773	0.010
Black et al. 2009	Bangladesh	12 months	0.723	0.412	1.269	0.259
Carvalheas et al. 2002	Brazil	12-23 months	3.100	0.966	9.949	0.057
de Miranda et al. 1996	Brazil	<24 months	2.900	1.268	6.633	0.012
Harpham et al. 2005	Ethiopia	6-18 months	1.100	0.872	1.387	0.421
Harpham et al. 2005	India	6-18 months	1.100	0.872	1.387	0.421
Harpham et al. 2005	Peru	6-18 months	0.900	0.667	1.214	0.490
Harpham et al. 2005	Vietnam	6-18 months	1.400	1.094	1.791	0.007
Patel et al. 2003	India	6 months	2.800	1.087	7.213	0.033
Rahman et al. 2004 (urban)	Pakistan	12 months	2.800	1.176	6.665	0.020
Rahman et al. 2004 (rural)	Pakistan	12 months	3.000	1.500	6.000	0.002
Santos et al. 2010	Brazil	48 months	1.500	0.802	2.806	0.205
Stewart et al. 2008	Malawi	9.9 months (median)	1.313	0.804	2.145	0.277
Surkan et al. 2008	Brazil	6-24 months	1.800	0.595	5.450	0.298
Tomlison et al. 2006	South Africa	18 months	2.320	0.899	5.990	0.082
Combined Estimate			1.472	1.215	1.782	0.000



Surkan et al. *Bull WHO* 287:607-615D, 2011

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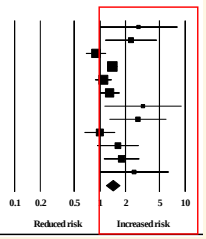
[Maternal Depression &] Short Stature: Results from 15 studies

Study	Location	Time point	Odds ratio	Lower limit	Upper limit	p-Value
Adewuya et al. 2008	Nigeria	9 months	2.840	0.979	8.235	0.055
Black et al. 2009	Bangladesh	12 months	2.317	1.147	4.681	0.019
Harphamet al. 2005	Ethiopia	6-18 months	0.900	0.682	1.187	0.455
Harphamet al. 2005	India	6-18 months	1.400	1.217	1.610	0.000
Harphamet al. 2005	Peru	6-18 months	1.100	0.872	1.387	0.421
Harphamet al. 2005	Vietnam	6-18 months	1.300	0.982	1.721	0.067
Patel et al. 2003	India	6 months	3.200	1.125	9.102	0.029
Rahman et al. 2004	Pakistan	12 months	2.800	1.293	6.065	0.009
Santos et al 2010	Brazil	48 months	1.000	0.658	1.519	1.000
Stewart et al. 2008	Malawi	9.9 months (median)	1.628	0.924	2.869	0.092
Surkan et al. 2008	Brazil	6-24 months	1.800	1.109	2.923	0.017
Tomlison et al. 2006	South Africa	18 months	2.520	0.981	6.475	0.055
Combined estimate			1.416	1.177	1.704	0.000



Surkan et al. *Bull WHO* 287:607-615D, 2011

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SUMMARY

- *Findings*
  - In developing countries, children of mothers with depressive symptoms presented higher risk of
    - Underweight (OR=1.47, p<0.01): [**Children of depressed mothers are 47% more likely to have an underweight child.**]
    - Short stature (OR=1.41, p<0.01): [**Children of depressed mothers are 41% more likely to have a stunted child.**]

Surkan et al. *Bull WHO* 287:607-615D, 2011

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SUMMARY

- *Findings*
  - **Population Attributable Risk Calculation**
    - **If infants were entirely <u>unexposed</u> to maternal depressive symptoms, 23% to 29% fewer children would be underweight or stunted**

Surkan et al. *Bull WHO* 287:607-615D, 2011

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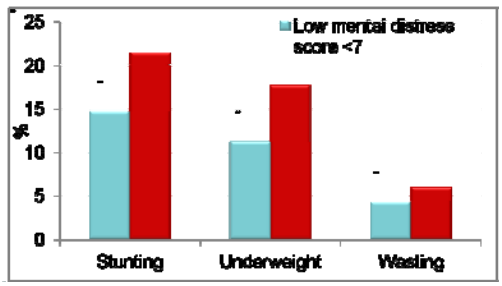
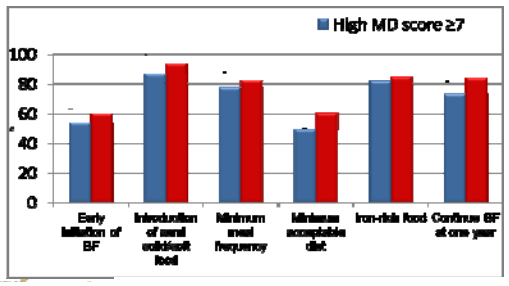


** p<0.05; *p<0.01

Maternal mental distress is associated with child feeding practices and anthropometry in Vietnam

Phuong H. Nguyen[1], Purnima Menon[2], Rawat Rahul[3] and Marie T. Ruel[3]
[1]International Food Policy Research Institute (IFPRI), Hanoi, Viet Nam; [2]IFPRI, New Delhi, India; [3]IFPRI, Washington, DC.
Poster presentation at the Experimental Biology conference in 2011

Higher Depression/Anxiety is associated with less IYCF behavior change



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Review

- ***What are the main things that we can learn from these findings?***

Fatalism and Food Security

Questions in Ethiopia study, summarized in *Ethiopia: The Path to Self-Resiliency* (IFPRI):

- *Each person is primarily responsible for his/her success or failure in life:* 67% agree
- *One's success or failure in life is a matter of his/her destiny*: 33%
- *To be successful, above all one needs to work very hard*: 65%
- *To be successful, above all one needs to be lucky*: 35%

Fatalism and Food Security

- "The feeling of hopelessness and resignation is a widespread phenomenon" .. but it varied by woreda (e.g., Chifira and Ziquala, 50% believe luck is primary driver of one's success vs. 80% of those in Dirashe woreda – spread through social networks??).
- Those who believed success is a matter of destiny/luck borrowed less when given option to choose amount (10% lower demand) and were less likely to make long-term investments.

Fatalism and Food Security

- "Overall, the results presented…offer preliminary, although robust, evidence that a person's perception of the degree of control/responsibility he or she has over his or her 'life' significantly impacts his or her future-oriented behavior…." and
- "..unless a household is pro-actively engaged in bettering its future, asset graduation may not lead to self-resiliency."
- "..these results already call for complimentary actions to enhance the effectiveness of programs such as the PSNP."

Resiliency: "PD" Households

- One source of ideas for these complimentary actions that may be helpful … Ethiopia (IFPRI): Communities asked to identify households that were most likely to be resilient in each livelihood context.
- Interviews conducted with these households to identify the characteristics that made them unique (or *positive deviants*).

Resiliency: "PD" Households

PD Study Findings (partial list):

- Good work ethic (despite community pressure not to work so hard)
- Joint decision making and positive relationships with spouse. Very important to successful income diversification strategies.
- Openness to change and early adopters of extension packages.
- Not drinking or chewing chat
- Seeing the value of sharing food and resources with other members of the community.
- Seeking opportunities to share their ideas and even resources to enable other households to follow their example.

Part II -- Interventions

EFFECTIVE PSYCHOSOCIAL APPROACHES

- **Social support**
  - Taiwan (support groups led by nurses)
  - Pakistan (support groups led by trained community women)
- **Group therapy**
  - Uganda (Interpersonal Group Therapy led by trained group leaders)
- **Use of existing health mechanism**
  - Jamaica (home-visit by community health workers)
    - Parenting issues discussed
    - Mother/child play activities introduced
- **Enhance mother-infant interactions**
  - South Africa (improvement in interactions/infant growth)

TREATING DEPRESSION TO TRIGGER HOPE & DEVELOPMENT IN AFRICA :

A focus on the Interpersonal Psychotherapy for Groups treatment (IPT-G)

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June 11-14, 2012
Addis Ababa, Ethiopia

Background

- Need for culturally appropriate mental health assessment and interventions in Africa came to fore after the Rwanda crisis in the 90s.
- WV needed to understand local views on psychosocial/mental health challenges among affected communities.
- There was lack of evidence based assessments and impact measurement of existing psychosocial programs among humanitarian agencies.
- A Partnership between Hopkins, Columbia and WV developed and tested culturally appropriate mental health assessment methods and the IPT-G intervention for locally defined depression .

What is Depression

Mental condition characterized by:

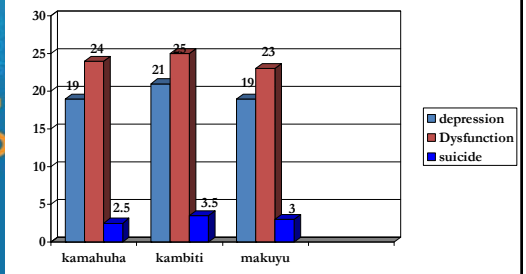
- Prolonged low mood
- Feelings of sadness
- Dejection, despair, conflicts etc.
- Hopelessness/helplessness
- Lack of energy and interest in things
- Dysfunction/inability to perform important tasks

This can last for Months/years and interferes with ability to participate in normal day to day activities e.g. food production (functional ability)

Triggers of Depression

- *Grief* -- death of an important person
- *Changes in a person's life* – any life change; bad or good
- *Disagreements* – unsolvable disagreement with someone important
- *Loneliness and social isolation* – the person feels frequently lonely and cut off from the others

Depression, function impairment and suicide rates(%) for adults in selected villages in central Kenya.



What is IPT-G

- Time limited psychotherapy 16-20 weeks
- Task Oriented
- Uses local language
- It is gender based
- Treats major depression
- Looks at what was happening in person's life when the current depression began

(Link symptoms to event/s)

IPT-G GOALS

- To reduce the symptoms of depression and other psychosocial problems
- To improve the quality of an individuals social and interpersonal relations
- To increase functionality e.g. productivity…including food production.. Taking care of self/family

IPT-G IMPLEMENTATION GUIDE

ESTIMATED COST OF IPT-G IMPLEMENTATION

	Activity		Cost @	Total Cost
1	Recruitment of PSS – Salary	Negotiated		
2	Sensitization /Recruitment	Negotiated		
3	Training Cost (Ethnographic Assessment /IPT-G facilitation Skills) e.g. Cost of hotel or Lunch/tea	10 days residential/non residential		
4	Ethnographic Assessment -IPT-G facilitators	Stipend negotiated		
5	Ethnographic Analyses – Keying clerk	Negotiated		
6	Consultancy Cost	10 days	$400	$4,000
7	Consultancy Debriefing/supervision Cost	7 days	$150	$1,050
8	Stationary	10 days training/survey/ monitoring books		

The numbers..

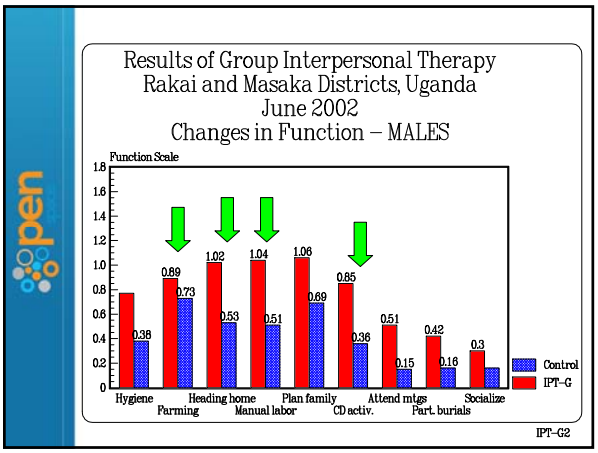
- One facilitator= 3 groups of 10-12 members (1-2 hours)per week for 16-20 weeks.
- E.g. 20 facilitators can treat 720 direct beneficiaries.
- 3,600 family members- indirect beneficiaries;

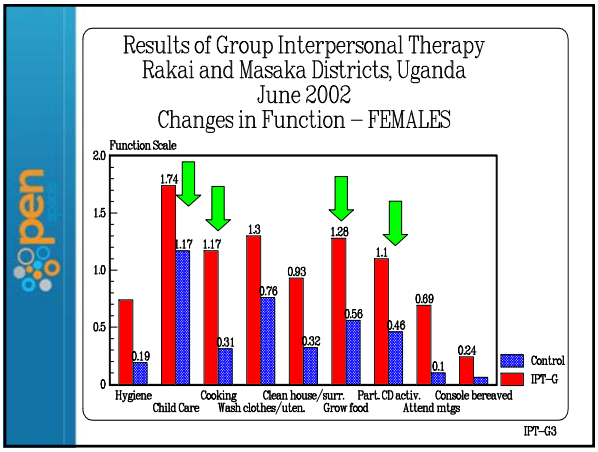
Post Intervention results

Two weeks after intervention participants are re-interviewed using the same pre-intervention assessment instruments.

Outcomes from Kenya:

- Mean reduction in depression severity 17.45 points for all groups (p<.001)
- Mean reduction in dysfunction 7.08 (p<.001)
- After intervention, only 3% of the group members met criteria for depression compared to 95% prior to intervention.





Typical IPT-G session

Men's group in session: conducted under a tree: no therapy rooms in the local setting!

Ladies group session: Near the group's farm.

IPT-G Publications/References

- Group interpersonal psychotherapy for rural Uganda six months follow up"-British Journal of psychiatry May 2006'
- Group Interpersonal psychotherapy for depression in Rural Uganda: A randomized controlled trial"JAMA (www.jama.ama-assn.org) June 18 Vol .289 ,no. 2003.
- "Adopting Group Interpersonal Psychotherapy for a Developing Country: Experience in Rural Uganda": World Psychiatric Organization (WPA) - Vol 2 ,No.2 June 2003 under Pg 114.
- Depression in Rwanda: Prevalence of depression in Rural Rwanda based on Symptom and function Criteria (Co-author). Journal of Nervous Mental Disorders.(USA) 2002; 190(9):631-637.

Thank you

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Can Learned Helplessness be Changed?

- Univ of Penn RCT (Seligman) found that "learned optimism" can be taught:
  - Screened college students to find bottom quarter in terms of pessimistic explanatory style, and offered workshop to help them learn "how to cope with this unfamiliar new environment." Randomized all who accepted into two groups.
  - 106 students (Intervention) receive **16 hours** of optimism training to change their explanatory style, and also receive assertiveness training, graded task assignment and stress management.
  - 119 students (Controls) receive complete diagnostic interview only (every 6m).
  - Moderate / Severe Depression: **22%** in people who received training (intervention) vs. **32%** of the controls. (**32% less depression**)
  - Generalized anxiety: **15%** of trained group vs. **7%** of controls. (**53% less anxiety**)
  - Also found that the change in explanatory style (from pessimism to optimism) was responsible for the decrease in depression and anxiety.

Can Learned Helplessness be Changed?

- Five studies with school children 10-12 years at risk of depression.
- Used skits, cartoons, and role playing to teach optimism.
- One of the studies (Jacox et al.):
  - Children with moderate to severe depression in entire group at 2y follow-up: **20-45%**
  - Children who had optimism training had **half** the rate of moderate/severe depression.
  - Benefits continued over time. During puberty, 22% of trained children were depressed vs. 44% of control group.
- Similar optimism training now being used by U.S. Army to build resilience and prevent psychological trauma ($125M *Comprehensive Soldier Fitness Program*).
- ***Unknown: Would it bear fruit in food security programs?***

Respect for Women and GBV (FH/Mozambique)

% of CGVs who say they have gained more respect from [each group] since they began participating in the project (n=200)	% of CGVs
... from health facility personnel	25%
...from their extended family	41%
... from their parents or husbands' parents	48%
... from their husbands	61%
... from their community leaders	64%
... from their mothers / other women / mother beneficiaries	100%
% of mothers who say that it is okay for a husband to hit his wife if he is not satisfied with her: Baseline, All mothers of children 12-59m	64%
% of mothers who say that it is okay for a husband to hit his wife if he is not satisfied with her: Final, mothers of children 0-23m	34% (CI:27-41%)
% of CGVs who say that it is okay for a husband to hit his wife if he is not satisfied with her: Final, Care Group Volunteers (all women)	3%
% of mothers who said daughters usually attended educational session	49%

Wetzel, C, Davis Jr., T. Results of Care Group Operational Research conducted April to May 2010 as part of the project: Achieving Equity, Coverage, and Impact through a Care Group Network. Funded by USAID, Cooperative Agreement: GHS-A-00-05-00014-00.

Land O'Lakes/Mozambique: Joint Decision-Making

- Initially, few women participated:
  - Unable to own cows, land, other assets
- Property controlled by men, only available to women through marriage:
  - If death or divorce, assets revert to man's family

Intervention:

- Men were told that two family members must participate in trainings, and in most cases, wives attended with their husbands
- **In separate focus group discussions, both men and women reported that women were consulted more frequently on dairy management decision-making**

Small Group Exercise:
What have you or others done to help people respond to opportunities better?

Questions:

- Groups 1 & 3: What are the things that have been done in your programs to address fatalism, learned helplessness, depression, aspirations failure, and "lack of agency"?
- Group 2: What activities do you think could possibly bring about change in these areas that could be tested and scaled up?
- **All Groups: What is the way forward?** What could be the next steps to advance this topic and move the issue forward? (Use cards.)

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