Published in final edited form as:

Lancet HIV. 2015 May ; 2(5): e172–e173. doi:10.1016/S2352-3018(15)00044-2.

Psychological therapy to improve HIV care and reduce stigma

Ingrid T Katz and Alexander C Tsai

Division of Women's Health, Brigham and Women's Hospital, Boston, MA 02115, USA (ITK); Harvard Medical School, Boston, MA, USA (ITK, ACT); Massachusetts General Hospital Center for Global Health, Boston, MA, USA (ITK, ACT); and Mbarara University of Science and Technology, Mbarara, Uganda (ACT)

Ingrid T Katz: ikatz2@partners.org

The Global Burden of Disease study introduced mental disorders to the global health agenda more than two decades ago. Mental disorders are among the principal causes of disability burden in low-income and middle-income countries.¹ Emphasising the value of treating mental disorders not only to relieve human suffering, but also to improve other health outcomes of interest (eg, HIV) or to enhance economic development has been partly effective in mobilising concern. Despite these efforts, resources to address this issue at a population level have yet to be organised on a large scale.^{2,3}

The successful scale-up of HIV treatment through the US President's Emergency Plan for AIDS Relief (PEPFAR) has provided a prominent example of the population health possibilities that can be achieved in low-income and middle-income countries through coordinated efforts to deliver effective treatment at scale.⁴ Life expectancy gains for people with HIV have been great.⁵ The same cannot be said for people with mental disorders: even in Scandinavian countries with among the most equitably distributed health-care resources in the world, life expectancy of people with mental health problems lags by two decades.⁶ Unfortunately, a PEPFAR for mental disorders is nearly impossible to imagine at this time. The specialty is too fractured, political will non-existent, and stigma too great.^{3,7}

In the meantime, the field continues to benefit from research on the development and testing of scalable, evidence-based treatments for common mental disorders that also improve other health outcomes of interest. In the setting of HIV, common mental disorders are of great public health importance: depression is highly prevalent in people with HIV,⁸ effective depression treatment improves HIV-related outcomes,⁹ and the stigma of HIV heavily compromises treatment adherence.¹⁰

In *The Lancet HIV*, Etheldreda Nakimuli-Mpungu and colleagues¹¹ report the findings of a randomised trial showing that a group psychotherapy intervention improved depression symptom severity, role and social functioning, and self-esteem in people with HIV in northern Uganda. They used an active comparison group, the short-term treatment effects were large and similar to those estimated in previous studies, and the researchers handled

Correspondence to: Ingrid T Katz, ikatz2@partners.org.

We declare no competing interests.

loss to follow-up appropriately. Their study offers an excellent example of a carefully planned approach to intervention development informed by qualitative research, instrument validation, and pilot testing.

The study also provides a starting point to explore several important questions. First, how can we provide scalable models of psychological treatments for common mental disorders in low-income and middle-income countries? Previous concerns have typically focused on limitations in human resources and the generalisability of treatments developed in high-income settings. However, human resource limitations can be overcome through task shifting (ie, to non-specialist health providers¹²) and task sharing (eg, through stepped or collaborative care¹³). Likewise, studies have shown that cultural adaptations of psychological treatments modify their implementation while preserving fidelity to the core content.¹⁴ The group psychotherapy intervention in the study by Nakimuli-Mpungu and colleagues¹¹ was delivered by mental health professionals with diploma and degree-level education. We believe that research showing how to adapt the intervention for delivery at scale by trained laypeople would be of great public health significance.¹²

Second, how can we expand on these findings to assess its implications for other aspects of health and wellbeing? Effective depression treatment has been linked to improved HIV-related outcomes in studies done in high-income countries.⁹ We do not know whether a similar effect was noted in this sample,¹¹ since these data are not reported. Future studies can extend the work of Nakimuli-Mpungu and colleagues by additionally studying HIV-related outcomes of interest, such as stigma, treatment adherence, virological suppression, and retention in care. By doing so they might help to build the evidence base for the integration of psychological interventions in the more established HIV treatment infrastructure.

Lastly, Nakimuli-Mpungu and colleagues postulated that “when [group support psychotherapy] reduces depression symptoms, livelihood strategies will be enhanced thereby leading to acquisition of livelihood assets”.¹¹ But which variable is the mediator, and which is the outcome? Could the income-generating skills taught through the intervention have improved livelihoods, thereby ameliorating depression symptom severity?¹⁵ The authors did not present data describing the extent to which the participants' income-generating activities were successful. We believe this represents an important area for future research. For people who are stigmatised and excluded, livelihood interventions can contribute powerfully to social reintegration and reversal of status loss.¹⁶

That this study raises more questions than it answers is appropriate for the somewhat nascent specialty of global mental health. More research like the study by Nakimuli-Mpungu and colleagues¹¹ will help to spur an effective response to the nearly decade-old call for action issued in the 2007 *Lancet* Series on global mental health. Programmatic work to optimise scale-up of treatments for mental disorders in low-income and middle-income countries is, now more than ever, urgently needed to address one of the most neglected aspects of human health and wellbeing.

References

1. Murray CJ, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 2013; 380:2197–223. [PubMed: 23245608]
2. Prince M, Patel V, Saxena S, et al. No health without mental health. *Lancet*. 2007; 370:859–77. [PubMed: 17804063]
3. Tomlinson M, Lund C. Why does mental health not get the attention it deserves? An application of the Shiffman and Smith framework. *PLoS Med*. 2012; 9:e1001178. [PubMed: 22389632]
4. Katz IT, Bassett IV, Wright AA. PEPFAR in transition—implications for HIV care in South Africa. *N Engl J Med*. 2013; 369:1385–87. [PubMed: 24106930]
5. Bor J, Herbst AJ, Newell ML, Barnighausen T. Increases in adult life expectancy in rural South Africa: valuing the scale-up of HIV treatment. *Science*. 2013; 339:961–65. [PubMed: 23430655]
6. Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatry*. 2011; 199:453–58. [PubMed: 21593516]
7. Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG. “A disease like any other?” A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *Am J Psychiatry*. 2010; 167:1321–30. [PubMed: 20843872]
8. Tsai AC. Reliability and validity of depression assessment among persons with HIV in sub-Saharan Africa: systematic review and meta-analysis. *J Acquir Immune Defic Syndr*. 2014; 66:503–11. [PubMed: 24853307]
9. Tsai AC, Weiser SD, Petersen ML, Ragland K, Kushel MB, Bangsberg DR. A marginal structural model to estimate the causal effect of antidepressant medication treatment on viral suppression among homeless and marginally housed persons with HIV. *Arch Gen Psychiatry*. 2010; 67:1282–90. [PubMed: 21135328]
10. Katz IT, Ryu AE, Onuegbu AG, et al. Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. *J Int AIDS Soc*. 2013; 16(suppl 2):18640. [PubMed: 24242258]
11. Nakimuli-Mpungu, E.; Wamala, K.; Okello, J., et al. Group support psychotherapy for depression treatment in people with HIV/AIDS in northern Uganda: a single-centre randomised controlled trial. *Lancet HIV*. 2015. published online April 1. [http://dx.doi.org/10.1016/S2352-3018\(15\)00041-7](http://dx.doi.org/10.1016/S2352-3018(15)00041-7)
12. Patel V, Weiss HA, Chowdhary N, et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *Lancet*. 2010; 376:2086–95. [PubMed: 21159375]
13. Tsai AC, Morton SC, Mangione CM, Keeler EB. A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care*. 2005; 11:478–88. [PubMed: 16095434]
14. Chowdhary N, Jotheeswaran AT, Nadkarni A, et al. The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychol Med*. 2014; 44:1131–46. [PubMed: 23866176]
15. Lund C, Breen A, Flisher AJ, et al. Poverty and common mental disorders in low and middle income countries: a systematic review. *Soc Sci Med*. 2010; 71:517–28. [PubMed: 20621748]
16. Tsai AC, Bangsberg DR, Weiser SD. Harnessing poverty alleviation to reduce the stigma of HIV in sub-Saharan Africa. *PLoS Med*. 2013; 10:e1001557. [PubMed: 24319400]