Psychological therapy to improve HIV care and reduce stigma

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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 colleagues[11] 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 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 providers[12]) and task sharing (eg, through stepped or collaborative care[13]). 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 colleagues[11] 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

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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 colleagues[11] 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.

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