Adapting a Cognitive-Behavioral Therapy Protocol for the Treatment of Depression in People Living with HIV in South Africa

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KidzPositive
The Kidzpositive Family Fund
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Overview

- Burden of HIV and MH in SA
- Services
- Goals of research
- CBT & CBT-AD
- Adaptation of CBT-AD
- Research Trajectory
- Status of Research

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Burden of Disease

- High burden of HIV-infection in South Africa
- 16.8% SA adults estimated to be living with HIV
- Significantly higher prevalence rates in particular low-income areas of the country

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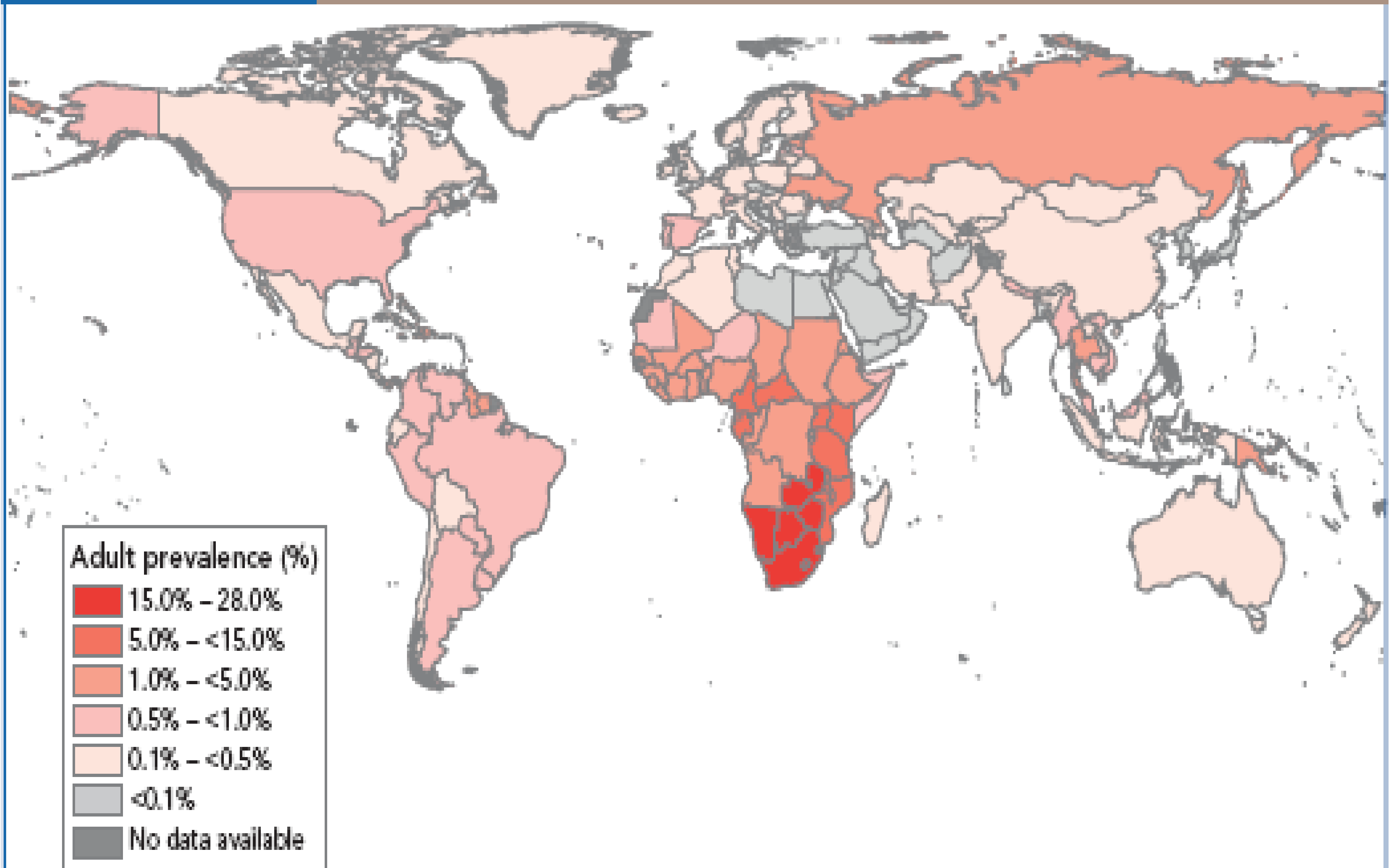
FIGURE 2.2 A global view of HIV infection, 2007

33 million people [30 – 36 million] living with HIV, 2007



Mental Illness in South Africa

- SASH Study – National Lifetime Prevalence
  - Any Disorder 30.3%
  - Mood Disorders 9.8%
  - PTSD 2.3%
  - Alcohol Abuse and/or Dependence 14%
  - Drug Abuse and/or Dependence 4.5%
- Freeman (2007) – Prevalence among HIV/AIDS Patients
  - Any Disorder 43.7%
  - Major Depression 11.1%
  - Mild Depression 29.9% (Total 41%)
  - PTSD 4.9%
  - Alcohol Abuse and/or Dependence 15.3%
  - Drug Abuse and/or Dependence 2.2%

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Limited Treatment Options

- Only 12 percent of people with mental disorders receive treatment in the public health care system
- The ratio of clinical psychologists to population is approximately 1:304,000
- Psychiatric services are available and utilized to a much larger degree than psychological services

(Paper commissioned by the Professional Board of Psychology of the South African Medical and Dental Council, November 1994)

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Goals of the research project

- To develop a culturally-appropriate, short-term, cost-effective treatment for depression
- Treatment must be highly structured and manualized in order for lay counselors to be able to implement it
- Feasibility, acceptability, and effectiveness need to be ascertained

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CBT for Depression

- Most empirically tested psychological treatment for depression
- Over 75 clinical trials have been conducted since 1977
- Treatment of Depression Collaborative Research Project (TDCRP; 1989)
  - CBT, IPT, imipramine hydrochloride with CM, placebo with CM
  - 16 weeks
  - All effective except with more severe
- DeRubeis, et.al. (2005)
  - CT versus paroxetine for 6 weeks
  - Response rates: CT (43%), SSRI (50%)
- Hollon (2005)
  - Relapse rates CT (30.8%) vs. SSRI (76.2%)
- Gloaguen, et.al. (1998)
  - meta-analysis 48 studies

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Cognitive-Behavioral Therapy for Adherence and Depression (CBT-AD)

- Developed by Steve Safren and colleagues at Massachusetts General Hospital/ Harvard Medical School
- Based on traditional CBT approaches
- Combined with techniques applicable to chronic illness, particularly HIV
- 7 modules
    - Life-Steps for medication adherence
    - Psychoeducation
    - Activity scheduling
    - Cognitive restructuring
    - Problem-solving
    - Relaxation and diaphragmatic breathing training
    - Review session: maintenance of changes / relapse prevention

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Life Steps

- Single-session intervention
- Designed for adherence
- Uses 11 informational, problem-solving and CBT steps
  - Education about adherence
  - Scheduling
  - Cue control strategies
  - Adaptive thoughts about adherence
  - Provider communication
- Clinician and patient define the problem, generate alternative solutions, make decisions about the solutions, and develop a plan for implementing them

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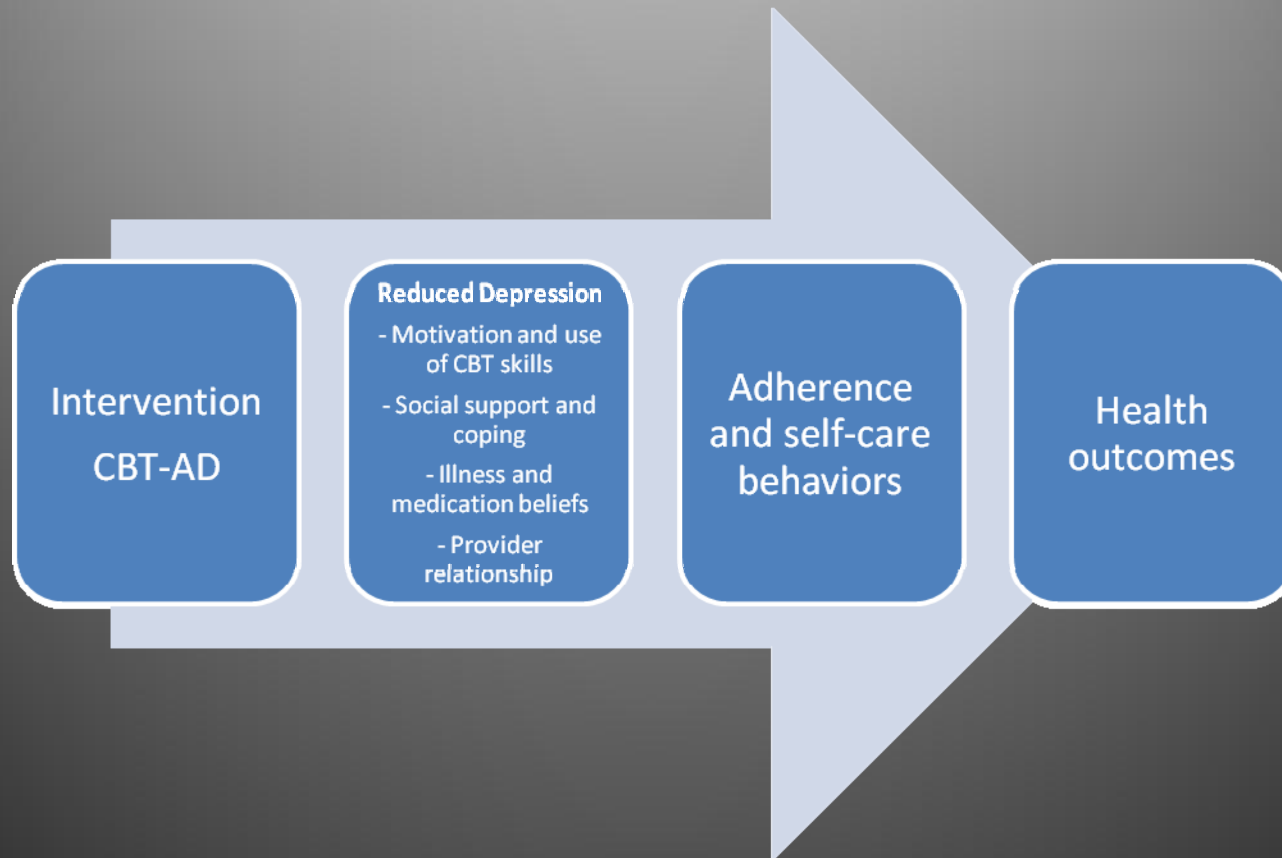
11 Steps of Life Steps

- 1. Provide education, interactively, about adherence
- 2. Plan for transportation to medical appointments
- 3. Plan for optimizing communication with medical and mental health care providers
- 4. Plan for coping with side effects of medications and medical regimen
- 5. Plan for obtaining medications or other self-care items
- 6. Formulate a daily schedule for medication and other self-care behaviors
- 7. Plan for sorting medications
- 8. Develop cues for taking medications
- 9. Prepare for adaptively coping with slips in adherence and relapse prevention
- 10. Review all plans
- 11. Make follow-up phone call (optional)

CBT-AD Model



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Adapted CBT-AD protocol (Siphamandla)

- The intervention will comprise 6-8 sessions of CBT-AD lasting 50 minutes each.
- The session modules are as follows:
  - **Module 1** – Life Steps for HIV Medication Adherence
  - **Module 2** - Psychoeducation/ MI
  - **Module 3** – Activity Scheduling
  - **Module 4** – Problem-solving
  - **Module 5** – Relaxation and Diaphragmatic Breathing

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Positive Events Checklist

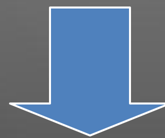
- Visiting family
- Playing cards with your friends
- Playing soccer/cricket with friends
- Going to a friend's house
- Going to the movies
- Having your hair braided
- Going on mixit and facebook and talking to friends
- Join a sewing club
- Going to church/mosque/temple
- Praying
- Joining a support group
- Speaking to a friend on the phone
- Relaxing in a park or backyard
- Singing
- Reading the local paper
- Joining a choir
- Going for a walk with a friend or partner
- Playing a game with a child or friend
- Helping other people
- Helping the environment by recycling
- Volunteering
- Getting involved in your community
- Getting a pet
- Playing board games
- Telling jokes and funny stories
- Going on a nature walk
- Starting a collection (shells, pretty stones…)
- Going on a date
- Going to a club
- Going to Mzoli's
- Going to Mapindi's
- Jogging, walking, running
- Listening to music
- Listening to gospel
- Reading the bible
- Reading a book for pleasure
- Recalling fond memories
- Reading magazines
- Lying in the sun
- Laughing
- Playing an instrument
- Spending an evening with good friends
- Planning a day's activities
- Meeting new people
- Eating healthy foods
- Repairing things around the house
- Having quiet evenings
- Taking care of plants
- Starting a small garden
- Swimming
- Doodling, drawing, painting
- Exercising
- Bird watching
- Going to the beach
- People watching
- Stargazing

Research Trajectory

✓(1) Qualitative interviews of HIV-positive patients' experiences of depression

✓(2) Case series of nurse administered CBT-AD intervention

(3) Pilot small RCT of CBT-AD administered by lay counselors



(4) Large-scale randomized controlled trial of lay-counselor administered CBT-AD

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Understanding Depression and Its Impact on Adherence to HAART in People Living with HIV/AIDS in South Africa

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Background: To tailor an intervention to the needs of a specific population, it is essential to understand the experiences of the people in question. In the case of people living with HIV/AIDS (PLWHA) in South Africa, little is known about individuals' subjective experiences of depression despite the elevated prevalence rates in this population. The purpose of this study was to document the experience and manifestation of depression in PLWHA, its impact on adherence to HAART, and the contributing psychosocial stressors. Information obtained from the qualitative interviews will be used to inform the cultural adaption of a cognitive-behavioural therapy intervention aimed at enhancing adherence and reducing depression known as CBT-AD.

Method: Thirteen semi-structured interviews were conducted with depressed, HIV-positive adults receiving HAART at two primary ARV clinics in the Langa and Khayelitsha townships in Cape Town. Participants were primarily Xhosa-speaking women between the ages of 35 and 55. Interview transcripts were thematically analyzed.

Results: Participants were unfamiliar with depression as a psychiatric illness. Symptoms consistently identified were somatic complaints, sleep disturbance, lethargy, sadness/irritability, and social withdrawal. Stressors consistently identified were HIV-related stigma, worry about children, lack of income, and fear of losing/loss of social support. 'Fear of others discovering their HIV-status' consistently emerged as the root of non-adherence, while other barriers included treatment fatigue, side-effects and poverty-related issues such as lack of food to take medication with. None of the participants had previously been treated for depression. All the participants expressed a willingness to participate in weekly therapy sessions, once the concept was explained to them, and the majority identified therapy as their preferred treatment option over medication.

Conclusion: The characteristics of depression appear to be consistent with those reported in the U.S., although the interviews reveal that depression is often initially expressed physically (i.e. somatic complaints, sleep disturbance, lethargy) in PLWHA in South Africa. This has important implications for the assessment of depression in primary care. Psycho-education, problem-solving, behavioral activation, relaxation training, and an adherence intervention appear to be relevant treatment components for this population given their expressed subjective experiences of depression.

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Status of Research

- Currently training two nurses in the adapted CBT-AD intervention
- Implementation of the intervention by the nurses is scheduled to begin the first week of October
- Application in process to obtain funding for Phase 3

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