Interventions

Review

Improving mental health among people living with HIV: a review of intervention trials in low- and middle-income countries

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People living with HIV (PLWH) experience greater psychological distress than the general population. Evidence from high-income countries suggests that psychological interventions for PLWH can improve mental health symptoms, quality of life, and HIV care engagement. However, little is known about the effectiveness of mental health interventions for PLWH in low- and middle-income countries (LMICs), where the large majority of PLWH reside. This systematic review aims to synthesize findings from mental health intervention trials with PLWH in LMICs to inform the delivery of mental health services in these settings. A systematic search strategy was undertaken to identify peer-reviewed published papers of intervention trials addressing negative psychological states or disorders (e.g. depression, anxiety) among PLWH in LMIC settings. Search results were assessed against pre-established inclusion and exclusion criteria. Data from papers meeting criteria were extracted for synthesis. Twenty-six papers, published between 2000 and 2014, describing 22 unique interventions were identified. Trials were implemented in sub-Saharan Africa (n = 13), Asia (n = 7), and the Middle East (n = 2), and addressed mental health using a variety of approaches, including cognitive-behavioral (n = 18), family-level (n = 2), and pharmacological (n = 2) treatments. Four randomized controlled trials reported significant intervention effects in mental health outcomes, and 11 preliminary studies demonstrated promising findings. Among the limited mental health intervention trials with PLWH in LMICs, few demonstrated efficacy. Mental health interventions for PLWH in LMICs must be further developed and adapted for resource-limited settings to improve effectiveness.

Received 11 February 2015; Revised 8 July 2015; Accepted 19 July 2015

Key words: HIV, intervention, low middle income countries, mental health, review, trials.

Introduction

Low- and middle-income countries (LMICs) bear a disproportionate burden of the world’s HIV infections, with over 85% of the world’s 35 million HIV cases located in LMICs (UN Joint Programme on HIV/AIDS, 2014). Studies across multiple settings have consistently observed that people living with HIV (PLWH) experience greater psychological distress, such as depression and anxiety, as compared with the general population (Bing et al. 2001; Ciesla & Roberts, 2001). Evidence from LMICs, though limited, has confirmed high rates of mental disorders and psychological distress among PLWH (Breuer et al. 2011; Chibanda et al. 2014). Mental disorders in LMICs must be addressed due to their impact on the lives of PLWH,
as well as HIV-related outcomes at an individual and population level (Hartzell et al. 2008).

Mental disorders and psychological distress not only compromise overall well-being and quality of life among PLWH (Bing et al. 2000), but also impact individuals’ ability to engage effectively with HIV care, including their adherence to antiretroviral therapy (ART) (Collins et al. 2006; Mayston et al. 2012; Uthman et al. 2014). The ability to halt disease progression and achieve full viral suppression, which requires proper care engagement, is a primary predictor of HIV infectiousness (Cohen et al. 2011). Poor HIV care engagement attributable to unaddressed mental health needs among PLWH may thus hamper proposed efforts to use ‘treatment as prevention’ to curb the spread of the HIV epidemic (Sikkema et al. 2010; Gupta et al. 2014). Additionally, mental disorders and psychological distress may be associated with HIV risk behaviors such as substance abuse, multiple sexual partners and unprotected sexual intercourse (Crepaz & Marks, 2001), further contributing to the forward transmission of HIV (Senn et al. 2010). Taken together, addressing mental health among PLWH appears to be a critical component of HIV treatment and prevention, and should be considered as part of population-level approaches to prevent HIV transmission, particularly in LMICs where the burden of HIV and its associated morbidities is high.

An emerging body of evidence, mostly from high-income settings, suggests that psychological interventions, primarily focused on treating depression and anxiety, can improve the mental health of PLWH (Crepaz et al. 2008; Brown & Vanable, 2011; Clucas et al. 2011; Harding et al. 2011; Sherr et al. 2011; Seedat, 2012; Spies et al. 2013; Wu & Li, 2013). Among the various treatment modalities, cognitive-behavioral interventions (CBIs) have received the most attention, with skills training and stress management CBIs that include 10 or more sessions demonstrating the greatest improvement in mental health symptoms. These interventions have been found to be equally if not more effective than pharmacological treatments (Clucas et al. 2011; Spies et al. 2013), though it has been suggested that pharmacological management can be beneficial as an adjunct treatment or combined with psychological approaches (Sherr et al. 2011). In addition, CBIs have been found not only to improve mental health symptoms in PLWH, but also to impact HIV-related clinical outcomes, including CD4 counts (Crepaz et al. 2008). Furthermore, a limited number of intervention studies have begun to examine the impact of mental health treatment on care engagement and risk behaviors in PLWH. For example, depression treatment has been found to enhance ART adherence (Sin & DiMatteo, 2014), and coping interventions to reduce traumatic stress have been found to decrease substance use (Meade et al. 2010) and sexual risk behaviors (Sikkema et al. 2008). There is further evidence that psychological interventions can be delivered in community settings, which has the potential for broader reach (Wu & Li, 2013). Intervention studies published subsequent to existing reviews suggest an emerging focus on aging populations (Heckman et al. 2013), increased emphasis on treating traumatic stress and post-traumatic stress disorder (PTSD) (Pacella et al. 2012; Sikkema et al. 2013), and the use of telephone and web-based modalities (Hersch et al. 2013; Himelhoch et al. 2013; Drozd et al. 2014), as well as alternative therapeutic approaches that draw on mindfulness (Gayner et al. 2012; Gonzalez-Garcia et al. 2014) and expressive writing paradigms (Ironson et al. 2013; Carroli et al. 2015).

Despite promising intervention efforts and related evidence, most of what has been appraised to date has emerged from high-income countries (HICs). Although previous reviews have included a limited number of studies from LMICs (Crepaz et al. 2008; Clucas et al. 2011; Harding et al. 2011; Sherr et al. 2011; Seedat, 2012; Spies et al. 2013), thus far, no reviews have focused on interventions that broadly address mental health for PLWH in these unique settings. Despite the dual burdens of HIV and mental disorders in LMICs, and evidence of their synergistic negative effects, strategies to address the mental health needs of PLWH in LMICs have received only limited attention (Mayston et al. 2012; Chibanda et al. 2014). Mental disorders in these settings often are untreated due to a lack of behavioral and pharmacological treatment opportunities (Kakuma et al. 2011; WHO, 2001). This treatment gap has implications for both the well-being of PLWH as well as the effectiveness of national HIV treatment programs (Mayston et al. 2012).

There is a need to take stock of existing efforts to respond to mental health distress challenges among PLWH in LMICs, so as to inform the development and scale up of appropriate mental health services in these countries. The goal of this review paper is to synthesize findings from mental health intervention trials for PLWH in LMICs. This information will extend our knowledge of mental health interventions for PLWH beyond those that have been developed and tested in HICs, and will illuminate avenues for future intervention development, testing, and delivery in LMIC settings where there is greatest need.

Methods

Inclusion criteria

Studies were included in this review if they met the following criteria:
(1) Described a trial evaluating a mental health intervention (e.g. CBT, coping, cognitive functioning, and pharmacological) among PLWH,
(2) Intervention was implemented in either a LMIC, as defined by the World Bank (The World Bank Group, 2015), or one of the emerging-economy (BRICS) countries,
(3) Trial assessed at least one negative psychological state or disorder (e.g. depression and anxiety), and
(4) Outcomes were assessed pre- and post-intervention.

Exclusion criteria

Studies with a heterogeneous (HIV-positive and HIV-negative) sample were excluded if mental health outcomes were not presented separately for the HIV-positive population. Trials with only substance use outcomes were not included in this review. Systematic and non-systematic review articles, as well as studies unavailable in English, qualitative exploratory studies, and studies not published in a peer-reviewed journal were also excluded from this review.

Search strategy

PubMed, EMBASE, and PsychInfo were searched between 9 and 11 November 2014. Limits to time period were not applied to the search. Standardized search terms and key words related to the constructs of (a) HIV or AIDS, (b) mental health, (c) intervention, and (d) LMIC/BRICS were used in all databases. For example, within PubMed, terms used to capture the construct of mental health included the following: mental health, mental*, depress*, anxi*, trauma*, PTSD, psycholog*, coping, stress, and psychiatrist. Search terms for LMIC/BRICS were derived from the World Bank's classification of low-income, lower-middle income, and upper-middle income economies (The World Bank Group, 2015). Conducting the search was a multi-step process. First, separate searches were conducted using HIV/AIDS, mental health, intervention, and LMIC/BRICS search terms, respectively. In the final step, results from these four separate searches were combined using ‘AND’ terms to capture manuscripts that possibly met study inclusion criteria. Where possible, studies with ‘orphan’ in the title were eliminated from the search using the term ‘HIV or AIDS not Orphan’ so as to more efficiently exclude studies focusing on HIV-impacted orphans who were not necessarily HIV-infected. Filters for the above constructs were applied within each database to restrict the search in the following ways:

(1) HIV or AIDS terms were restricted to title only,
(2) Mental health terms were restricted to title or abstract,
(3) Intervention terms were restricted to title only, and
(4) LMIC/BRICS terms were restricted to title, abstract or topic.

Study selection and data abstraction

A list of all titles and abstracts were considered independently by two researchers, eliminating those studies that did not appear to meet study inclusion criteria; the full study team then reached consensus on articles to be assessed for eligibility. The full text of all relevant articles were then independently reviewed by two researchers to determine inclusion, with >85% agreement between researchers. Discrepancies about the remaining studies were reconciled through discussion with the full study team. Data display matrices were used to extract data from included studies. Data extracted from studies were as follows: author, year, title, date of study, city/country, sample characteristics (age, sex, HIV-status, sample size of intervention and control conditions, mental health inclusion criteria), intervention characteristics (name, level, components, duration, deliverer), study design, evaluation design (control or comparison condition, follow-up, retention), outcome measures, and relevant findings.

Results

Search results

Initial database searches yielded 454 records, and 369 unique records remained after elimination of duplicates across databases. Screening of titles and abstracts resulted in 44 articles. The full text of these 44 articles was reviewed, which yielded 25 articles (describing 21 unique studies) that met the inclusion criteria for this review (see Fig. 1). One additional article was identified through examination of the reference lists of relevant systematic and non-systematic reviews (Field & Kruger, 2008), for a total of 22 unique intervention studies included in this review. All included studies were published in peer-reviewed journals between 2000 and 2014. The summaries of the 10 randomized control trials (Table 1) and the 12 pilot or feasibility trials (Table 2) are presented separately.

Randomized controlled trials (RCTs)

Study location

RCTs were conducted in Uganda (Boivin et al. 2013), South Africa (Peltzer et al. 2012; Eller et al. 2013; Eloff et al. 2014; Richter et al. 2014; Rotheram-Borus et al. 2013).
Participants

A total of 2,893 participants were reported across all trials, of which 1,664 individuals participated in the experimental intervention condition. A median sample size of 233.5 at baseline (range 67–1200) was reported across all trials. All studies included HIV-positive participants, yet study samples were diverse. Four RCTs were designed for implementation within families (Li et al., 2010, 2011, 2012, 2014; Boivin et al., 2013; Eloff et al., 2014); no studies included only child or adolescent participants. Of the six remaining RCTs, four were designed for implementation with HIV-positive men and women (Olley, 2006; Peltzer et al., 2012; SeyedAlinaghi et al., 2012; Eller et al., 2013), and two were for women only (Kaaya et al., 2013; Richter et al., 2014; Rotheram-Borus et al., 2014). Only one study had a specified mental health inclusion criterion, depressive symptoms (Eller et al., 2013). None of the RCTs utilized a mental disorder as inclusion criteria.

Study design

One RCT (Li et al., 2011, 2014) randomized by cluster; all other RCTs randomized individual participants to the intervention or control condition. In all studies, outcomes were assessed post-intervention (median retention rate reported of 87.5%, range 57–98%), with most trials also reporting longer-term follow-up assessments between 2 and 18 months (median retention rate reported final follow-up of 82%, range 24–97%). (Note: outcomes in Tables 1 and 2 correspond to post-intervention measurements, unless otherwise noted).

Intervention content and delivery method

The interventions reported in these studies had diverse characteristics. Most interventions were designed to be implemented with groups (Li et al., 2010, 2012; Peltzer et al., 2012; SeyedAlinaghi et al., 2012; Kaaya et al., 2013;
<table>
<thead>
<tr>
<th>Citation(s) and date of study</th>
<th>Location</th>
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<th>Outcome measures</th>
<th>Relevant findings</th>
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<tr>
<td><strong>Boivin et al. (2013)</strong> A year-long caregiver training program to improve neurocognition in preschool Ugandan HIV-exposed children</td>
<td>Uganda</td>
<td>119 child-caregiver dyads: caregivers (&gt;90% HIV + mothers) – Children (aged 2–4 years; all HIV-exposed but uninfected)</td>
<td>Name: Mediation intervention for sensitizing caregivers (MISC) Level: individual Components: mediational processes (focusing, exciting, expanding, encouraging, regulating) Duration: MISC sessions delivered biweekly over 1 year, alternating between home and clinic settings Deliverer: MISC trainer trained caregiver</td>
<td>Control: health and nutrition curriculum delivered biweekly over 1 year Follow-up: (p) 12 m Retention: NR</td>
<td>Caregivers MH outcomes: depression and anxiety (HSCL-25) Other outcomes: N/A Children MH outcomes: – Motor, language, overall cognitive skills (MELS) – Memory (COAT) – Internalizing and externalizing symptoms (CBCL)</td>
<td>Caregivers (HIV +) – No significant effect Children (HIV −) – Significant effect – Receptive language (12 m) – Expressive language (12 m) – Overall cognitive ability (12 m) – Memory (12 m)</td>
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### Table 1 (cont.)

<table>
<thead>
<tr>
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<tr>
<td>Eloff et al. (2014) A randomized clinical trial of intervention to promote resilience in young children of HIV-positive mothers in South Africa</td>
<td>Pretoria, South Africa</td>
<td>390 mother-child pairs</td>
<td>Name: The Kgolo-Mmogo Project</td>
<td>Control: standard care and information about local resources</td>
<td>Mothers (HIV+) – No significant effect&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Mothers (HIV+) – No significant effect&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>Date of study: NR</td>
<td>–Mothers (all HIV+)</td>
<td>Components: sessions for mothers focused on issues relating to living with HIV, parent–child interactions and positive parenting behavior.</td>
<td>Follow-up: (p) 6, 12, and 18 m</td>
<td>–Depression (CES-D)</td>
<td>Children (HIV–) – Significant effect</td>
<td>Children (HIV–) – Significant effect</td>
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<td></td>
<td>–Child (eldest HIV-child, aged 6–10 years)</td>
<td>Sessions for children focused on self-esteem and interpersonal skills. Joint sessions focused on parent–child interaction</td>
<td>Retention: 74% = 6 m 74% = 12 m 75% = 18 m</td>
<td>–Coping (Brief COPE)</td>
<td>–Child externalizing behavior (18 m)</td>
<td>–Adaptive functioning (18 m)</td>
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<td>Intervention (n = 199)</td>
<td>Duration: 24 weekly sessions, each lasting 75 min. First 14 sessions were separate for mothers and children. Last 10 sessions were joint sessions</td>
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<td>–Parenting stress (PSI)</td>
<td>–Daily living skills (18 m)</td>
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<td>Control (n = 191)</td>
<td>Deliverer: two trained community care workers supervised by a social worker</td>
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<td></td>
<td>No MH inclusion criteria&lt;sup&gt;c&lt;/sup&gt;</td>
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<td>Study</td>
<td>Date of Study</td>
<td>Population</td>
<td>Intervention Duration</td>
<td>Delivered by</td>
<td>Control</td>
<td>Follow-up</td>
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<tr>
<td>Kaaya et al. (2013)</td>
<td>2001–2004</td>
<td>331 HIV+ pregnant women attending ANC</td>
<td>6 weekly sessions</td>
<td>Social worker or psychiatric nurse</td>
<td>Standard of care</td>
<td>57% = 6 m</td>
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<td>Li et al. (2010)</td>
<td>2007–2008</td>
<td>507 HIV+ individuals and 308 HIV-negative family members</td>
<td>12–90 min sessions and one preparation session over 13 weeks</td>
<td>Two trained facilitators</td>
<td>Standard of care (including support group for PLWHA and family member)</td>
<td>98% = 6 m</td>
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<td>Li et al. (2012)</td>
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<th>Relevant findings&lt;sup&gt;b&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Li et al. (2011) A multilevel intervention for HIV-affected families in China: together for empowerment activities (TEA)</td>
<td>Anhui Province, China</td>
<td>79 families from four villages. All families included at least one HIV+ and one HIV-negative family member. 167 participants intervention (&lt;i&gt;n&lt;/i&gt; = 80) Control (&lt;i&gt;n&lt;/i&gt; = 87)</td>
<td>Name: together for empowerment activities (TEA) Level: multilevel Components: three modules: healthy body and healthy mind, positive family interactions, and Quality of Life Duration: six small group sessions, six home-based family activities and three community events. Intervention activities took about 2.5 months. Deliverer: trained health educators recruited from local agencies</td>
<td>Control: standard of care (educational material and classes on health education, personal hygiene and nutrition) Follow-up: (p) 3 and 6 m Retention: 96% = 3 m 94% = 6 m</td>
<td>HIV+ Adult MH outcomes: depression (Zung Self-Rating Depression Scale) Other outcomes: social support (MOS social support survey) Family functioning (Family functioning scale) Children MH outcomes: -self-esteem (RSE) Other outcomes: -perceived parental care (PBI) -Problem behavior (count of list of behaviors related to withdrawal, aggression, and delinquency)</td>
<td>Adults (HIV+) – Significant effect –Depressive symptoms (3 and 6 m) –Social support (3 m) –Family functioning (3 m) Children (HIV-) – No significant effect&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Li et al. (2014) Effect of a family intervention on psychological outcomes of children affected by parental HIV</td>
<td>Anhui Province, China</td>
<td>79 families from four villages. All families included at least one HIV+ and one HIV-negative family member. 167 participants intervention (&lt;i&gt;n&lt;/i&gt; = 80) Control (&lt;i&gt;n&lt;/i&gt; = 87)</td>
<td>Name: together for empowerment activities (TEA) Level: multilevel Components: three modules: healthy body and healthy mind, positive family interactions, and Quality of Life Duration: six small group sessions, six home-based family activities and three community events. Intervention activities took about 2.5 months. Deliverer: trained health educators recruited from local agencies</td>
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<tr>
<td>Olley (2006) Improving well-being through psycho-education among voluntary counseling and testing seekers in Nigeria: A controlled outcome study</td>
<td>Abuja, Nigeria</td>
<td>67 HIV+ individuals recruited from VCT Intervention (&lt;i&gt;n&lt;/i&gt; = 34) Control (&lt;i&gt;n&lt;/i&gt; = 33)</td>
<td>Name: psycho-education level: individual Components: cause and course of HIV/AIDS, its psychosocial impact, and self-management skills Duration: 4 weekly 1-h sessions Deliverer: NR</td>
<td>Control: 4 weekly 1-h sessions of unstructured individual support Follow-up: (p) 4 weeks Retention: 93% = 4 weeks</td>
<td>MH outcomes: depression (BDI); Generalized anxiety disorder (CCEI) Coping (Brief COPE) Other outcomes: sexual risk behavior Self-disclosure intention</td>
<td>Significant effect –Depression (4 weeks) –Neurotic disorders (4 weeks) –Safe sex practices (4 weeks) –Self-disclosure of status to partners (4 weeks)</td>
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<td>Study Authors</td>
<td>Year</td>
<td>Study Title</td>
<td>Study Design</td>
<td>Study Location</td>
<td>Study Population</td>
<td>Intervention Details</td>
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<td>Peltzer et al. (2012)</td>
<td>Efficacy of a lay health worker led group antiretroviral medication adherence training among non-adherent HIV-positive patients in KwaZulu-Natal, South Africa: Results from a randomized trial</td>
<td>2012</td>
<td>KwaZulu Natal, South Africa</td>
<td>152 HIV+ adults who were new to ARVs and had adherence challenges</td>
<td>Name: medication adherence intervention (MAI)</td>
<td>Control: standard of care; (monthly visit to review health status with medical provider, 20 min)</td>
</tr>
<tr>
<td>Richter et al. (2014)</td>
<td>Pregnant women living with HIV (WLH) supported at clinics by Peer WLH: a cluster randomized control trial</td>
<td>2014</td>
<td>KwaZulu Natal, South Africa</td>
<td>1200 HIV+ pregnant women on their first antenatal visit; randomized by clinic recruitment site</td>
<td>Name: Masihambisane (‘We Walk Together’)</td>
<td>Control: standard of care (clinical care per the national protocol)</td>
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<tr>
<td>Rotheram-Borus et al. (2014)</td>
<td>A cluster randomized controlled trial evaluating the efficacy of peer mentors to support South African women living with HIV and their infants. e84867</td>
<td>2008–2010</td>
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<td></td>
<td>Control: standard of care (monthly visit to review health status with medical provider, 20 min)</td>
<td>Follow-up: (p) 1.5 m post-birth, 6 m post-birth, 12 m post-birth</td>
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<tr>
<td>Citation(s) and date of study</td>
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<td>Intervention description</td>
<td>Evaluation designa</td>
<td>Outcome measures</td>
<td>Relevant findingsb</td>
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<tr>
<td>SeyedAlinaghi et al. (2012)</td>
<td>Tehran, Iran</td>
<td>245 HIV+ adults who had not yet initiated ART</td>
<td>Name: mindfulness-based stress reduction (MBSR)</td>
<td>MH outcomes: self-reported mental health (SCL-90R)</td>
<td>No significant effect</td>
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<tr>
<td>Randomized controlled trial of mindfulness-based stress reduction delivered to human immunodeficiency virus-positive patients in Iran: effects on CD4+ T Lymphocyte count and medical and psychological symptoms</td>
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<td>Intervention (n = 120)</td>
<td>Level: group Components: mindfulness body scan practices, awareness of body postures using light Hatha yoga, sitting mindfulness meditation, application of MBSR techniques in daily life</td>
<td>Control: education and support, including educational information and pamphlets about living with HIV/AIDS Follow-up: (p) 8 weeks, 3, 6, 9, and 12 m</td>
<td>Other Outcomes: CD4+ T lymphocyte count (MSCL)</td>
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<td>Date of study: 2008–2010</td>
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<td>Control (n = 125)</td>
<td>No MH inclusion; Excluded if reported current psychosis or history of PTSD</td>
<td>Retention: NR</td>
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a Number of months (m) since baseline; (p) = immediate post assessment.

b No significant effect’ or ‘significant effect’ refer to between-condition effects.

c Indicates that mental health was a secondary outcome.

d No significant difference between conditions; both conditions improved.

NR, not reported; AACTG, Adult AIDS Clinical Trials Group adherence measure; BDI, Beck Depression Inventory; BDI-II, Beck Depression Inventory II; CBCL, Achenbach Child Behavior Checklist; CCBL, Child Behavior Checklist; CCEI, The Crown Crisp Experimental Index; CCNES, Coping with Children’s Negative Emotions Scale; CDI, Child Depression Index; CES-D, Center for Epidemiologic Studies-Depression Scale; COAT, Color-Object Association Test; GHQ, General Health Questionnaire; HSCL-25, Hopkins Symptom Checklist; MELS, Mullen Early Learning Scales; MOS-HIV Medical Outcomes Study HIV Health Survey Instrument; MSCL, Medical Symptom Checklist; PBI, Parental Bonding Instrument; RCMAS, Revised Child Manifest Anxiety Scale; RSE, Rosenberg Self-Esteem Scale; SCL-90R, Symptom Checklist-90-Revised; VABS, Vineland Adaptive Behavior Scales.
## Table 2. Pilot and feasibility studies

<table>
<thead>
<tr>
<th>Citation(s) and date of study</th>
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<th>Sample</th>
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<th>Outcome measures</th>
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<tr>
<td><strong>Adams et al. (2012a)</strong>. Feasibility of nurse-led antidepressant medication management of depression in an HIV clinic in Tanzania. Date of study: NR</td>
<td>Northern Zone of Tanzania</td>
<td>20 HIV+ adults MH inclusion: elevated depression (PHQ-9 ≥10)</td>
<td>Intervention: measurement-based care (MBC) to monitor and treat depression Level: individual. Components: antidepressant medication using MBC treatment algorithm Duration: 12 weeks, with visits at 4, 8, and 12 weeks and optional visits at 2, 6, and 10 weeks to monitor side effects Deliverer: nurse and clinical officer</td>
<td>Pre-experimental, one-group pre-post design O X O</td>
<td>Comparison: none Follow-up: post Retention: 85% = post</td>
<td>HIV+ Participants MH outcomes: depression (PHQ-9) Other outcomes: Antidepressant and antiretroviral therapy adherence (AARC)</td>
<td>Depression decreased from baseline to post 100% adherence to antidepressants when prescribed</td>
</tr>
<tr>
<td><strong>Bhana et al. (2014)</strong>. The VUKA family program: piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. Date of study: NR</td>
<td>KwaZulu-Natal, South Africa</td>
<td>65 families with an HIV+ child aged between 10 and 14 years Intervention (n = 33) Control (n = 32) No MH inclusion criteria</td>
<td>Intervention: VUKA family program Level: group Components: session topics included: AIDS related loss and bereavement, stigma and discrimination, social support and adherence among other topics Duration: Six sessions over 3 m (two sessions per month) Deliverer: lay counselors supervised by one masters level psychologist</td>
<td>Randomized, pre-post, wait list control group pilot design R O X O Control: wait list control (n = 32); received VUKA intervention after the study ended (3 m later) Follow-up: post Retention: 91% = post</td>
<td>HIV+ Youth MH outcomes: child depression (CDI) Youth mental health (SDQ) Other outcomes: Adherence to ART (PACTG) HIV treatment knowledge Self-concept (TSAS) Caregiver: HIV/AIDS stigma Youth and caregiver communication and comfort</td>
<td>Improvements in ART adherence and in HIV treatment knowledge No findings on depression reported Less stigma and greater comfort in communicating with the children</td>
<td></td>
</tr>
<tr>
<td>Citation(s) and date of study</td>
<td>Location</td>
<td>Sample</td>
<td>Intervention description</td>
<td>Study design</td>
<td>Evaluation design</td>
<td>Outcome measures</td>
<td>Relevant findings</td>
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<tr>
<td>Chan <em>et al.</em> (2005). Cognitive-behavioral group program for Chinese heterosexual HIV-infected men in Hong Kong.</td>
<td>Hong Kong, China</td>
<td>16 adult males with symptomatic HIV</td>
<td>Intervention: cognitive-behavioral program (CBP) intervention</td>
<td>Randomized, pre-post, wait list control design</td>
<td>Control: wait list control Follow-up: post Retention: 81% = post</td>
<td>HIV+ Participants MH outcomes: depression (CES-D) Other outcomes: health-related quality of life (SF-36)</td>
<td>Reductions in depression and distress</td>
</tr>
<tr>
<td>Field and Kruger (2008). The effect of an art psychotherapy intervention on levels of depression and health locus of control orientations experienced by black women living with HIV.</td>
<td>Soshanguve, South Africa</td>
<td>18 HIV+ women attending an HIV support group</td>
<td>Intervention: art psychotherapy</td>
<td>Experimental, pre-test, post-test and post-post-test design</td>
<td>Comparison: timed matched entertainment workshop. Follow-up: post, 2 weeks Retention: 100% = post 100% = 2 weeks</td>
<td>HIV+ Participants MH outcomes: depression (BDI-II) Other outcomes: health locus of control (MHLCS)</td>
<td>Improvements in depression and health locus of control</td>
</tr>
</tbody>
</table>
Molassiotis et al. (2002). A pilot study of the effects of cognitive-behavioral group therapy and peer support/counseling in decreasing psychologic distress and improving quality of life in Chinese patients with symptomatic HIV disease. Date of study: NR

**Intervention:**
1. Cognitive-behavioral group therapy (CBT)
2. Peer support/counseling group therapy (PSC)

**Components:**
1. CBT: cognitive restructuring, behavior change strategies, assertive skills, relaxation training, coping, supportive relationships and disclosure
2. PSC: CBT topics without training in behavior change and cognitive problem solving skills

**Duration:** CBT and PSC: 12 sessions, delivered over 3 m

**Deliverer:** Qualified nurse supervised by mental health nurse and psychologist.

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**Intervention:** Structured psychosocial support group intervention

**Components:**
- Sessions covered relational issues, coping, stigma and stress management

**Duration:** Ten sessions, weekly

**Deliverer:** Master’s level psychology students and HIV+ women from the community

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**Intervention:** ASHA-Life

**Components:**
- Coping with HIV/AIDS, ART knowledge, parenting, coping, nutrition, and life skills.
- Weekly visits by trained lay-village women (ASHA) to assist in adherence and care.

**Duration:** Six sessions and weekly visits

**Deliverer:** Health care providers, trained lay-village women (ASHA)

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Nyamathi et al. (2013). Impact of Asha intervention on stigma among rural Indian women with AIDS. Date of study: 2009–2011

**Intervention:** ASHA-Life

**Components:**
- Coping with HIV/AIDS, ART knowledge, parenting, coping, nutrition, and life skills.

**Duration:** Six sessions and weekly visits

**Deliverer:** Health care providers, trained lay-village woman (ASHA)

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(Continued)
Table 2 (cont.)

<table>
<thead>
<tr>
<th>Citation(s) and date of study</th>
<th>Location</th>
<th>Sample</th>
<th>Intervention description</th>
<th>Study design</th>
<th>Evaluation design</th>
<th>Outcome measures</th>
<th>Relevant findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pence et al. (2014). Feasibility, safety, acceptability, and preliminary efficacy of measurement-based care depression treatment for HIV patients in Bamenda, Cameroon.</td>
<td>Bamenda, Cameroon</td>
<td>55 HIV+ patients</td>
<td>MH inclusion: major depressive disorder (PHQ-9 ≥10 and physician assessment)</td>
<td>Pre Experimental, one-group pre-post design O X O</td>
<td>Comparison: none Follow-up: post Retention: 100% = post</td>
<td>HIV+ Participants MH outcomes: depression (PHQ-9) Other outcomes: N/A</td>
<td>~87% of participants achieved remission of depression</td>
</tr>
<tr>
<td>Petersen et al. (2014). A group-based counseling intervention for depression comorbid with HIV/AIDS using a task shifting approach in South Africa: a randomized controlled pilot study.</td>
<td>KwaZulu Natal province, South Africa</td>
<td>76 HIV+ ART clinic patients</td>
<td>MH inclusion: major depressive disorder (SRQ-20 &gt;8, confirmed with SCID-II)</td>
<td>Randomized, pre-post, control design R O X O R O O</td>
<td>Control: standard of care, including counseling Follow-up: post Retention: 45% = post</td>
<td>HIV+ Participants MH outcomes: depression (PHQ-9, HSCL-25) Other outcomes: Social support (MSPSS)</td>
<td>Reductions in depression</td>
</tr>
<tr>
<td>Ravaei et al. (2013). Effectiveness of cognitive behavioral and spiritual trainings on improving mental health of HIV positive drug addicts.</td>
<td>Terhan, Iran</td>
<td>30 HIV+ drug using males</td>
<td>MH inclusion criteria</td>
<td>Pre-post with control group R O X O R O O</td>
<td>Control: no treatment Follow-up: post Retention: 100% = post</td>
<td>HIV+ Participants MH outcomes: mental health (MOS-HIV) Other outcomes: N/A</td>
<td>Improvement in mental health</td>
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<thead>
<tr>
<th>Study Setting</th>
<th>Participants</th>
<th>Intervention</th>
<th>Comparison</th>
<th>MH Outcomes</th>
<th>Follow-up</th>
<th>Retention</th>
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<tbody>
<tr>
<td>Rural China</td>
<td>75 HIV+ adults, infected via blood/plasma donations</td>
<td>Intervention: intervention to improve resilience, psychosocial well-being, and QOL</td>
<td>Single-arm open evaluative study using a pre-and post-intervention study design</td>
<td>HIV+ Participants</td>
<td>MH outcomes: resilience (CD-RISC), depression, anxiety, and stress (DASS)</td>
<td>Post, 3 m</td>
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<tr>
<td></td>
<td>36 HIV-negative community members</td>
<td>Level: group (groups included both HIV+ and HIV− participants)</td>
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<td>O X O</td>
<td>O X O</td>
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<tr>
<td></td>
<td>No MH inclusion criteria</td>
<td>Components: improving resilience (self-worth, emotional control, optimism, social support, and empathy toward vulnerable people)</td>
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<tr>
<td></td>
<td>Duration: 8 biweekly sessions conducted over 4 m</td>
<td>Delivery: family planning staff</td>
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* Indicates that mental health was a secondary outcome.

MH, Mental Health; NR = not reported; AACTG, Adult AIDS Clinical Trial Groups Adherence Measure; BDI-II, Beck Depression Inventory; Brief COPE, abbreviated version of the COPE inventory; CBP, Cognitive Behavioral Program; CBT, Cognitive Behavioral Therapy; CES-D, Center for Epidemiologic Studies Depression Scale; CDI, Child Depression Inventory; CD-RISC, Connor-Davidson Resilience Scale; DASS, Depression, Anxiety, and Stress Scale; HIV-KQ, HIV Knowledge Questionnaire; HSCL-25, Hopkins Symptom Checklist; JCS, Jalowiec Coping Scale; MBC, Measurement Based Care; MCQ, Maternal Caregiving Questionnaire; MHLCS, Multidimensional Health Locus of Control Scale; MOS, Medical Outcomes Study; MOS-HIV, Medical Outcomes Study HIV Health Survey Instrument; MSSI, Multidimensional Social Support Inventory; MSPSS, Multidimensional Scale of Perceived Social Support; MUIS, Mishel Uncertainty in Illness Scale; PACTG, Pediatric AIDS Clinical Trial Groups Adherence Measure; PHQ-9, Patient Health Questionnaire-9; POMS, Profile of Mood States; PSC, Peer support/counseling group therapy; QOL, Quality of Life; RSE, Rosenberg Self-Esteem Scale; SCID-II, Structured Clinical Interview for DSM Disorders; SDQ, Strengths and Difficulties Questionnaire; SF-36, Medical Outcomes Study Short-Form 36; SPQL, Perceived Life Quality Index; SRQ-20, Self-Reporting Questionnaire; TSCS, Tennessee Self-Concept Scale; WHOQOL-BREF-HK, World Health Organization Quality of Life scale.

Control/comparison groups


Outcome measures

Mental health outcomes were reported in all studies (Table 1); all primary mental health outcomes were measured using standardized psychological symptom scales. None of the studies reported including a diagnosis of mental disorder. Outcomes related to depression were reported in all but two studies (Li et al. 2010, 2012, SeyedAlinaghi et al. 2012). In the latter, composite mental health outcome measures were utilized. See Table 1 for mental health and related psychological assessments utilized across studies. Six studies (Olley, 2006; Li et al. 2010, 2012; SeyedAlinaghi et al. 2012; Boivin et al. 2013; Kaaya et al. 2013; Eloff et al. 2014) noted attention to cultural adaptation of measures or validation of measures in the country in which the study took place.

Intervention effects

Four of the 10 studies reported a significant between-condition intervention effect for PLWH (Olley, 2006; Li et al. 2010, 2011, 2012, 2014; Richter et al. 2014; Rotheram-Borus et al. 2014). Further, Boivin et al. (2013) and Eloff et al. (2014), both family studies with HIV-infected caregivers and HIV-uninfected children, found significant effects in the child sample but non-significant effects in the HIV-infected adult caregivers; notably, these studies were designed to improve neurocognitive (Boivin et al. 2013) and resiliency (Eloff et al. 2014) outcomes in children. Four studies (Peltzer et al. 2012; SeyedAlinaghi et al. 2012; Eller et al. 2013; Kaaya et al. 2013) resulted in positive but non-significant intervention effects on mental health outcomes.

Pilot, feasibility, and quasi-experimental studies

In addition to the 10 RCT studies described in detail above, 12 additional preliminary studies were identified that provide future directions for mental health intervention with PLWH in LMIC settings. These studies, details shown in Table 2, were either described by the authors as pilot trials (many with RCT methods) or were not conducted using an RCT design.

Study location

Pilot, feasibility, and quasi-experimental studies were conducted in, Tanzania (Adams et al. 2012a), South Africa (Field & Kruger, 2008; Mundell et al. 2011; Bhana et al. 2014; Petersen et al. 2014), Cameroon (Pence et al. 2014), China (Molassiotis et al. 2002; Chan et al. 2005; Yu et al. 2014), Thailand (Jirapaet, 2000), India (Nyamathi et al. 2012, 2013), and Iran (Ravaei et al. 2013).

Participants

A total of 924 HIV-infected individuals participated across all studies. A median baseline sample size of 60 (range 16–361) was reported across all trials. The median retention rate reported post-intervention was 88.3% (range 45–100%). Study samples were diverse, and included drug-addicted males (Ravaei et al. 2013), women only (Nyamathi et al. 2012, 2013), pregnant women or mothers (Jirapaet, 2000; Mundell et al. 2011), children (Bhana et al. 2014), patients screened for depression (Field & Kruger, 2008; Adams et al. 2012a; Pence et al. 2014; Petersen et al. 2014), individuals in a symptomatic stage of infection (Molassiotis et al. 2002; Chan et al. 2005), and a general population of HIV-infected men and women (Molassiotis et al. 2002; Adams et al. 2012a; Pence et al. 2014; Petersen et al. 2014; Yu et al. 2014). Four of the studies reported inclusion criteria based on depressive symptoms or disorder (Field & Kruger, 2008;

**Study design**

Five of the pilot studies randomized individual participants (Molassiotis et al. 2002; Chan et al. 2005; Bhana et al. 2014; Petersen et al. 2014; Pence et al. 2014) and one study randomized clusters (Nyamathi et al. 2012) to the intervention or control condition. Three studies were quasi-experimental, and did not randomize participants to condition (Jirapaet, 2000; Field & Kruger, 2008; Mundell et al. 2011). Three studies were pre-experimental with a one-group, pre-posttest design (Adams et al. 2012a, Pence et al. 2014; Yu et al. 2014). Most of the studies (8 of 12) measured effects at post-test only and utilized sample sizes appropriate for pilot studies.

**Intervention content and delivery method**

The interventions tested in these studies were diverse. Most interventions were designed for delivery within groups (Jirapaet, 2000; Molassiotis et al. 2002; Chan et al. 2005; Field & Kruger, 2008; Mundell et al. 2011; Ravaei et al. 2013; Bhana et al. 2014; Petersen et al. 2014; Yu et al. 2014), one was designed for delivery with individuals (Nyamathi et al. 2012, 2013), and two were pharmacological studies that utilized a clinic-based model for task-shifting antidepressant management (Adams et al. 2012a; Pence et al. 2014). The individual-level intervention (six sessions) addressed behavioral outcomes using psychoeducation, coping, and skills training (Nyamathi et al. 2012, 2013). Group interventions (1–12 sessions) targeted behavioral (Jirapaet, 2000; Molassiotis et al. 2002; Bhana et al. 2014) and psychological (Molassiotis et al. 2002; Chan et al. 2005; Field & Kruger, 2008; Mundell et al. 2011; Ravaei et al. 2013; Petersen et al. 2014; Yu et al. 2014) outcomes through utilization of art therapy (Field & Kruger, 2008), cognitive behavioral therapy (Molassiotis et al. 2002; Chan et al. 2005), peer support counseling/group therapy, coping and stress management (Molassiotis et al. 2002; Mundell et al. 2011; Yu et al. 2014), skills building (Jirapaet, 2000), and interpersonal therapy (Petersen et al. 2014). Both of the pharmacological interventions aimed to reduce depression symptoms over a period of 12 weeks through a task-shifting model (Adams et al. 2012a; Pence et al. 2014). A wide range of professionals and non-specialists delivered the interventions.

**Control/comparison condition**

Most studies (eight) used a comparison or control condition, with six of the 12 studies randomizing participants to condition (Molassiotis et al. 2002; Chan et al. 2005; Nyamathi et al. 2012, 2013; Ravaei et al. 2013; Bhana et al. 2014; Petersen et al. 2014). As shown in Table 2, these included, for example, standard of care, wait list control, and counseling as needed.

**Outcome measures**

All studies assessed mental health outcomes using various standardized psychological scales (Table 2). Depressive symptomatology was the most commonly assessed mental health outcome; one study (Pence et al. 2014) used major depressive disorder based on a symptom scale and physician assessment.

**Preliminary intervention effects**

Eleven of the 12 pilot, feasibility, or quasi-experimental studies demonstrated promising effects related to improvements in mental health (Jirapaet, 2000; Molassiotis et al. 2002; Chan et al. 2005; Field & Kruger, 2008; Adams et al. 2012a; Nyamathi et al. 2012, 2013; Ravaei et al. 2013; Pence et al. 2014; Petersen et al. 2014; Yu et al. 2014), or behavioral (Adams et al. 2012a; Yu et al. 2014) outcomes. One study (Mundell et al. 2011) demonstrated mixed effects, with improvements in active coping and self-esteem in the intervention group, but not in depression or social support.

**Discussion**

There is an urgent need to address mental health in the context of HIV/AIDS in LMICs, which bear the brunt of global HIV infections. Although previous reviews (Crepaz et al. 2008; Brown & Vanable, 2011; Clucas et al. 2011; Harding et al. 2011; Sherr et al. 2011; Seedat, 2012; Spies et al. 2013; Wu & Li, 2013) have identified a large number of RCTs to improve mental health in high-income settings, they have only included a small number of intervention trials conducted in LMICs. The purpose of this review was to systematically identify intervention trials that have addressed mental health among PLWH in LMIC settings, and to synthesize the lessons learned from those studies. Our review identified 22 unique intervention studies, 10 of which were evaluated using rigorous RCT methodology. Although this systematic search included a range of terms for mental health, only intervention trials with depression, anxiety or overall psychiatric distress outcomes were identified. Despite the fact that only a small number of full scale trials provided evidence for improvements in mental health, the findings of the review point to opportunities for further
research on interventions to address the mental health needs of PLWH in LMIC settings.

The four RCT intervention trials in our review that demonstrated an impact on mental health primarily utilized a multi-component approach. Interestingly, the most robust outcomes, including over longer term follow up assessments, were found in community based trials (Li et al. 2010, 2011, 2012, 2014; Richter et al. 2014; Rotheram-Borus et al. 2014) that contextualized HIV/AIDS and mental health within family interactions or through peer support that addressed issues related to pregnancy and child outcomes. The inclusion of pilot studies and quasi-experimental trials in our review provided a framework for mental health interventions that are in the development phase and potentially proceeding to full scale trials. Although the study methods were acknowledged as less rigorous, many used RCT methodology albeit among small sample sizes, and all reported encouraging results using several innovative intervention approaches.

A number of studies, both RCTs and preliminary studies, were group-based interventions, utilizing a cognitive behavioral approach (including stress management and coping interventions), and often delivered in a task-shifting or task-sharing model with lay counselors or community health workers. Future directions explored in pilot trials included a measurement based care (MBC) stepped approach to antidepressant medication management (Trivedi et al. 2007; Adams et al. 2012b) that employed non-specialists to screen and monitor depressive symptoms, thereby supporting intervention at the clinic system level. These trials, as well as two others that evaluated psychotherapeutic approaches, were the only studies that used an inclusion criterion for mental disorder or depressive symptoms. Several of these pilot trials included an intervention focus or secondary outcome measure of adherence to ART. These study methods and intervention approaches point the way forward for mental health intervention trials with PLWH in LMICs, including integration with HIV care and treatment.

The studies we identified had methodological limitations similar to those documented in prior reviews of trials conducted primarily in HICs (Crepaz et al. 2008; Clucas et al. 2011; Sherr et al. 2011; Seerat, 2012; Spies et al. 2013). Of key importance only a few studies used mental disorder or above threshold symptom levels as an inclusion criterion for trial selection. This suggests that either the interventions may not have targeted PLWH experiencing significant psychological distress or that symptom levels were sub-threshold, making it difficult to demonstrate an intervention effect. In addition, a limited number of studies provided information on the cultural appropriateness of the intervention or the adaptation and validation of the mental health measures utilized (Bass et al. 2007). Several other secondary limitations of the methodologies used in our included studies should be noted. Even among the RCTs, the majority of the intervention trials assessed either immediate post- or short-term intervention effects, with longer term follow up assessments needed to determine sustainability of intervention effects. Most studies provided a general description of the intervention approach, but a detailed description of intervention components and fidelity to them in delivery would enhance the understanding of intervention outcome findings. Finally, intervention trials using non-specialists to deliver mental health interventions (i.e. a task-sharing model) did not provide adequate information on the training and supervision of the providers (Patel et al. 2007).

Despite the methodological limitations of the studies included in this review, it is encouraging to see an increasing number of mental health intervention trials for PLWH conducted in LMICs, which span a wide range of populations, countries, and intervention approaches. Additional lessons can be drawn from efficacious interventions for depression treatment in LMICs, (Bolton et al. 2003; Patel et al. 2007, 2009; Rahman et al. 2008), even if not specific to PLWH. Such interventions have been integrated into routine health care, adapted to local cultural context, and implemented by non-specialists. The intervention approaches for treating depression varied, but reflect approaches identified in this review for PLWH, including a collaborative stepped care approach (Patel et al. 2007, 2009), home-based individual CBT (Rahman et al. 2008), and interpersonal group therapy (Bolton et al. 2003). Although mental disorders in HIV care settings in LMICs often go undiagnosed due to lack of screening protocols (Breuer et al. 2014; Tsai, 2014), these studies suggest that integration of mental health screening and intervention into health care settings would be an effective approach for improving mental health among PLWH. Two of the preliminary studies we identified support the feasibility of a MBC approach for antidepressant medication in the HIV care setting (Adams et al. 2012b; Pence et al. 2014), similar to the stepped approach in the MANashanti Sudhar Shodh (MANAS) trial (Patel et al. 2007, 2009), yet more medication-based or combined medication and therapy based trials are needed.

CBIs, including problem solving, skills training, and stress management, commonly used in both HIC and LMIC, support the use of cognitive-behavioral treatments as a key mental health intervention approach. However, there is a need for cultural adaptation and tailoring mental health idioms to the local context, which may preclude the ready transplant of existing...
CBIs for PLWH. Research trials are still needed to test factors such as required intervention length for feasibility, effectiveness and maintenance of effect, and delivery by non-specialists. There is a need for task-sharing and interventions that can be delivered by non-specialists that are brief and scalable, while providing supervision and fidelity monitoring.

While mental health interventions for PLWH should draw upon the broader evidence of efficacious mental health interventions, they must also remain attuned to issues that are unique for a population living with HIV. These include potential barriers related to HIV-related stigma (Skinner & Mfecane, 2004), substance abuse co-morbidities (Gonzalez et al. 2011; Kader et al. 2012), and other disorders prevalent among PLWH such as PTSD (Machtinger et al. 2012). Multilevel system-strengthening approaches that integrate mental health care into HIV care and prevention within health care and community based organizations has been recommended (Joska & Sorsdahl, 2012; Lund et al. 2014). Areas for future research in LMICs include the integration of mental health treatment with adherence, HIV care engagement, and HIV prevention (Sikkema et al. 2010; Chibanda et al. 2014). Thus, one priority for future research is to conduct RCTs of mental health interventions that improve mental health and enhance HIV treatment and prevention.

The findings from this review of interventions to improve mental health among PLWH in LMICs also provide lessons learned and potential future directions to improve related efforts in HICs. Effective interventions in LMICs utilized family or multilevel interventions and were integrated within community based health care – approaches that contextualize mental health and provide an opportunity to address comorbidities. These approaches, in combination with addressing structural barriers to care such as poverty, health care access, and mental health care policies, are also relevant in HICs, especially in settings where health disparities clearly exist. Given the limited mental health resources in LMICs, including the absence of specialists trained in mental health treatment, the LMIC interventions incorporated approaches delivered by non-specialists. This task-sharing approach is also relevant and should be evaluated in HIC settings, particularly in communities and settings where access to mental health care is limited. Research methodologies related to monitoring intervention fidelity and supervision of non-specialists could enhance our understanding of key elements of effective interventions in both settings. Lastly, this review of interventions in LMIC settings offers lessons for the adaptation of available evidence-based interventions with attention to language, culture, and literacy, as well as feasibility of intervention length. These factors may also impact the effectiveness of mental health intervention for PLWH in HICs, and if better addressed, could improve the outcomes in higher income settings where disparities and cultural differences exist.

Our search strategy, while systematized, cannot guarantee the identification of all interventions to improve mental health among PLWH in LMICs, and omission of related intervention research is possible and may have influenced our conclusions. Unlike prior reviews (Clucas et al. 2011; Seedat, 2012; Spies et al. 2013), we intentionally cast a wide net that resulted in the inclusion of studies ranging from multilevel family and community based approaches to a group adherence intervention that also assessed the impact on depression. In addition, we included trials that reported mental health as secondary outcomes (4 of 22 studies). Although this approach broadly defined mental health and supports the importance of addressing mental health in context, a limited number of RCTs were identified, and only a portion of these trials provided evidence for the efficacy of the mental health intervention, even when looking for post-only mental health outcomes. Despite these potential shortcomings, this review provides an overview of the body of evidence available on mental health treatment of PLWH on LMICs, and offers suggestions for the path forward for understanding and addressing these needs.

Conclusion

There is a paucity of empirical data investigating the effectiveness of interventions for mental disorders and psychological distress among PLWH in LMICs. The available data are restricted to several RCTs with widely varied approaches and methodology; and to several smaller pilot, and innovative studies. It is not possible therefore to describe from such a review, the nature, content, and delivery of an ideal intervention. Key issues such as adapting the intervention to suit local culture, language, and resource-limitations are typically not addressed. We are some way from being able to define an ideal intervention, and so a framework for building interventions of this kind is a desirable next step.

Acknowledgements

This manuscript was supported by the Duke Center for AIDS Research (P30 AI064518) and a grant from NIMH (R34 MH102001).

Conflict of Interest

None.


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