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Collaborative Interpersonal Psychotherapy For HIV-Positive Women in Kenya: A Case Study From the Mental Health, HIV and Domestic Violence (MIND) Study

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Abstract

We examine the efficacy of nonspecialists delivering interpersonal psychotherapy (IPT) to HIV-positive (HIV+) women. We describe a case in which local personnel without prior mental health training delivered IPT for the treatment of depression and posttraumatic stress disorder in an HIV+ woman who reported experiencing gender-based violence and was enrolled in HIV care at the Family AIDS, Care, Education and Services program in Kisumu, Kenya.

Keywords

HIV; depression; women; Africa; mental health; non-specialist; interpersonal psychotherapy

Introduction

Interpersonal psychotherapy (IPT), a time-limited (8–16 weeks) and diagnosis-focused psychotherapy, was developed in the 1980s by Gerald Klerman and Myrna Weissman to address interpersonal issues in depression (Markowitz & Weissman, 2004). IPT is now considered evidence-based, first-line treatment for depression and is noninferior to the gold standard treatment (exposure therapy) for posttraumatic stress disorder (PTSD; Cuijpers et al., 2011; de Mello, de Jesus Mari, Bacaltchuk, Verdeli, & Neugebauer, 2005; Markowitz et al., 2015). IPT helps patients cope with interpersonal crises such as grief, an interpersonal dispute, a role transition, or social isolation by building social skills, improving communication, and mobilizing social support. IPT proceeds systematically through three phases (see Figure 1).

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ClinicalTrials.gov Identifier:

IPT begins with a medical model that educates patients on the nature of mood and anxiety disorders, underscoring that mental disorders are not the "fault" of the patient. Psychotherapeutic techniques emphasized in IPT include the use of the "interpersonal inventory," a systematic review of important interpersonal relationships, changes, conflicts, and losses, which is used heavily during the first three sessions, but continues throughout IPT treatment. In the middle phase, IPT strategies include "communication analysis," which involves identifying communication breakdown(s) by (a) reviewing interpersonal incidents in detail and (b) engaging in in-session role-play to practice more effective communication strategies with the IPT therapist. In the final two to three sessions, IPT therapists help clients identify their successes and plan for independent application of IPT principles after the conclusion of treatment.

Mental disorders are now the leading global cause of years lived with disability and the majority of the burden lies in low- and middle-income countries (LMICs; Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015), where 75% of adults who need mental health care do not have access to services. Given the dearth of mental health professionals in LMICs, strategies for training local nonspecialist personnel to deliver adapted, evidence-based treatments have been developed over the past 10 years.

Our team trained female nonspecialists (fluent in local languages/dialects and English and with no prior health or mental health training) to deliver individual IPT for major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) in three LMICs: Darfur refugees in Cairo (Meffert et al., 2009); Sichuan earthquake survivors (Jiang et al., 2014); and our current trial of individual IPT for HIV-positive (HIV+) women affected by gender-based violence (GBV) in Kenya. This trial uses an effectiveness-implementation hybrid type I design, which can be used in situations in which both clinical data on individual response and preliminary implementation data are needed (Curran, Bauer, Mittman, Pyne, & Stetler, 2012).

The ongoing study is located in Kisumu, Kenya, at Family AIDS, Care, Education and Services (FACES), a longstanding collaborative HIV clinic run by University of California, San Francisco and the Kenya Medical Research Institute. The study team trained local nonspecialists to deliver IPT for MDD and PTSD to HIV+ women with a history of GBV (n = 300, ongoing; Meffert et al., in press; Onu et al., 2016; Zunner et al., 2015). Here, we will discuss a case from this study. Note that the case identifiers have been changed or removed to protect privacy.

Local Context for HIV and GBV

Antenatal HIV testing is supported by an "opt-out" HIV testing policy for pregnant women, with the goal of preventing mother-to-child transmission of the virus. Pregnant women are often the first people in the family to undergo an HIV test. If a woman tests positive (HIV+), current practice among HIV care providers is to ask her to inform all her intimate partners of the infection and begin using condoms for protection, in addition to implementing the protocol for the prevention of mother-to-fetus transmission of HIV. In many cases, this series of events leads to an HIV+ woman informing her partner (who often has not been tested)

that she is HIV+. Male intimate partners or husbands often accuse HIV+ women of infidelity and become physically, sexually, and emotional abusive.

Traditionally, married women live with their husbands at their in-law's compound, in close proximity to her husband's mother and father. The in-laws sometimes become violent toward the woman, accusing her of endangering their son's life. Some husbands die from HIV without ever being tested. In such cases, HIV+ widows are at risk of being thrown out of their home on the compound, with her in-laws claiming all the property and funds that she and her deceased husband had accumulated (Dworkin et al., 2013). Such scenarios often lead to abuse, social isolation, and extreme poverty among HIV+ women.

Case Illustration

Presenting Problem and Client Description

The client was a 42-year-old unmarried woman, Andaiye (pseudonym), who was diagnosed with HIV in 2008 while being pregnant with her thirdbaby. She refused to believe that she was infected with HIV and retested at many locations, attempting to disconfirm the result. She realized she became infected by her partner and father of her child. The Center for Disease Control clinic in Kisumu encouraged her to start an antibiotic commonly used for prophylaxis in HIV+ patients (sulfamethoxazole-trimethoprim), which she did. In 2015, Andaiye became ill and her physicians urged her to begin antiretroviral HIV medication. However, she soon developed side effects from the drugs and her body become so swollen that she was unable to continue her work as a hairdresser, her only source of financial support.

Andaiye was the oldest of three siblings. After completing high school, she developed a relationship with a man for several years. They had three children together. She had her first daughter at age 23, another daughter at 25, and her son when she was 26. Her father died of malaria right after the birth of her first child. After her father's death, Andaiye lived with her mother, with whom she was very close. Her mother died of malaria and gout-related complications when Andaiye was 31. The client came from a wealthy family, but her relatives took the money and property when her mother died, a strategy commonly used by older relatives to appropriate valuables from orphans and widows.

When the client was 20 years old, her partner and father of her children suddenly left the area, without warning. He was following his mother's encouragement to leave Andaiye and marry someone else who was not HIV+. She has not had contact with the man since then, and because he stopped providing for her and the children, she now had to be the sole breadwinner in the family. After he left, she was rejected by members of her *chama* (community welfare group, which provides loans between members to support small business ventures) and by the staff of her children's schools due to stigma related to her HIV status. She appealed to her siblings for financial support, but they claimed they were unable to help. Eventually, she was able to begin a job as a hairdresser, which was quite successful until she developed side effects from the HIV medication and had to discontinue the work.

At her initial presentation, Andaiye was particularly distressed by her lack of money to pay for her daughter's schooling. To graduate from high school, her daughter needed to take an exam that cost 34,000 Kenyan Shillings (approximately 340 U.S. dollars). The client was simply unable to find the funds. She was despondent and stated that she felt "abandoned and all alone."

At intake, Andaiye met criteria for MDD and PTSD on the Mini International Neuropsychiatric Interview (MINI 5.0; Sheehan, 1998). She indicated 15 symptoms corresponding to mild depression on the Beck Depression Index (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and 43 high-level PTSD symptoms on the Posttraumatic Stress Disorder Checklist-Civilian (PCL-C; modified for symptoms over the past week; Weathers, Litz, Herman, Huska, & Keane, 1993). She scored 21 for severe disability on the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0; Ustun, Kostanjsek, Chatterji, & Rehm, 2010). Her HIV viral load was 8,860 RNA copies per ml (goal is < 20 copies/ml or undetectable). All psychosocial measures were translated, back-translated, and checked for local conceptual and linguistic validity using standardized procedures (Sousa & Rojjanasrirat, 2011).

Case Formulation

Per IPT protocol, the case formation was developed over the first three sessions, informed by the interpersonal inventory and confirmed through collaborative agreement with Andaiye. She reported that she was emotionally close to her children, who often reminded her to take her HIV medications. She also noted she has one friend with whom she "discusses everything." Working with her IPT therapist over the first three therapy sessions, she decided that her life's role transition as an HIV+ woman taking antiretroviral medication was the most emotionally distressing aspect of her interpersonal life. Specifically, she felt that the stigma of her HIV+ diagnosis, more apparent now that she was taking medication for HIV (i.e., antiretrovirals), prevented her from interacting with others and affected her ability to earn a living. She agreed with the therapist's idea to focus on role transition to an HIV+ woman taking antiretrovirals for the remaining eight sessions of therapy, including between-session homework as needed.

Course of treatment.—In the middle sessions of IPT (four to nine), Andaiye was given homework to communicate to others her HIV status and recruit social support related to the disease stigma and associated financial challenges. Each session began with a reminder to turn off cell phones and a check-in regarding Andaiye's mood over the past week. IPT role-play was used to successfully prepare Andaiye for homework involving conversation with other HIV+ women served by the FACES clinic.

Andaiye also disclosed her HIV status to a suitor, who responded negatively, expressing distain for HIV-infected individuals and their presumed promiscuity. Communication analysis was used to review this interpersonal incident. During these sessions, Andaiye also spontaneously reached out to a local politician she knew and informed him of her difficulty in paying her daughter's examination fee required for graduation. The politician responded by pledging 30,000 Kenyan Shillings to the school to assist with examination fees for the

client's daughter and meeting with the school principal to discuss the problem created by examination fees for advancement. Andaiye also reported that she had begun a *harambee*–an informal money drive involving calling friends and relatives to donate money toward a personal goal–to pay the remaining 4,000 Kenyan shillings. The harambee successfully raised the remaining money necessary for her daughter's examination.

After her antiretroviral medications were adjusted, Andaiye was able to return to her work as a hairdresser. She also started washing clothes and helping with domestic chores to supplement her income. As her earnings increased, she had funds to pool into the group fund, and was therefore able to rejoin her former chama, which provided critical social support and a measure of security for business ventures and periodic fiscal challenges. She also began talking with her pastor about her current life stress. Noting the positive effects of these social interactions on her mood, Andaiye also joined a women's support group at church.

Outcome and Prognosis

Andaiye responded well to IPT. She reported that she felt empowered in managing her HIV+ condition and communicating about it. The IPT therapist and client made a plan for how to address future stressors using IPT strategies. In her final session (termination), she reported, "I now know that talking is the most important thing."

At the conclusion of treatment, Andaiye was in remission from MDD and PTSD, no longer meeting MINI criteria for either disorder. Her symptoms of depression on the BDI had decreased by 60% (9 points); her symptoms of PTSD had decreased by 58% (25 points); and her disability had decreased by 33% (7 points) on the WHODAS, representing a substantial improvement in daily function.

Clinical Practices and Summary

This IPT case illustrates many of the common stressors faced by HIV+ women in East Africa, including both depressive and trauma-related sequela. With this 12-session course of IPT, led by a community therapist with no prior IPT training, both depression and PTSD were in full remission by the end of treatment. This case is illustrative of the many recent successes achieved by training nonspecialists to deliver structured psychotherapies in LMICs. Given the dearth of mental health professionals in these countries, this focus on training local nonspecialists can be seen as a critical step toward filling the 75% mental health treatment gap that exists in these regions.

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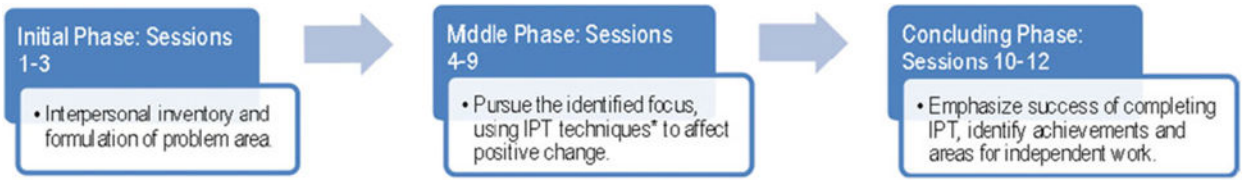

Figure 1.
IPT Treatment Schedule
*For example, communication analysis, role-playing.