Mental Health and HIV/AIDS

Psychotherapeutic Interventions in Anti-retroviral (ARV) Therapy (for second level care)
Mental health and HIV/AIDS series

This is module 5 in the Series ‘Mental Health and HIV/AIDS’.

Other modules are:-

1. Organization and systems support for mental health interventions in anti-retroviral (ARV) therapy programmes
2. Basic counselling guidelines for anti-retroviral (ARV) therapy programmes
3. Psychiatric care in anti-retroviral (ARV) therapy (for second level care)
4. Psychosocial support groups in anti-retroviral (ARV) therapy programmes

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Preface

The AIDS epidemic is one of the most serious public health and social challenges the world has ever faced. It not only destroys individuals, but also families, communities and the whole societal fabric. Worst hit are communities least able to put in place appropriate measures for its containment and control. It is probably the biggest hurdle to the attainment of the Millennium Development Goals.

As a bold measure to counteract it, WHO has launched the 3 by 5 Initiative that, while primarily aimed at providing treatment to millions of people in need of it, also aims at building the elements of the health system that will be needed to deliver it.

Therefore, treating mental disorders of people living with HIV/AIDS has huge humanitarian, public health, and economic consequences; the same applies to providing people in need with appropriate psychosocial support. This is not an easy task, in view of the scarcity of human, technical and financial resources.

The present series is a contribution from the Department of Mental Health and Substance Dependence to the WHO 3 by 5 Initiative, but also goes beyond that. Its production brought together experts on mental disorders in people with HIV/AIDS from around the world. They graciously contributed their knowledge, expertise, energy and enthusiasm to this endeavour. We are profoundly indebted to them all, as well as to the agencies and organizations to which they are connected. The contributors’ names are indicated in each of the modules in this series. A special thanks goes to Prof Melvyn Freeman, who steered this illustrious group, sometimes through uncharted waters, with patience and efficiency.

Now, we make this material available, not as a finalized product, but rather as a working tool, to be translated into local languages, adapted as needed, and improved along the way. A set of specific learning/training instruments, related to this series will soon be released, as another contribution to the mammoth task of improving the skills of the human resources available and needed, particularly where the 3 by 5 Initiative is being rolled out. Comments, suggestions and support are most welcome.

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Foreword

Among those affected by or at risk of acquiring HIV/AIDS are people with mental disorders. This happens primarily through two mechanisms:

(i) some mental disorders make people more vulnerable to infection with the virus (e.g., intravenous drug use, alcohol abuse, major depression and psychotic disorders, developmental disabilities, and other mental disorders that impair judgement and decision-making) and more vulnerable to situations that increase the risk of passing the virus to others; and

(ii) some forms of HIV infection affect the brain thus creating clinical pictures that initially resemble several different mental disorders.

Unfortunately the interplay between HIV/AIDS and mental disorders goes beyond the mutual facilitation of occurrence. Perhaps the most relevant practical aspect of this interaction relates to adherence to treatment. It is well known that the presence of an untreated mental disorder – particularly depression, psychotic and substance use disorders – considerably decreases adherence to the treatment of any condition, including HIV/AIDS.

The failure of adhering to the proper regimen of anti-retroviral (ARV) treatment carries three major consequences. First, the expected benefit of the treatment does not take place, the clinical situation worsens and mortality increases. Second, the irregularity of the intake of the ARVs brings new resistant strains of the virus, thus complicating its future control. Third, the interrupted or incomplete course of treatment wastes money and other resources that could otherwise have produced more cost-effective results in adherent patients.

In addition, being HIV-positive, or having someone with HIV/AIDS in the family can be stressful for some people with HIV and for carers. In many countries where HIV prevalence is high it is not infrequent to find more than one person with HIV/AIDS in the same household, at the same time. The stress of living with a chronic illness or caring for an ill relative – even if it does not lead directly to a mental disorder such as major depression – may result in a chain of psychosocial reactions that cause considerable pain and dysfunction. Such dysfunction and
distress may decrease resistance and resilience to co-morbid conditions, and contribute to reduced adherence to medical regimens.

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Introduction

A number of psychiatric syndromes and diagnoses will trigger referral to second level care. These include delirium, dementia, psychosis, severe anxiety disorder, depression, serious suicide risk, alcohol abuse, and alcohol withdrawal.

This module is aimed at assisting second level health workers to deal with problems which require psychotherapeutic (or counselling) intervention. Practitioners at this level providing mental health care should be familiar with psycho-social techniques and these guidelines aim to complement psychotherapeutic skills already acquired. If a health worker is not conversant with or trained in any of these approaches, additional training will be needed before these techniques are used.

A person referred to second level mental health care as part of a comprehensive HIV treatment programme may require psychotherapeutic intervention, either in addition to medical treatment, or as the preferred intervention. This module offers five different approaches that may be used, none of which is recommended above any other. There are other useful approaches not covered here. The different approaches presented provide broad frameworks which have been found to be effective in the treatment of people living with HIV/AIDS. The choice of which model to use will depend on the presenting problem(s), what the health worker is comfortable and familiar with, past experience, and what is seen as culturally appropriate and adaptable in different circumstances.

This module should be used in conjunction with the WHO Integrated Management of Adolescent and Adult Illness (IMAAI), Guidelines for First-Level Facility Health Workers. In particular, health workers should be familiar with the guidelines which outline the assessment and care of psycho-social problems, pgs 48-52 (Acute Care Guidelines).
Common problems and concerns in people referred for second-level mental health care

People with HIV/AIDS referred to Second Level Care will often suffer from mental health problems of a more severe nature than can be dealt with by health or community workers at primary care level. Health workers will need to assess which people referred with mental health problems require psychotropic medication, who may benefit from psycho-social intervention, and who may require both medication and psycho-social assistance. Medication will often be required in the early stages of treatment for conditions such as delirium, psychosis and alcohol withdrawal, while in other cases medication may need to be continued for some time, as may be the case when dealing with severe depression.

This module focuses on psychological interventions, one form of psycho-social support, for people experiencing emotional distress. These interventions are sometimes more appropriate and more effective than psychotropic medication, and can be administered by trained counsellors. For example, when a person’s mental health problem is linked with difficulties in relationships with a partner, relatives, or friends; fears of death and dying; concerns about living with HIV; fears of rejection; anxiety about taking ART; disclosure of HIV infection; dealing with side-effects of medication; or bereavement counselling interventions may be particularly useful. During the counselling sessions, the counsellor will be able to assess and deal with factors such as emotional distress, fear of physical changes due to HIV and its treatment, social isolation, treatment failure, or planning for death.

Health workers who address mental health problems at second level care will need to have some familiarity with both the medical treatment of HIV/AIDS and psychotropic drugs. They should also be familiar with and able to make referrals to support groups and appropriate NGOs in order to help build up a network of local support for the patient. They should also be aware of, and able to refer to, organisations that provide food, housing, financial assistance and legal services.

The five psychotherapeutic approaches discussed in this module are:

- Interpersonal Psychotherapy;
- Motivational Interviewing;
Cognitive Behaviour Therapy;
Supportive Psychotherapy; and
Psychotherapeutic Interventions for Grief.

Following each approach, various references and resources are provided for further follow-up.
Psycho-social interventions for people with mental health problems referred to second-level care

Interpersonal Psychotherapy

What is Interpersonal Psychotherapy?
Interpersonal Psychotherapy of depression (IPT) is a psychological intervention initially developed for the treatment of major depression. It has been described as a ‘focused, short-term, time limited therapy that emphasises the current interpersonal relations of the depressed client’. In IPT, depression is recognised as a medical illness that is deeply affected by the state of the client’s relationships with other people. Problems in important relationships can lead to psychological distress just as psychological problems or mental illness can lead to disturbed relationships. IPT focuses on addressing the problems in relationships in the client’s current life.

IPT is conducted in 14-16 structured sessions that address one of four primary problem areas in a person’s interpersonal relationships, including grief, interpersonal role disputes, role transitions, or interpersonal deficits. Early in the treatment, usually in the first few sessions, the counsellor establishes the diagnosis of depression, explains what depression is, gives the client permission to take the sick role (i.e. to recognise that depression is an illness and that while recovering from this illness, one needs to slow down, take special care of oneself, etc.), and decides whether the person may also need medication for depression. Next, the counsellor conducts an interpersonal inventory. He or she carefully reviews how the illness started and asks the client to review what was happening in his or her personal or social life when the symptoms began. The counsellor and the client review the current important relationships in the client’s life with the goal of identifying the primary problem area.
A role dispute is selected when the main problem involves a relationship in which the client and the significant person have conflicting expectations of each other’s behaviour or responsibilities in the relationship. Grief is selected when the main problem involves the death of an important person in the client’s life.

A role transition is selected when the person reports difficulty with taking on new life roles that might be the result of changes in his or her life. For example, a woman who marries a man with children takes on the role of a wife, but may also take on the new role of mother. The interpersonal deficit is selected when the person’s main problem involves the lack of meaningful relationships.

After identifying the main problem, the counsellor explains to the client that his or her depression is related to an inability to relate to the important people in his or her life. The counsellor and client set goals for the treatment and the counsellor reviews with the client his or her role in the treatment. This includes regular attendance of sessions and disclosure of current events in his or her life. Throughout the course of the treatment the counsellor continues to monitor the client’s depressive symptoms.

In the middle sessions of the treatment, the counsellor keeps the sessions focused on the main problem area, and helps create a comfortable environment in which the client is able to confide in the counsellor.

In order to help the client address the problem, the counsellor should:

- Explore the problem (e.g. encourage the client to paint a clear picture of the relationship, providing details that clarify the situation);
- Discuss the client’s expectations and understanding of the problem;
- Review the alternatives (e.g. what are the various ways of handling the problem?); and
- Support the client’s attempts to change his or her behaviour.
In the last three to four sessions of the treatment, the counsellor discusses the approaching end of treatment, and helps the client recognise his or her accomplishments during the course of the treatment. General counselling techniques discussed in the *WHO Basic Counselling* manual can be used in IPT.¹

The following case example illustrates how IPT can be initiated in a depressed client with HIV.

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**Case Example**

*Keli is a 29 year-old woman who lives with her two daughters and her mother. Five years ago she learned that she was HIV-positive. Although she continues to work, Keli has experienced increased fatigue and weight loss in the last year, and has been worried that her health is failing. She visited the primary health care clinic in her neighbourhood and learned that, indeed, her CD4 cell count has fallen significantly and she now has AIDS. While Keli was devastated by the news, she was encouraged to learn that she was eligible to start antiretroviral therapy (ART) and that the clinic would provide the medications. The providers*

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¹ In several randomised clinical trials, IPT has been found effective in reducing depressive symptoms. The procedure for conducting IPT is available in a manual that provides a detailed guide for both the group and individual formats. These manuals allow users to adhere to the therapy as prescribed. Counsellors who wish to conduct IPT should undergo training in its use. Lay people trained in the methods have successfully conducted IPT with the benefit of ongoing supervision.

IPT has been used effectively to treat depression among people with HIV infection (2,3). For people living with HIV the death of friends or relatives, learning that the disease is progressing, or experiences changes in close relationships after disclosing one’s status could be associated with mood changes. The IPT counsellor helps clients to link these life experiences to shifts in mood, and supports them in managing these difficulties pragmatically. The counsellor supports clients as they make and communicate decisions to the important people in their lives (3).

IPT has also been modified for use in groups (4). Group IPT has been tested for a variety of psychiatric disorders including binge-eating disorder, social phobia, post-partum depression, and depression in adolescents (5-10). Recently, group IPT was adapted for the treatment of depression in a rural Ugandan setting, taking into account local expressions of depression (11). In a randomized clinical trial, IPT in this setting was more effective in reducing symptoms of depression than the control intervention (12). The study was conducted in villages with high HIV prevalence where many community members had died of AIDS. The investigators modified the primary problem areas in response to their understanding of the cultural context. For example, they found that problem areas such as the role dispute, role transition, and bereavement were relevant to men and women in these communities, but the concept of interpersonal deficit had little meaning in rural Uganda.
at the clinic start Keli on ART, and she adheres to the programme of care, initially.

One month into treatment, Keli begins to miss her appointments. When a nurse visits her home, she finds Keli lying in bed, crying quietly. Keli’s 12 year-old daughter tells the nurse that Keli does not eat enough, that she has missed several days of work, and that she ‘always seems very worried’. The nurse refers Keli to the district hospital for a thorough medical evaluation as well as a psychiatric evaluation. The treating team stabilises Keli medically, and refers her to a counsellor for evaluation. The counsellor suspects that Keli may be depressed, and her evaluation confirms a diagnosis of a moderately severe major depressive episode without suicidal ideation.

The counsellor suggests to Keli that they meet for weekly counselling sessions, and introduces Keli to interpersonal psychotherapy. In the first phase of the treatment, the counsellor educates Keli about depression and performs an interpersonal inventory. Keli talks about her relationships with her close friends and family members. She describes these relationships to the counsellor. They also discuss Keli’s recent medical problems, and the implications of Keli’s illness for the family. Keli explains to the counsellor, “I get so worried about the children. I am their mother, but I just don’t have the energy I used to have. I am so afraid that my eldest daughter will have to take care of me. She is already treating me as if I am the child. She is sometimes disobedient. She acts as if I am no longer her mother”. Keli also discusses her worries about her mother, who experienced the death of Keli’s oldest brother one year ago. “She shouldn’t have to care for her sick children. We are supposed to be caring for her. I don’t know how she will survive if I get sicker. It will be terrible for her if I die,” says Keli.

Discussion
The counsellor decides that Keli’s condition will be amenable to IPT. Of note, the referring clinician made sure that Keli’s symptoms were not due to her medical condition first, before referring her to the specialist counsellor. Symptoms of
depression, like fatigue, weight loss, and poor appetite are similar to symptoms of chronic illness like AIDS, and the possibility of a change in the client’s medical condition must always be addressed.

The counsellor and Keli discuss recent events in Keli’s life. Keli has recently received an AIDS diagnosis, she is worried about recent illness and fatigue, she fears becoming dependent on her daughter, and she worries about her mother’s ability to cope with Keli’s illness. The counsellor also learns that Keli lost her brother to AIDS one year ago. At this point the counsellor and Keli must work together to select a problem area on which to focus. Of the four possibilities (interpersonal deficit, role dispute, role transition, and bereavement), Keli and the counsellor might decide to focus on the role dispute between Keli and her 12 year-old daughter. The counsellor and Keli may choose to include the daughter in selected sessions to discuss communication problems or other aspects of the relationship. One could consider focusing on bereavement due to the death of Keli’s brother, but Keli emphasises changes in her relationships with her mother and her daughter.

When necessary, antidepressant medications can also be used with IPT, however, after 14 -16 weeks of IPT, without antidepressant medication, many clients will improve considerably.

References, further reading and resources


Motivational Interviewing (MI)

What is Motivational Interviewing (MI)?
Counsellors and health workers in the HIV field seek to influence a wide variety of behaviours in their patients, which may include sexual practices, disclosure of HIV status to partners and families, use of condoms, adherence to treatment, family planning, use of alcohol and other substances, exercise, diet, and smoking. Some of these behaviours may be interconnected, such as the abuse of alcohol and lower adherence to treatment. Consultations between patients and health workers that deal with behaviour change are therefore common, and the need for interactions that are skilful and effective is self-evident.

Motivational interviewing was originally developed by specialist psychiatrists and psychologists for intensive treatment programmes that were focused on helping people with addictions to change their behaviour. Brief motivational interviewing (BMI) is an adaptation of motivational interviewing, designed for use in more general health care settings, in short sessions of even 5–10 minutes that can be embedded in a longer consultation.

BMI is more than a number of techniques and should not be regarded as a ‘magic bullet’ for getting patients to do what you want. The BMI approach may require a significant shift in the stance that the practitioner adopts in relation to the client or patient. Adopting the spirit or style of BMI, therefore, is as important as learning specific communication skills. A practitioner who genuinely adopts this style may find that his or her approach to the whole consultation changes.

The spirit of BMI
The spirit of BMI refers to the paradigm or way of viewing reality within which the particular methodology and specific techniques are nested.

Collaboration
Practitioners who practice BMI see their relationship with the patient as a partnership within which both the practitioner and patient collaborate. The practitioner is patient-centred in seeking to understand the patient’s perspective or view of reality, and creates an atmosphere that is conducive to change. This is in contrast to an approach that confronts the patient with the correct view of reality from the practitioner’s perspective and seeks to coerce the patient into accepting this viewpoint.
**Evocation**

A practitioner who practices BMI believes that the patient has the necessary internal resources and motivation to change, although the practitioner may need to evoke or enhance them through working with the patient’s own perceptions, goals and values. Again this is in contrast to an educational approach which attempts to externally correct the patient’s perceptions, goals and values, which are presumed to be deficit.

**Autonomy**

The BMI practitioner is genuinely respectful of the patient’s right to make his or her own choices regarding change, and puts the responsibility for change in the hands of the patient. The practitioner guides the patient in his or her decision-making process, directing the patient towards healthy choices, but this also releases practitioners from carrying the burden of responsibility themselves. This is in contrast to the practitioner who tells the patient what he or she must do and if the advice is not followed, feels hurt, frustrated, or even angry.

**The principles of BMI**

Within the viewpoint outlined above the practitioner aligns him or herself with 4 key principles which define the methodology.

**Express empathy**

BMI recognises that change is a process and not an event and individual patients may be at different places (Fig 1). This cycle is helpful in reminding us that not all patients will be ready to change when we counsel them and that a successful consultation may entail understanding where they are in this cycle, as well as facilitating movement around it. The cycle also reminds us that relapse is a predictable aspect of attempting to change and that even patients who successfully change, are likely to have set backs. Most patients will be at the contemplative stage where they experience internal ambivalence about changing. There will be ‘good things’ and ‘not so good things’ about staying the same or changing. The practitioner seeks to understand and accept the patient’s beliefs and feelings while not necessarily agreeing with them. Skills in reflective listening are vital.
Figure 1: Stages of change model

Develop discrepancy
BMI seeks to enhance the importance of change by paying attention to the discrepancy, that is, the difference between where the patient is now and where he or she would like to be in terms of his or her own goals and values. This principle means that BMI is directive in guiding the patient to think about a specific change, but does not impose the practitioner’s own goals and values. If done skilfully, the patient should present the arguments for change, and not the practitioner.

Support self-efficacy
Many people struggle with having confidence in their ability to change. Indeed some people may be convinced about the importance of change, but don’t feel able to do it, or have already tried and seemingly ‘failed’. Supporting and building the patient’s belief in the possibility of change is therefore essential. At the same time, it is important that the practitioner genuinely believes that change is possible, as despondency may be contagious, and so may the conviction that the patient is able to change should they choose to do so.
**Roll with resistance**

BMI avoids labelling people as resistant or non-compliant, and instead resistance is largely seen as a product of the interaction itself. The skilful practitioner can reduce resistance to change, whereas a less skilful practitioner may actually increase it. For example, direct persuasion, prescriptive advice, and arguing for change, may actually have the opposite effect on the patient. Resistance is a sign that a change of direction or approach is needed rather than an indication that more pressure or confrontation is required.

**Examples of BMI**

The following section outlines specific techniques and illustrates them with examples.

**Agenda setting**

Before the practitioner begins to discuss a specific behaviour, permission should be elicited from the patient that they are willing to spend time considering it in the consultation. With some topics there may be multiple behaviours that are equally relevant, and the patient can be asked which one he or she is most ready to discuss. In addition, there should be openness towards the patient introducing his or her own topics, that are relevant from his or her perspective.

**Reflective listening**

Early on it is important for the patient to express his or her perspective in an atmosphere of trust and acceptance. Open questions can be used to encourage the patient to elaborate on their viewpoint.

For example:

*Practitioner:* “I understand that you have some concerns about the medication. Tell me about them.”

The practitioner should respond carefully to what is said in order to facilitate further elaboration and exploration of the topic by the patient. Reflective listening gives feedback to the patient as to what the practitioner has understood in the form of a statement. The practitioner shows genuine curiosity and interest in understanding what the patient means and at the same time encourages amplification of what is meant by the patient.

*Patient:* “I worry sometimes that I may be drinking too much for my own good.”
Practitioner: “You’ve been drinking quite a bit.”
Patient: “I don’t really feel like it’s much. I can drink a lot and not feel it.”
Practitioner: “More than most people.”
Patient: “Yes. I can drink most people under the table.”
Practitioner: “And that’s what worries you.”

The practitioner may also use longer summaries of what he or she understands at key points in the interview. Summaries act in the same way as reflective listening statements, but also add structure and transition points in the interview.

Understanding patients’ readiness to change

For the particular behaviour under discussion, the practitioner seeks to understand the patient’s readiness to change, for example, if the patient has never thought about the need for change (pre-contemplative), has mixed feelings about change (contemplative), or is ready to make a change (action). Most people will have varying degrees of mixed thoughts and feelings or ambivalence about change. In this situation it is helpful to explore the pros and cons of staying the same as well as changing. It is important to value and understand both sides of their ambivalence.

Practitioner: “Tell me about your use of alcohol. What do you like about it? (later) And what’s the other side? What are your worries about using it?”

With some patients the practitioner can explore how important change is and how much confidence the patient has about changing (Fig 2).

**Fig 2: Dimensions of readiness to change**

![Diagram of readiness to change model]
Practitioner: “How important would you say it is for you at the moment to take your anti-retroviral medication? On a scale from 0 to 10, where 0 is not at all important and 10 extremely important, where would you say you are?”

Practitioner: “And how confident would you say you are that if you decided to take anti-retroviral medication, you could do it? On the same scale from 0 to 10, where 0 is not at all confident and 10 is extremely confident, where would you say you are?”

It is not necessary to use the rating scale if the patient will struggle with this concept. If it is appropriate, the answers can be used to elicit further talk about change.

For example in terms of confidence:

Practitioner: “Why are you at a 3 and not 0?”

Practitioner: “What would it take for you to go from 3 to 6?”

**Sharing information carefully**

Information should be shared in a neutral way. The practitioner should avoid the temptation to add on a solution or prescribe what the patient should do with the information. The practitioner should be sensitive to the patient’s prior knowledge as well as to the amount and type of information that he or she is interested in. One technique that can be used is that of elicit-provide-elicit. Initially the practitioner draws out the patient’s interest in the information and willingness to hear more, secondly the information is shared in a neutral way, and lastly, the practitioner elicits the patient’s reaction to the information. This last step requires the patient to understand and process the information himself or herself in terms of its relevance to his or her own situation and how he or she may utilise this information.

Practitioner: (elicit) “Would you be interested in discussing how to take the anti-retroviral medication?”

Patient: “Yes, that would be good.”

Practitioner: (provide) “Well, one of the things that we know from the research is that in order to be effective a patient must take more than 95% of the tablets. That means, for example, that if you are taking tablets twice a day for two weeks, at the very most, you can only miss one of the doses. We also know that people struggle to take tablets on a regular basis and often only manage to take half of what they should be taking. (elicit) How do you think you would cope with this?”
Patient: “Well, that sounds difficult, but I can ask my daughter to help me remember.”

Acknowledging challenges of change

Change is often a lot more complex than practitioners think. For example, giving up smoking may require significant changes in a person’s social network and ways of coping. The practitioner should not under-estimate the difficulties that people face in successfully changing, but at the same time should affirm the personal strengths that the person has to overcome these challenges. Most people have attributes that contribute towards successful change that they have shown in other situations.

Practitioner: “What is there about you, what strong points do you have that could help you succeed in making this change?”

Brainstorming

When people are ready to make a change it is tempting to breathe a sigh of relief and slip back into telling them what to do. Brainstorming, however, is a technique of generating creative ideas in a collaborative manner that allows the patient to contribute possible practical solutions. Some ideas may be discarded later as impractical or unrealistic.

Practitioner: “So, we’ve thought of getting support from your daughter and using a pill box. Is there anything else that you can think of that might help you remember to take the tablets?”

Patient: “Well I’m very good at brushing my teeth every morning so I could try and take the tablets at the same time and maybe keep them in the bathroom.”

Practitioner: “Yes, that could work. Anything else that comes to mind? What about the evening?”

Patient: “Well I always have a coffee in the evening so maybe I could link it with that.”

Once a number of possible solutions have been generated, the practitioner and patient can select the ones that seem most likely to succeed and to clarify them so that they are quite concrete and specific and can be acted upon.
Discussion

Training other practitioners in BMI inevitably involves encouraging a change of behaviour in those practitioners who would like to motivate patients to change their own behaviour! It is therefore important that the training approach demonstrate and evoke the same spirit and principles as BMI itself. Practitioners who train others should try to avoid being prescriptive, defensive or too forceful with those who question, challenge, and appear to resist.

After an initial workshop it will be important for ongoing support to be offered. Ideally this could be in the person’s own working environment. However ongoing modelling and simulation elsewhere may also be beneficial.

References, further reading and resources

6) http://www.motivationalinterview.org
7) http://www.sahealthinfo.org/
Cognitive Behaviour Therapy

What is cognitive behaviour therapy?
Cognitive behavioural therapy was initially developed for the treatment of depression, but is now also used for treating anxiety disorders and other problems. It is a psychological intervention which highlights the role of thinking (negative thinking, anxious thinking etc.), in the maintenance of depression or other problems. By helping the person identify and modify dysfunctional thoughts, the counsellor can help individuals improve their mood and change their behaviour. Negative thinking as seen in depression is thought to start with assumptions, which are developed in childhood. While some of these assumptions may be helpful and guide behaviour successfully, other assumptions may be less helpful and lead the individual to cope less well when faced with criticism or disappointment. In such cases the person may develop negative automatic thoughts, which in turn lower the person’s mood and reinforce the development of further negative automatic thoughts. At this point the person may develop a set of cognitive distortions, such as what is know as the cognitive triad: negative view of oneself, the present and the future.

In cognitive behaviour therapy the counsellor helps the individual to recognise patterns of distorted thinking, low mood and dysfunctional behaviour. The counsellor discusses these patterns of thinking and behaviour systematically, and carefully plans practical assignments that help the person assess and change his or her distorted thoughts and dysfunctional behaviours. The treatment is very much based on the present, and the emphasis is on helping people develop ways of thinking, and skills that bring about improvement in their ability to cope. All aspects of cognitive behaviour therapy are made explicit and discussed with the individual, the counsellor being a collaborator who helps plan strategies to deal with specific problems. Cognitive behaviour counsellors often use reading material, self-help, or self-instruction books to strengthen the content of the therapy session.

Therapy is time-limited, usually lasting between 10 and 20 sessions, and the counsellor and client make the goals explicit at the outset.

A brief outline of the cognitive behaviour therapy approach is given below.

Cognitive behaviour therapy for depression
The first step will be to assess the nature of the presenting complaint and to identify the therapy goals. The counsellor and client will clarify current difficulties by describing how they began, how they developed, and their future...
consequences. They will also explore the content of the person’s negative thoughts. Other practical problems (financial, job-related, child care or family-related, etc.), relationship problems, or long-standing personal difficulties will also be identified. The next stage will involve identifying the goals of the current therapy. The counsellor will then discuss matters such as the number of sessions and their frequency, the nature of the homework assignments, and the components of therapy. These include identifying the vicious cycle of negative thinking and low mood, the possibility of changing negative thoughts, and the person’s willingness to engage in therapy.

Treatment will start with homework assignments that ask clients to monitor their activities and mood, and to monitor their negative automatic thoughts. These are thoughts, sometimes in the form of self-talk which tend to happen without prompting. They may accompany low mood, and they give some idea of the underlying beliefs and expectations that the person holds. Therapy sessions will usually involve setting the agenda for the session, reviewing events since the previous session, including review of homework assignments and then focusing on specific topics arising from the homework assignments, and feedback from the previous week. A number of strategies can be used, such as cognitive strategies (distraction techniques), behavioural strategies (monitoring activity, increasing pleasurable activities, increasing exposure, graded task assignments), cognitive-behavioural strategies (identifying negative automatic thoughts, questioning negative assumptions, behavioural experiments) and preventive strategies (identifying assumptions and challenging them, using setbacks and planning for the future).

**Cognitive behaviour therapy for anxiety and panic**

As when dealing with depression, the initial assessment will help to clarify the nature of the difficulties including situations, specific features, bodily reactions, thoughts, and behaviour. Detailed situations likely to worsen or improve the problem, as well as details of what situations and activities are avoided, are part of the initial valuation.

Sessions, like in the case of treating depression, will involve setting the agenda for the session, reviewing events since the previous meeting, discussing homework assignments, and focusing on specific problems and techniques. Distraction techniques, activity scheduling, challenging of automatic thoughts, using behavioural experiments, and dealing with avoidance behaviour can be used. Relaxation techniques can also increase the person’s sense of control over his or her symptoms.
Mandla is a 38 year old man who has known of his HIV infection for about three years. He is not currently in a relationship and his last important attachment was to a partner who died of AIDS four years before. Mandla was found to be positive when he went for testing a year after his partner’s death. Mandla was fearful of dying in a similar way, but without having someone to care for him. His mother had died a number of years previously and his close family were all poor and lived in shacks or houses without room for another person, especially a sick person. Mandla was recently put onto ART but paradoxically, as his own health began to improve, he began to feel more despondent and had regular periods of low moods when he would avoid seeing people and would take to his bed for days at a time. When he emerged from this state, he would go through phases of misusing alcohol and marijuana. Mandla’s periods of sadness and avoidance of people had become more prevalent. The health worker at the clinic where Mandla was receiving his HIV treatment noticed his condition getting worse and referred him to a counsellor who made use of cognitive behaviour therapy.

After assessment, Mandla and the counsellor agreed to focus on his low mood and his avoidance of contact with people. When discussing factors that contributed to Mandla’s low mood, it became clear that he felt guilty for not having got better care for his deceased partner and allowing her to die without calling her family to her bedside. He felt a failure for having acquired HIV infection himself, and further felt that he had failed in life as he was unemployed and unable to support his children. Mandla and his counsellor agreed to start monitoring his mood, thoughts and behaviours, and it became apparent that his negative feelings about the death of his partner were still prominent and contributed to the automatic cycle of negative thoughts, whenever he attempted to make plans or develop an interest. Similarly his feelings about his own body being tainted by HIV added to the cycle of negative automatic thoughts regarding his own ability to survive and cope with life.
Mandla started to challenge his negative thoughts by exploring other explanations and reviewing the evidence as situations arose. Gradually it became clear in Mandla’s mind that his role in getting someone to look after his partner and informing her family about her illness had been more positive than he himself had appreciated. He was also able to identify feelings of anger towards his partner, as well as feelings of relief when she finally died. Mandla also began to question whether having HIV infection made him such a bad person after all. Challenging his automatic thoughts about his responsibility for his HIV infection showed him many examples of his kindness to others and his willingness to help people in difficulties. He began to remember instances when other people had been grateful to him, had shown interest in seeing him, or had simply accepted him as he was. Mandla was able to identify patterns of all or nothing thinking (‘if I cannot achieve a little, I have failed completely’) and of overgeneralisation (‘this small mistake shows my whole life has been a disaster’). Mandla also started to recognise that his current lifestyle did not include any enjoyable or stimulating activities, so he began to list and explore possible sources of enjoyment, either by himself or with others. These included going to church again, seeing friends for initially brief and manageable social contact, and later to consider the possibility of joining a support group for people with HIV infection. As he began to socialise and meet people through the HIV support group, he also discovered that others were now undertaking further training, and after some hesitation, he decided to start a brick-laying course to upgrade his skills. By the end of therapy, four months later, Mandla was more able to deal with bad days and low moods, by identifying both the facts that had contributed to them, and his own automatic negative thinking. He began to take more care of himself in terms of his diet and regular exercise, and he began to feel more confident about his ability to cope with social situations and his chances of finding employment in future.
Discussion

Mandla’s case illustrates how even long-standing difficulties can respond to fairly short intervention. Dealing with unresolved issues related to his partner’s death provided the impetus to examine his own feelings about himself and his future. The cognitive behaviour therapy approach allowed Mandla to find strategies to deal with his low mood, his uncertainty about the future and the pattern of negative thought he had shown in the past.

References, further reading and resources

Supportive psychotherapy

What is supportive psychotherapy?
The term ‘supportive psychotherapy’ describes two different kinds of interventions. The first is the brief support that can be offered to healthy individuals who are suffering from an acute trauma or crisis such as bereavement. The second is a longer-term treatment offered to people with ongoing, serious problems for whom supportive psychotherapy, as opposed to other forms of therapy, is their treatment of choice. While support is a component of all forms of psychotherapy (and includes regular appointments, reliability, and attentiveness of the counsellor towards the patient so as to develop a working alliance), support is, in itself, the main ingredient in this intervention. Supportive psychotherapy aims at maintenance rather than radical change, uses reflection rather than interpretation or direction, and often takes place less than once a week, (eg. fortnightly, monthly or even less frequently). There is often no restriction on the long-term pattern of meetings.

In certain settings, and in particular when dealing with people with chronic physical disorders, as well as mental health difficulties, the provision of supportive psychotherapy may prove effective, where other forms of therapy have failed.

The techniques involved in supportive psychotherapy include the following:

**Holding and containment**

‘Holding’ involves acting as a secure ‘container’ for the fears, distress and guilt which effect the patient. It involves the capacity to ‘do nothing’, other than providing a quiet point in a chaotic world of loneliness and struggle. An inexperienced counsellor may not always find it easy to make this minimalist decision and avoid generating new suggestions for action. The counsellor will also provide containment at times of crisis and offer more frequent appointments when required. Improvement in the process of coping, or reduction in distress, may lead to a lower frequency of meeting or even discontinuation of contact, but with the possibility of returning to the counsellor if needed.

**Active Real Counsellor**

A counsellor may be more prepared to reveal aspects of himself or herself than in other forms of therapy, and to answer personal questions. This may help to normalise the patient’s experiences. Self disclosure may help the person to feel that the therapist has faced similar problems and overcome them, and so help
to normalise the patient’s response. Use of humour could also help to validate the patient’s experience.

**Positive Re-enforcement**

Praise and positive comments on the patient’s experience or willingness to cope can be given to balance the patient’s repeated examples of low self-esteem or failure discussed in the sessions.

**Working Positively with Defences**

This may include using language to describe painful and difficult feelings, to provide techniques such as relaxation training to reduce tension, and to allow the use of distancing and even denial, to cope with painful feelings, at least on a temporary basis.

**Coping**

The therapeutic focus is on the here-and-now, and focuses on the patient’s current difficulties. The therapist tries to find ways to help the patient deal with them in the least stressful or destructive way. This usually means having modest objectives. People with HIV may be assisted to acknowledge the difficulties caused by being unwell, tired, or having to take regular medication. This allows the patient to feel less responsible for his or her inability to be happy or contented.

**Paradox and Re-framing**

Paradox refers to the contrast between what was expected or thought possible, and what actually happened. The therapist may point out to the patient that a meeting with the patient’s boss that the patient was very anxious about resulted in a good deal of praise. Positive re-framing involves finding positive aspects of a situation that the patient had initially regarded as completely negative. Positive re-framing can be used as a coping skill. Reframing would mean, stress for example, that in spite of the person being anxious and tearful, he or she managed to carry on and face a difficult situation without running away.

**Transference and Countertransference**

Positive transference is important in successful supportive psychotherapy, without having to make implicit transference interpretations. The counsellor also needs to monitor his or her own countertransference as the flexibility of the therapy may prevent the counsellor from becoming aware of boundary difficulties.
Case Example

Maria is a 39 year old woman who was found to be HIV-positive two years ago, after she became ill with severe diarrhoea and weight loss. She was very distressed to discover her HIV status, which she assumed was the result of her unprotected sexual contacts some years previously. Her health worker became concerned about her tearfulness and distress, which appeared to have become worse over the previous 18 months, even though her health had started to improve following antiretroviral use. A mental health specialist diagnosed dysthymia with labile mood, low confidence in her own abilities, and disturbed relationships with men. Maria had not disclosed her HIV status to her mother or any other relative, and she was fearful about the possibility of becoming ill and needing to reveal her condition to her family.

The mental health specialist discussed his view of the difficulties with Maria, stressing that while she was not depressed in the sense of needing antidepressant medication, she was clearly unhappy and struggling with a number of complex issues, both HIV related, as well as issues from her earlier life and upbringing. The counsellor indicated that he would be willing to meet on a regular basis to help her find better ways of coping.

Initially Maria was quite distressed in the sessions, but felt that the counsellor accepted her as a person, despite her HIV status. He made positive comments about how she seemed to be establishing self-control in the midst of this difficult situation. Gradually Maria was able to talk to her family about her status and was surprised by their very supportive response. The counsellor commented on how well she had handled the disclosure of her status and the questions that her family had raised. Maria became very concerned about the possible side effects of her anti-retroviral medication, and the counsellor was able to give her information verbally, provide pamphlets, and refer her to a local NGO where she could ask specific questions about her medication. Maria made use of these suggestions and became more confident about discussing with her practitioner what drugs she was unhappy about. She also talked about previous failed relationships, and how her demands and insecurity had contributed to the problems.
Within six months of therapy she became involved with a man and was able to disclose her HIV status to him. The counsellor offered to meet Maria’s partner with her to discuss any issues that he might have doubts about, and they had two sessions together. They discussed issues related to Maria’s partner’s risk of acquiring HIV infection, and his concerns about treatment and prognosis. Maria’s relationship with her partner continued to develop in spite of occasional difficulties which became topics that Maria discussed in therapy. After each session, the counsellor asked Maria when she would like to schedule the next meeting. After one year they decided to end the therapy, but the possibility of open access remained.

Discussion
Maria was given clear information at the outset about what kind of help might be available and her efforts to cope with disclosure and fears of side effects from treatment. The counsellor acknowledged difficulties in her relationship with her partner and stressed to Maria how, in spite of her problems, she was able to face them successfully. The counsellor established regular appointments to provide consistency and stability—something Maria had never experienced in a predictable manner. In these sessions Maria could express her distress, but also learn to see the positive aspects of herself. The counsellor’s offer to meet with Maria’s partner was part of the counsellor’s recognition of Maria’s potential problems in a relationship with a new partner. That meeting allowed her partner to ask questions about the issues related to Maria’s illness that he was anxious about. The flexible nature of the meetings allowed Maria could determine their frequency. This reinforced her feelings of being in control of her contact with the counsellor and of having some control over the treatment of her HIV infection.

References, further reading and resources

Psychotherapeutic interventions for grief

What is Grief?
Grief is a universal experience but its manifestations are influenced by many factors: the circumstances of the death, the nature of the relationship between the bereaved and the dead person, the personality of the bereaved, and the social, cultural and interpersonal circumstances of the survivor. The majority of bereaved individuals experience a pattern of psychological distress and social dysfunction which is within the culturally sanctioned range of response, while a minority suffer more significant and severe disruption of their psychological and social well-being.

Grief can be understood as a process of adaptation to loss. Therefore, it is a dynamic phenomenon, rather than a static event. For this reason, preparing to die and mourning the death of another have been understood to occur through a number of ‘stages’: denial, anger, bargaining, depression, and acceptance, or ‘phases’ such as numbness, yearning, anger, despair, and re-organisation.

The concept of ‘tasks of mourning’ include:

- Acceptance of the reality of the loss;
- Working through the pain of grief;
- Adjustment to an environment without the deceased person; and
- Emotional relocation of the dead person.

In practice, not everyone responds to loss in a predictable way and it is clear that the descriptions of the process of normal grief provide only an idealised model of the process. A number of psychological and social factors will contribute to modulate the expression of grief, including the closeness of the dead person, the nature of the relationship with the bereaved, including the presence of ambivalence and conflicts, the mode of death, previous experience of losses, the personality of the bereaved, and the nature of the supports available.

People bereaved due to AIDS will likely experience multiple losses due to other infected members of their social networks. In addition to the features discussed above, AIDS-related loss is unique due to the stigma associated with the disease, the quantity of loss, the cumulative effect, relentlessness of loss, and the protracted and episodic nature of the illness.

Mourners with AIDS may in fact experience greater distress when bereaved than those who are HIV-negative. A death due to AIDS is a painful reminder of
the eventual outcome of the disease process for people with AIDS. Regardless of HIV serostatus, people experiencing multiple losses often report resignation, the sense of a lost future, loss of community, loss of companions to grow old with, a sense of over-whelming stress, a sense of uncertainty about the future, blame, and judgment.

The psychological consequences of AIDS-related bereavement have been reflected in symptoms of traumatic stress, increased prescription drug use, disordered sleep, depression, and suicidal ideation. The number of losses is directly related to the severity of grief symptoms, pre-occupation with the deceased, and searching for the deceased.

**What can be done to help the bereaved?**

The majority of people experiencing normal grief do not come to professionals for help with their loss, and most studies show that professional intervention in normal grief does not usually help. But in the context of HIV infection, people may be in contact with health and social care professionals who may be in a position to offer support as people grieve. Providers can also guide family members in ways to support each other. Ten principles to support bereaved people as they work through grief are described below:

- Help the person to express his or her feelings, for example by encouraging him or her to describe the death and its circumstances and aftermath.
- Help the person to identify and express feelings, in particular anger and guilt, especially if they are seen as unacceptable.
- Help the person to start living without the dead person, which may involve making decisions and changes without feeling paralysed by the need to guess what the dead person might have done or expected.
- Help the person to relocate the dead person emotionally, in particular with regard to establishing new relationships.
- Encourage the person to allow time to grieve, recognising that the whole process does take time and give the bereaved person permission to do it at his or her own pace.
- Reassure bereaved people about the normality of their feelings, so that they do not feel they are losing their mind as a result of the experience.
- Allow for individual differences while providing reassurance about the range of responses and ways of coping.
- Give access to longer term, non-intensive support.
Assess the person’s coping styles, in particular the use of potentially maladaptive methods such as alcohol misuse.

Encourage the use of mourning rituals.

If the person develops a severe depression and is unable to care for himself, attend to daily activities, or feels suicidal after a long period of grieving, a combination of psychological and pharmacological interventions may be required. Note that what is considered a ‘normal’ duration of grieving will vary in different settings.

Amongst the psychological interventions that can be helpful when grief is complicated by psychiatric illness or prolonged emotional distress are:

- Group or individual behavioural therapies, including ‘guided mourning’
- Individual psychodynamic psychotherapy for grief

Other psychosocial interventions for complicated grief include the use of informal social support and more structured support groups. These groups often reach people who may not be in contact with professional services (See Module 4 Psychosocial support groups in anti-retroviral (ARV) therapy programmes)

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**Case Example**

Anna is a 41 year old single woman with advanced HIV infection. She cared for her son, Ayanda who died from HIV related complications five years before. Ayanda was seven years old when he died. Anna felt responsible for Ayanda’s HIV infection, and blamed herself daily for his death. Anna herself remained reasonably healthy, and this added to her feelings of guilt. Anna kept Ayanda’s belongings and his room as they were when he was alive, and did not throw away any of his personal belongings. She continued to visit Ayanda’s grave on a monthly basis on the anniversary of his death, and continued to carry a photograph of her dead son around with her, looking at it several times a day, and before going to sleep at night. She cried whenever she gazed at the photograph.

Anna was referred to a mental health specialist when the practitioner looking after her learned that Anna wanted to discontinue her antiretroviral therapy. Anna felt she did not deserve to be in good health. Although initially reluctant
to see a mental health specialist, Anna finally agreed. She was seen over a period of three months, on a weekly basis, and later every two to three weeks. Initially the focus of the sessions was her description of the final illness and death of Ayanda, a topic associated with intense distress for Anna. Her feelings of guilt were easy to identify, but it took a little longer for her to acknowledge the anger she had felt towards Ayanda for having left her alone and unhappy. The next stage of therapy explored ways of allowing Anna to enjoy and develop interest in her own life while not completely giving up her thoughts and memories of her son.

Initially Anna was able to spend a few minutes every day actively doing something enjoyable and she was surprised to discover she did not feel uncomfortable while doing so. At the same time the counsellor began to address behaviours which were perpetuating Anna’s grief, such as her very frequent visits to the cemetery, and the unchanged state of Ayanda’s room and belongings. Anna herself began to make suggestions about the disposal of Ayanda’s belongings. Anna finally donated them to an AIDS charity; however, she was not ready to reduce the number of visits to the cemetery. She and the counsellor continued to discuss the visits and their significance for Anna. By the end of therapy Anna had decided to continue with her anti HIV treatment and had started to look for work. She also decided to take in a boarder as she now realised she did not need all the space she had when her son was still alive. She continued to carry her son’s photograph in her purse but the intensity of grief she experienced when looking at it, diminished somewhat.

Discussion
This case shows how a combination of active efforts proved effective in what appeared to be a fixed and chronic pattern of grieving. The practitioner helped Anna relive the distressing event within the safe context of the therapeutic relationship, explore undesirable feelings such as anger at the deceased person, and make behavioural changes aimed at altering her response to loss and change.
References, further reading and resources

Conclusion

These guidelines are **not** training materials for the interventions presented in the five models. Rather, they assist providers who have been previously trained to specifically apply these interventions to people living with HIV/AIDS. Alternatively, health workers not familiar with these models, but who see the usefulness of one or other model for their work, may read further in the area, and may seek training to become qualified service providers. Once trained in the model, the provider can then use these guidelines to assist in his or her work as part of a comprehensive HIV/AIDS treatment, care, and support programme.