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The Art and Skill of Delivering Culturally Responsive Trauma-Focused Cognitive Behavioral Therapy in Tanzania and Kenya

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Objective: This study explored the facilitators, barriers, and strategies used to deliver a child mental health evidence-based treatment (EBT), trauma-focused cognitive behavioral therapy (TF-CBT), in a culturally responsive manner. In low- and middle-income countries most individuals with mental health problems do not receive treatment due to a shortage of mental health professionals. One approach to addressing this problem is task-sharing, in which lay counselors are trained to deliver mental health treatment. Combining this approach with a focus on EBT provides a strategy for bridging the mental health treatment gap. However, little is known about how western-developed EBTs are delivered in a culturally responsive manner. ***Method:*** Semistructured qualitative interviews were conducted with 12 TF-CBT lay counselors involved in a large randomized controlled trial of TF-CBT in Kenya and Tanzania. An inductive approach was used to analyze the data. ***Results:*** Lay counselors described the importance of being responsive to TF-CBT participants' customs, beliefs, and socioeconomic conditions and highlighted the value of TF-CBT for their community. They also discussed the importance of partnering with other organizations to address unmet socioeconomic needs. ***Conclusion:*** The findings from this study provide support for the acceptability and appropriateness of TF-CBT as a treatment approach for improving child mental health. Having a better understanding of the strategies used by lay counselors to ensure that treatment is relevant to the cultural and socioeconomic context of participants can help to inform the implementation of future EBTs.

Keywords: global mental health, task sharing, trauma-focused cognitive behavioral therapy (TF-CBT), cultural responsiveness

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Globally, mental health disorders account for 22.2% of years lived with disability, with those living with mental illness more likely to have other health problems that can lead to serious conditions such as cancer and heart disease (Pike, Susser, Galea, & Pincus, 2013). Evidence also suggests a link between the social determinants of health, such as poverty and violence, and mental health disorders (Patel, 2012). These issues may be particularly salient for those living in low- and middle-income countries (LMICs; gross national income of $12,736 a month; World Bank, 2016) where a large majority of those with mental health problems are not treated due to lack of resources and limited access to services (Becker & Kleinman, 2013).

One aim of the global mental health field is to improve mental health by reducing the mental health treatment gap (Patel, 2012). Task-sharing is a demonstrated effective approach to improving access to mental health care, given the shortage of mental health professionals (see Padmanathan & De Silva, 2013; World Health Organization (WHO) 2008). This approach involves shifting certain aspects (or "tasks") of mental health care normally carried out by mental health professionals to lay counselors with little to no former mental health training, who are then trained and supervised in delivering interventions.

A second approach, supported by WHO, involves bringing evidence-based mental health treatments from other settings to LMICs (WHO, 2008). Findings from studies combining these two approaches suggest that with training and supervision, lay counselors can effectively deliver mental health treatments, with reductions in mental health disorders and symptoms (Bolton et al., 2014; Murray et al., 2011; Patel, Chowdhary, Rahman, & Verdeli, 2011;

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Rahman, Malik, Sikander, Roberts, & Creed, 2008). Positive results have led to relatively widespread agreement that task-sharing evidence-based mental health treatment is a viable and necessary strategy for scale up (Patel et al., 2011; WHO, 2008).

In addition to using lay counselors, specific attention to ensuring that interventions implemented in LMICs are culturally appropriate has been supported through actions such as conducting in-depth interviews or focus groups with health care providers and consumers to inform implementation (O'Donnell et al., 2014; Patel et al., 2011; Rahman, 2007); including the community in the development process (Poulsen et al., 2010); making adjustments to intervention materials where necessary (Kaysen et al., 2013; Murray, Dorsey, et al., 2013); and including locally developed measures to assess symptoms (Bolton et al., 2003, 2007). However, to our knowledge, research has not specifically examined how lay counselors deliver these interventions. Additional research is needed that addresses how lay counselors are delivering these interventions in a *culturally responsive* manner—in a way that acknowledges participants' cultural identity and takes into account their beliefs, norms, and values when implementing (Winiarski, Beckett, & Salcedo, 2005) while still maintaining intervention fidelity (e.g., flexibility within fidelity; Beidas & Kendall, 2010).

The majority of global mental health intervention research in LMICs has focused on adults; however, studies focused on children are increasing. One with the most empirical evidence in high income countries (Silverman et al., 2008), and growing evidence in LMICs (e.g., Murray et al., 2015), is trauma-focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). TF-CBT has been implemented in LMICs (i.e., Democratic Republic of Congo, Tanzania, and Zambia), using a task-sharing approach with positive outcomes at end of treatment, including improved child posttraumatic stress symptoms (PTS), depression symptoms, grief, and behavioral adjustment (McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Murray, Familiar, et al., 2013; Murray et al., 2015; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; O'Donnell et al., 2014). One open trial in Tanzania demonstrated maintained outcomes at 12 months (O'Donnell et al., 2014). In addition to positive mental health outcomes, qualitative research with lay counselors, children, and caregivers involved in the implementation of TF-CBT in LMICs has indicated satisfaction with and acceptability of the intervention (Murray, Skavenski, Michalopoulos, et al., 2014).

These data suggest that TF-CBT may offer an effective and culturally acceptable intervention approach in LMIC for traumatized children with mental health problems. Before more widespread dissemination, it is important to better understand perspectives of lay counselors delivering TF-CBT. Thus, this study sought to supplement the treatment effectiveness, satisfaction, and acceptability research to better understand how lay counselors deliver TF-CBT to families. Specifically, this study aimed to explore: (a) facilitators and barriers to delivering TF-CBT in a culturally responsive manner and (b) lay counselor strategies, characteristics, and behaviors related to culturally responsive TF-CBT delivery.

Background: TF-CBT in Tanzania and Kenya

This qualitative study was part of a larger NIMH-funded randomized controlled trial (RCT) of TF-CBT in Moshi, Tanzania, and Bungoma, Kenya (Dorsey & Whetten, MPIs; NIMH-funded, RO1 MH96633; $N = 640$), for children ages 7–13 with mental health symptoms (PTS, grief) subsequent to parental death. The RCT involves delivery of TF-CBT to 320 youth in both Tanzania and Kenya (20 groups in each site; 160 youth per site). All study procedures were approved by the Duke University Institutional Review Board (IRB), Kenya Medical Research Institute (KEMRI), Kilimanjaro Christian Medical Centre (KCMC), and Tanzania National Institute for Medical Research (NIMR). Six counselors were trained to deliver TF-CBT in each site (12 total) in October 2012 by the last author (SD), study PI and international TF-CBT trainer. Training followed the apprenticeship model for lay counselors in LMIC—a 2-week experiential and active training for counselors and local supervisors, followed by substantial counselor practice prior to delivering TF-CBT to children and their guardians (Murray et al., 2011).

Local supervisors were three experienced lay counselors in Moshi, Tanzania from a previous open trial (O'Donnell et al., 2014). Local supervisors conducted in-person supervision with the six counselors in Moshi and remote supervision via Skype and telephone with the six counselors in Bungoma, Kenya. Counselors in Bungoma also received two multiday in-person supervision meetings each year in Bungoma. Throughout the training, practice, and supervision, counselors were taught to hold fidelity to critical intervention elements (e.g., trauma narrative) by using the analogy of a recipe. All counselors should make the recipe with the same main ingredients but can "spice it up," operationalized as using local stories, creative strategies, and other more effective means of teaching the intervention elements to children and their guardians (e.g., different examples, analogies, supplementing standard treatment rationales).

Counselors began delivering TF-CBT in April 2013 (Kenya) and June 2013 (Tanzania). In both countries, TF-CBT was delivered in Kiswahili. TF-CBT has evidence for both individual and group delivery (Deblinger, Pollio, & Dorsey, 2016; Dorsey et al., in press; Dorsey, Briggs, & Woods, 2011), with group delivery the modality used in this trial. Counselors delivered weekly, group-based TF-CBT with orphans and their guardians over 12 weeks, as well as two to four individual visits with each family during those 12 weeks (between Group Sessions 4 and 7, to conduct the trauma narrative/imaginal exposure component). Each group had eight child-guardian dyads. Group sessions involved concurrent, separate child and guardian groups, with conjoint child-guardian activities during the final five sessions (see O'Donnell et al., 2014, for more information).

The first four groups focused on psychoeducation about parental loss and grief and the development of behavioral and cognitive coping strategies for children and guardians. Guardians also received parenting skills training. Groups 4 through 8 and the individual visits interspersed between these groups focused on trauma narrative development, desensitization, processing, and building guardian support (note: children were not exposed to each other's trauma narratives, but did share their narrative with their guardian, after guardian preparation). Groups 9 through 12 focused on the specific grief elements for TF-CBT: resolving ambivalent feelings, converting the relationship from interaction to memory, connecting to other individuals in their lives, and planning for coping after the group was over (see Cohen, Mannarino, & Deblinger, 2006, for more information).

Method

Participants

The lay counselors ($N = 12$) involved in the RCT participated in the qualitative study. Counselors were hired by the two partner organizations for the RCT: Tanzania Women Research Foundation (TAWREF; Moshi, Tanzania; $n = 6$) and Action in the Community Environment Africa (ACE Africa; Bungoma, Kenya; $n = 6$). Hiring procedures involved job advertisements in local publications and interviews with the most qualified applicants. Two of the counselors (one at each site) had previous experience working with the organizations and were specifically recruited for the counselor positions. Counselors did not need to have mental health training of any kind, but were expected to have experience and interest in working with children and families. All counselors had undergraduate degrees from universities in their respective countries, most in social work or education.

Qualitative Approach

The research team took an inductive approach to qualitative data collection and analysis. This method, often used in social science evaluation research, begins with an area of study and allows a theory to emerge from analysis of the raw data (Strauss & Corbin, 1990). Consistent with the General Inductive Approach, data analysis was guided by the study aims, which were to better understand the facilitators and barriers, as well as the strategies, characteristics, and behaviors related to culturally responsive TF-CBT delivery.

Study Procedures and Data Collection

Counselors were interviewed in English by two American research team members who were not part of the RCT (CA, BWJ) after counselors completed delivery of four TF-CBT groups (i.e., 32 children; half female, half male, and their 32 guardians). The groups were delivered at the same time, with the two boys' groups staggered to begin two weeks later than the two girls' groups. The research team created an interview guide comprised of 30 questions aimed at accomplishing the study aims (see appendix in the online supplemental material for full interview guide). Given the distance between the researchers and the counselors (United States; Kenya), the team collected data through one-on-one interviews recorded via Skype rather than meeting face-to-face, each interview lasted about one hour. The recorded interviews were transcribed verbatim and served as the raw data to be analyzed.

Data Analysis

After an initial reading of the raw data, the analysis team created a preliminary codebook that categorized the counselors' responses. The codebook included the names of the codes, their definitions, and examples of how to apply them to the raw data (MacQueen, McLellan, Kay, & Milstein, 1998). Before coding began, the three coders who comprised the analysis team met on several occasions to discuss codes and to further define the proper application of each code in order to ensure reliability and validity (Yeh & Inman, 2007). The coding team included both researchers that collected the data as well as one additional team member; all coders were American. Prior to coding, the analysis team also underwent several rounds of training with qualitative analysis software, Atlas.ti 7. The coders divided the interviews between them and met at regular intervals to discuss and ensure the reliability of coded data, to reach consensus on the application of the codes, and to make alterations to the codebook. After interpreting the raw data the analysis team met to discuss how each code could be grouped into a broader category. Further interpretation resulted in a hierarchy that linked these categories into a superordinate, parallel, or subordinate system (Thomas, 2006). The categories and their linkages were operationalized into themes that represented key elements and strategies that could facilitate effective delivery of TF-CBT in a culturally responsive manner.

Data Trustworthiness

The research team further ensured the trustworthiness of the data through a system of reliability and stakeholder checking (Erlandson, Harris, Skipper, & Allen, 1993). Before finalizing the findings, the team met with the counselors as a group via Skype to discuss the themes that emerged from the raw data. Crucial to ensuring the trustworthiness of the data, this process of member checking allowed for the participants to review findings in order to provide guidance to the research team. Member checking has been described as the most crucial technique for establishing credibility in qualitative research (Lincoln & Guba, 1985). The research team incorporated the counselors' final commentary, which produced the findings below.

Results

The interviews conducted provided a better understanding of key elements and strategies that helped to facilitate the effective delivery of TF-CBT in a culturally responsive manner. Two key themes and several subthemes emerged from the qualitative analysis. The first key theme related to cultural responsiveness, where counselors described the importance of being aware of and responsive to local customs and beliefs when teaching new skills and concepts to intervention participants. The second key theme that emerged related to social and economic circumstances. Counselors discussed the socioeconomic conditions that participants faced and the impact that it had on intervention delivery, highlighting the importance of being aware of and responsive to these conditions when delivering TF-CBT. These key themes and subsequent subthemes are described in detail below.

Cultural Responsiveness: Incorporating Culture in TF-CBT

In delivering TF-CBT to participants, counselors demonstrated cultural responsiveness in a number of ways. First, counselors discussed being open to and aware of the cultural norms that impacted the lives of participants. They also discussed aspects of TF-CBT that promote cultural responsiveness and enabled them to present TF-CBT materials to guardians as an approach to interactions with their children that could be integrated into the participants' social and cultural context.

Importance of cultural norms ($n = 9$). Cultural norms can be defined as "the specific cultural expectations for how to behave

in a given situation" (Andersen & Taylor, 2012, p. 33). Three-fourths of the counselors highlighted several cultural norms that were important to be aware of and described how they responded to these norms in their presentation of TF-CBT components. One of the most commonly mentioned cultural norms related to praise, one of the parenting skills taught in TF-CBT. Prior to the TF-CBT intervention, praise was used infrequently and not typically viewed as an acceptable parenting strategy:

> So many of them say like praise it was difficult for them to praise the children. Because first of all, their custom, their culture, they do not accept that praise because . . . when you praise a child, the child can become tough-headed . . . he will not do what he's supposed to do.

Another cultural norm frequently discussed was the use of physical punishment. TF-CBT teaches guardians that consequences other than physical punishment can be more effective, such as removing privileges or things that the child enjoys (e.g., toys). This parenting skill was initially difficult for guardians to accept and understand, as physical punishment was a common behavior management technique in their culture (e.g., one counselor stated, "we believe that the child must be punished by giving a stroke if the child is behaving badly").

Counselors also described the challenges associated with getting participants to express their feelings, noting that in their culture, feelings often go unrecognized (e.g., "Sometimes even sadness does not have a term in their native language"). Counselors noted that typically it is not culturally appropriate to discuss death or talk ill of the deceased (e.g., "You are not supposed to discuss or talk about any event that relates to the death because you study the soul and you are studying the resting"). This norm presented challenges for some of the TF-CBT components such as resolving ambivalent feelings (i.e., "What I Miss and Don't Miss"), in which children were asked to discuss positive memories and interactions as well as upsetting memories (e.g., seeing a father beat the mother) or interactions (e.g., being yelled at) with their deceased parent.

To overcome some of these challenges, counselors acknowledged and respected differences while encouraging participants to try the skills being taught, explaining to them that TF-CBT can help to make positive changes in their lives:

> Okay then, the component of talking about discussing memories in the culture, maybe people are told that you are not supposed to discuss or talk about any event that relates to the death because you study the soul and you are studying the resting. So, when we are teaching this component, we tell them that we respect their culture and we respect the community of your beliefs of thinking that you are not supposed to talk about dead people, the stories that are about them when they are alive. But we tell them that it is okay for us to talk about these things because if you talk, then you are going to heal.

Counselors also connected many of the skills that were being taught in TF-CBT to behaviors and actions that were already occurring within the community:

> If you connect them to the community, they will get it . . . like praise because the common thing is somebody does something good most of the time, they are praise[d]. Yeah, and consequences. It was also fitting in the community because you could see if you are telling the guardians, they could say, "Yeah that at some point, we do that."

In connecting the components of TF-CBT to the cultural beliefs and practices of the community, participants were able to see that many of the skills being taught were not completely different from what they were already practicing, nor were they completely new concepts (e.g., "for those that you are teaching, at some point you could connect them with the cultural beliefs in the community and they will see that it is something that it is not like new from nowhere"). Counselors discussed providing culturally relevant examples and using metaphors while teaching as a way to further incorporate TF-CBT skills within the local culture (e.g., "By giving examples that are appropriate and maybe as I'll be teaching, I'll be demonstrating many things and talking about our cultural beliefs"). Counselors provided examples of metaphors they used to make the information clearer for participants:

> So I had to use some of the stories of CBT like the story of the wound or the story of the sprinter so I had to use those ones so that they can understand. I think it is the best way to make it so that they can get used to the situation more than hiding it.

Counselors' awareness and responsiveness to cultural norms was clearly described. In particular, welcoming these norms and being flexible and creative in the delivery of TF-CBT content in response to these norms was echoed throughout.

Approaching and presenting new concepts ($n = 8$). Many of the counselors described how they approached and presented these new skills to guardians, with attention to helping and supporting guardians in integrating these components into their lives. One approach described by counselors was to first ask the guardians what strategies they were currently using to accomplish a particular goal (e.g., improve child behavior; provide emotional support to children around the parent's death). By starting here, counselors were more equipped to assist them with incorporating the TF-CBT skills into their existing strategies and practices, respecting the guardians' expertise and highlighting these skills as different and effective rather than *right*, or the only option, which may imply that what the parent/guardian was already doing was wrong:

> So, at that point, I call the parent and ask the parent to tell me how he had done it . . . then I can see where the faults were . . . so having learned about the faults it is easier now to call the child and ask, "now can you do it as we watch" . . . because you do not want to fault the parent, we *do not want to tell the parent that you did it the wrong way*, but the child now appreciates the different way that now the parent or guardian is now doing it. Then we tell them, you can move on like that, next time I believe there will be a difference. . . .

Similarly, counselors stressed the importance of asking guardians what parenting skills, specifically, were currently being practiced in their culture and community. In doing so, guardians could reflect on how well those practices have worked, and how TF-CBT skills could be integrated into these practices:

> So maybe first of all we should ask the community, we should know what they do- what do they use and which system do they use for parenting; we should learn from them which system are they using and then assess the systems if they're healthier to the child, if they are good for the child's development, so we will pick the good ones and maybe add [to] them so they can become the best two systems.

Several other approaches were used to present new concepts. Counselors described having a friendly and open demeanor:

> It's just . . . being friendly to them, telling them that I am young but they should not be caring of me, they should not worry about me, just being friendly, talking to them as my parent, treating them equally, allowing them to be free talking to me and all that.

Counselors also encouraged guardians to participate in session, praising them for their current practices as a way to support and encourage them to integrate the new components into their lives (e.g., "If they tell me what they've been doing, I will praise them, then I'll give them the new technique. . . ."). When presenting new ideas to guardians that were challenging for them to understand, the counselors made sure to take additional time to explain these new ideas (e.g., "I took much time to show them the importance [of not hitting the child] and to encourage them to practice so that they can see the outcome more clearly"). Counselors also described being attuned to participants' experience of learning new components, with one counselor describing planning how to deliver TF-CBT content in a way that would help participants "feel happy":

> Before I used to take long time to make them more understandable, more elaboration to give more example, make more practice so that they are going to understand . . . maybe should replan so that they feel happy.

Usefulness of TF-CBT ($n = 12$). All 12 counselors discussed how TF-CBT was useful to guardians and how these skills could be practiced within the local culture. For example, despite some of the initial challenges in getting participants to express their feelings, counselors described how TF-CBT allowed them to do so, which was extremely beneficial (e.g., "But in TF-CBT, they get the chance to talk about death, which is like letting go what they've been having in them"). By allowing guardians to express these feelings, the counselors described how TF-CBT has changed the cultural norms and beliefs surrounding death and grief:

> I remember one of the guardians, or two of them, they were saying that before coming to TF-CBT, they could never talk more openly about the death of their beloved ones and now they're talking about it, even discussing what happened, even that they're connected to the dead, they're free to talk about it . . . so CBT in one way or another it has helped us change the whole society, the whole community around us, even the way the culture that we have about the grief.

Counselors also noted the changes that they saw in the guardians because of TF-CBT, which led to positive changes in the children:

> . . . you see a very big change in the child and the parent in fact the parent says that "through this child, I've seen a lot of changes and no-not grieving a lot because, before we started the sessions, it was very hard for me, it was very hard to do *A*, *B*, *C*, *D*" . . . So we saw that in the parents it was also working very well and you see when there's a change in the parent, they're able to help these children.

Furthermore, counselors described high appreciativeness from guardians regarding learning these skills and seeing positive changes in their child's behavior:

> When I talked about the parenting skills component, praise, effective instructions, rewards and others . . . when I talk to guardians, most of the guardians are more happy because they didn't know about that. When they go to their home, they went to their home . . . they stay with their children and did the homework I give them you know? We continue with the session, maybe we are in Session 8. Most of the guardians appreciate about their changes, you know? They used to tell me that their children at the beginning, they were having a bad behavior but now that TF-CBT, it helped them because their child has the good behavior.

Last, counselors described using the parenting skills with their own biological children, with positive effects (e.g., "I am also practicing [the parenting skills] with my [child] and I can feel some good behavior from my [child] so it really helps me").

Social and Economic Circumstances: Attending to the Importance of Basic Needs

Social determinants of health, in particular the unmet social and economic needs of participants, were noted by counselors as challenging to the delivery of TF-CBT in a manner responsive to participants' context. Counselors commented on some of the specific circumstances that participants faced, and how these circumstances influenced TF-CBT implementation. They also discussed their own personal struggles in seeing some of these unmet needs, and provided recommendations for how to attend to these needs in order to ensure that TF-CBT is responsive to the context and conditions faced by participants.

Social and economic barriers to TF-CBT delivery ($n = 9$). Specific social and economic needs of children and guardians who participated in TF-CBT were highlighted as barriers to intervention delivery. Counselors frequently commented on the fact that the children lacked money for school-required purchases such as uniforms and examination money:

> So five in the morning she [child in TF-CBT] starts walking up to school, she doesn't have a uniform, they test away from school because of the examination money. And even some of them when they were coming to the sessions, they were telling us that week they've not been in school. They have not done any exam because they do not have that examination money.

Counselors also described how some of the participants' unmet social and economic needs became apparent during TF-CBT, and provided examples of actions they took to help:

> During the individual visits, we realized that most of the children, they come from poverty but it gives us a chance to see they did not have food to eat, because the children are supposed to come to the session, so before the session we normally give them a snack or food to eat. But where they come from, they come from poverty background.

Challenges unmet needs caused for counselors ($n = 4$). The impact of witnessing the social and economic needs of participants that often go unmet was discussed as something that weighed on some counselors and made it difficult to implement TF-CBT at times:

> Many in our community are affected by poverty so sometimes it is hard to fulfill basic needs of the child, like food. A mother cannot feed, her child eats only one meal for a day, and it is [a] struggle . . . to make sure the food is on the table because of poverty.

Having to face the social and economic realities of having HIV or having a family member with HIV was also something that many participants faced. Counselors went on to explain that although they had a desire to help participants, they were not necessarily able to do so within the research study, which was testing a specific, short-term mental health treatment (note: counselors were not able to provide additional supports themselves but referred families with needs to the local study coordinator for additional support/safety assessment and linkage to community agencies). This was something that was hard for some counselors:

> Sometimes they also challenge to us, because you get touched. . . . So like—Sometimes you feel that you want to help them [children with things such as school fees and clothing, as discussed earlier]. But now you are not allowed to do that. So it was very challenging to us . . . when I was going to the individual visits, I got many challenges because, for example, the surroundings where those people are coming from. . . . So like in the session when they come- you know you are very touchy, you want to help that child but you cannot. So to me it was very challenging.

Given the guardians' lack of economic resources, the counselors encouraged the guardians not to spend money when implementing the parenting skills. In teaching guardians "Rewards and Special Thanks" as a way to increase positive behaviors in their children, counselors made sure to emphasize the fact that these rewards should be small and do not need to be bought (e.g., free play time):

> I kept on encouraging them it is not a must that it is something that will cost you. You can choose a thing that is common or something that you can find easily in the . . . home so that you can reward your child and . . . maybe encourage them to do that.

During Christmas time, guardians often spoke of wanting to buy presents and material goods for their children. It was particularly challenging during this time for counselors to encourage the guardians to consider nonmonetary ways to help children feel cared for and loved, as many children noted in session that Christmas was an especially hard time to think about their parent's death:

> Most children wanted their parents to buy them gifts like a dress for Christmas or good food or buy so many gifts but to me, I kept on encouraging the guardians of the children that I know it is important for you to get a Christmas dress but you know the economy, maybe that money, you have to save that money for your school fees so that you can do something good that is going to the child or maybe visiting a friend or relative in the country. So, it was very hard for me, individually, to encourage the child that they do not really need that big gift, or that they do not really need that dress for the Christmas time.

Partnerships with other organizations to address social and economic needs ($n = 6$). Some counselors highlighted the importance of partnering with other agencies/groups to address the varied needs of participants, which included both mental health and social and economic needs. Thus, even if TF-CBT could not directly address these needs, there were still opportunities for participants to receive help. Counselors indicated that the study referral system was beneficial in directing guardians to services that could help children with school-related purchases (e.g., "We have some other programs within our organization that could bring [help with school fees] so that we could just refer them to such a program in the organization that they can get such help").

Similarly, counselors also described such a referral system as beneficial for other economic needs, like shelter and housing (e.g., "We told them that the TF-CBT cannot address the problems of housing, shelter, food . . . we forward them to . . . other people who can help them"). A need for additional links to organizations that provide other social and mental needs (i.e., beyond support for basic needs) for children was described as a recommendation for the future (e.g., "Other suggestions . . . maybe if we can link with other organizations . . . for more recreation for the children").

Discussion

The purpose of this study was to explore how lay counselors in Tanzania and Kenya delivered a child trauma evidence-based treatment (EBT), TF-CBT, in a culturally responsive manner to children experiencing mental health symptoms after the death of a parent and to their guardians. Facilitators and barriers, as well as strategies used by lay counselors to ensure cultural responsiveness, were explored. The counselors described the importance of cultural norms in delivering TF-CBT, indicating that many of the skills being taught were initially difficult for participants to accept and understand. However, when the TF-CBT lay counselors related TF-CBT skills and concepts to activities and behaviors already occurring within the community and to participants' goals, TF-CBT participants were able to accept and apply new skills and techniques as well as recognize the connection between many skills they were learning and familiar approaches within their community. Lay counselors made a point of taking the time to assess and respond to current cultural norms and practices, helping participants to integrate the skills being taught through TF-CBT with their cultural norms. Counselors were intentional in being culturally responsive and described specific techniques that enhanced this approach such as using metaphors, in-session practice that accounted for participants' context, and linking content to participants' goals and existing practices.

Notably, all counselors (12/12) also described the usefulness of TF-CBT for both the lives of participants and their own, indicating that participants' cultural norms surrounding certain topics (e.g., death and grief) had been positively transformed. Potentially most indicative of TF-CBT acceptability and adoption, counselors reported using the TF-CBT skills with their own biological children. Counselors noted positive changes in the behavior of children who received TF-CBT, from both their own observations and from guardian reports. Interestingly, counselors did not talk about making substantial adaptations to the TF-CBT intervention (e.g., removing TF-CBT elements; needing longer overall treatment duration to teach TF-CBT). This finding is inline with other work on TF-CBT (Murray, Dorsey, et al., 2013; Murray, Skavenski, Michalopoulos, et al., 2014) and other studies examining implementation of other evidence-based psychosocial treatments (e.g., Kaysen et al., 2013). Lastly, the social and economic circumstances with which participants were faced posed challenges to TF-CBT delivery. It was difficult for some counselors to witness the challenging social and economic conditions that many of the participants faced without being able to directly assist them. This highlighted the importance of implementing strategies suggested in the literature such as providing networking opportunities and partnering with

other agencies and groups that could help to address some of these conditions and needs. Findings suggest that future research examining if self-care and peer support for counselors coupled with training and supervision in how to respond effectively to participants' needs enhances EBT implementation. Indeed the value of having a team was noted in our study (e.g., "I could come back here and maybe share with my team and ask them to maybe elaborate to make some things that I'm not very clear and it helps me a lot."). Future research expanding upon this to better identify important training and consultation team characteristics is needed.

Cultural Humility and Responsiveness

Cultural humility was evident throughout the descriptions lay counselors shared regarding their approach to delivering TF-CBT. The seminal definition of cultural humility provided by Tervalon and Murray-Garcia (1998), "commitment and active engagement in a lifelong learning process that individuals enter into on an ongoing basis with patients, communities, colleagues, and themselves", was evident not only in counselors' discussion of the strategies they used to deliver TF-CBT, but also in their critical self-reflection regarding facilitators and barriers to this process. A recent concept analysis that reviewed 62 articles on cultural humility identified the following common attributes of cultural humility across studies: openness, self-awareness, egoless, supportive interaction, self-reflection and critique (Foronda, Baptiste, Reinholdt, & Ousman, 2016). Lay counselors consistently embodied these attributes of cultural humility in their approach to TF-CBT implementation through respecting, acknowledging, and learning from cultural norms and practices as they introduced new skills and techniques to TF-CBT participants. Through lay counselors instituting an overall approach of ongoing colearning, TF-CBT participants experienced benefits of the new skills and strategies they were learning, found ways to integrate these skills and strategies into their lives in a sustainable way, and actually influenced cultural norms.

In addition to lay counselors' culturally humble approach, several components of TF-CBT itself, and CBT more generally, naturally lend themselves to cultural responsiveness. For example, relaxation and affective modulation can incorporate a variety of activities that accomplish the same goal, but are tailored to what an individual finds worthwhile and helpful (e.g., local child games for improving mood). The imaginal exposure component (i.e., trauma narrative) can be conducted in a variety of creative formats (e.g., narration, drawings, writing) in order to fit specific needs, interests, and abilities. Furthermore, the examples used to teach any of the TF-CBT components may be updated to reflect locally appropriate examples, metaphors, and idioms. When teaching the parenting skills, counselors were encouraged to tell a short story at the beginning of each group to elicit group thoughts about how the specific skill was appreciated and effective (i.e., increased behavioral recurrence) even in adult interactions (e.g., Praise: being told a meal was delicious [the meal is made again]; Rewards: being given two tomatoes after assisting a friend with selling produce in the market [would likely help the friend sell again]).

Lay Counselor Support and Self-Care

Our findings suggest that lay counselors may need support to deal with their own emotions when working with children who not only have mental health problems and have experienced parental death but who also experience substantial economic adversity. One potential barrier to task-sharing approaches noted in the Padmanathan and De Silva (2013) review was distress experienced by lay counselors themselves. Anecdotally in our own work supporting lay counselors to deliver TF-CBT, hearing children's stories about their parents' deaths, particularly the first few, can be very impactful. In the pilot study, the last author (SD) was on site to support lay counselors in this work. The literature on secondary traumatization offers some strategies, such as encouraging a team approach to care, providing regular supervision that includes problem-solving difficult situations that arise related to participants' needs, fostering supportive working relationships among colleagues, building a safe work environment, providing training on secondary trauma, developing written plans for work-life balance, and networking with colleagues (Padmanathan & De Silva, 2013; Ray, Wong, White, & Heaslip, 2013; Salloum, Kondrat, Johnco, & Olson, 2015). Our findings support future research examining the effectiveness of these strategies in helping counselors deal with impact of being exposed to the ongoing economic adversity. Indeed counselors reflected on the use of some of these strategies such as accessing networks to be able to refer families for additional services. Procedures for identifying local resources and building safety plans and procedures into EBT implementation described in recent publications (see Betancourt et al., 2014; Murray, Skavenski, Bass, et al., 2014) are needed. Interestingly, community members still seem to prioritize mental health needs (see Dorsey et al., 2015) even in the context of ongoing adversity supporting the development and implementation of multilevel interventions.

These findings should be considered within the context of a few study limitations. First, the sample size was small, consisting of only 12 counselors. Second, given the small sample, we could not examine any differences by country (i.e., Kenya vs. Tanzania). Third, although TF-CBT has robust evidence of effectiveness in the United States and growing evidence of effectiveness in LMIC (e.g., Murray et al., 2015), the results from this randomized controlled trial of TF-CBT are forthcoming, as such, the effectiveness of TF-CBT in Tanzania and Kenya is unknown. Finally, TF-CBT was conducted in Kiswahili, but the research interviews for this study were conducted in English. Counselors are fluent in both languages; however, the language differences could have impacted counselors' ability to convey some of their experiences with TF-CBT.

Conclusions

This study sought to better understand how lay counselors deliver TF-CBT to families with particular attention to (a) facilitators and barriers to delivering TF-CBT in a culturally responsive manner and (b) lay counselor strategies, characteristics, and behaviors related to culturally responsive TF-CBT delivery. Although barriers around culturally incongruent components (e.g., how to respond to death and grief; use of praise with children) and social and economic challenges were noted, numerous facilitators and strategies were identified that enabled culturally responsive delivery of TF-CBT, including (a) adopting a culturally humble approach, (b) recognizing the flexibility within the intervention to be culturally responsive, (c) attending to participants' social and

economic needs and challenges, and (d) building networks and partnerships to address needs that TF-CBT does not specifically target. Future research to examine the impact of intentionally incorporating these facilitators and strategies into EBT implementation in LMICs is warranted.

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