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Psychotherapy in a Resource-Constrained Setting: Understanding Context for Adapting and Integrating a Brief Psychological Intervention into Primary Care

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Abstract

Low- and middle-income countries have few mental health professionals, and efforts to increase access to treatment are a global priority. A key gap is the lack of integration of psychotherapy interventions as a part of accessible evidence-based care. Current recommendations suggest that the integration of mental health treatments, including psychotherapy, into existing primary care pathways may serve as a means to address this disparity. Understanding the cultural and contextual factors that affect this process is a critical step in identifying necessary adaptations. The aim of this qualitative study was to identify contextual factors associated with integrating psychotherapy in primary care in a predominantly rural district in south-central Ethiopia. Purposive sampling was used to recruit 48 mental health service users, caregivers, health care providers, and

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community leaders. Semi-structured interviews were conducted, recorded, and transcribed in Amharic and translated into English. While challenges (e.g., stigma, job strain, lack of belief in formal treatments) are present, other existing strengths (e.g., openness to seeking treatment, increasing knowledge about mental health treatment, familiarity with practices similar to therapy) support subsequent psychotherapy adaptation and implementation. These findings suggest possible mechanisms to improve delivery and adaptation in the effort to lower the existing global treatment gap.

Keywords

global mental health; psychotherapy; low- and middle-income countries; Ethiopia

Increasing access to evidence-based mental health care is a primary focus of many international and federal organizations around the world (Collins et al., 2011; Patel et al., 2018; World Health Organization [WHO], 2013a). The need for services is particularly acute in low- and middle-income countries (LMICs), where the treatment gap between those who need services and those who receive them often exceeds 80% (Eaton et al., 2011; Wang et al., 2007). Most LMICs have few trained mental health specialists (Kakuma et al., 2011), resulting in psychological care often being delivered via task-sharing (i.e., having providers without specialized mental health training deliver mental health interventions) (Padmanathan & De Silva, 2013; Van Ginneken et al., 2011). Research advances in this area have successfully demonstrated the effectiveness of task-shared models of psychotherapy in LMICs (e.g., Chibanda et al., 2011; Galárraga et al., 2017; Rahman et al., 2016; Singla et al., 2017).

As government-supported primary care services are commonly available in LMICs, these settings may be a sustainable, accessible environment in which to provide mental health care (Beaglehole et al., 2008; Mayston et al., 2015). Indeed, past efforts demonstrate the feasibility and effectiveness of integrating mental health care for common mental disorders (i.e., depressive and anxiety disorders) into primary care in LMICs (Araya et al., 2003; Patel et al., 2010) and for severe mental illness (SMI; i.e., psychotic, bipolar, and severe major depressive disorder) in high-income countries (HICs) (Gilmer et al., 2016, Scharf et al., 2013). Stemming from these successes, delivering psychotherapy in primary care settings is a reasonable next step.

As a foundational step, critical analysis of the application of Western-developed psychological practice into diverse global settings is a key consideration. Existing critiques in the literature frequently revolve around the challenges inherent in implementing psychotherapies rooted in beliefs about psychopathology and ideas of effective psychological interactions from Western perspectives into non-Western cultures (Kidd et al., 2016; Kirmayer & Pedersen, 2014). There is evidence to suggest that greater attention to cultural and contextual factors is needed (e.g., Rosso Buckton, 2015), and that many current efforts do not give enough weight existing methods that promote community coping (Kirmayer & Pedersen, 2014) or overly focus on only individual effects of mental illness, while neglecting to attend to impacts of mental illness on community and group

levels (Fernando, 2012). Necessarily, interventions that lack cultural relevance increase the potential for harm (Kirmayer & Pedersen, 2014).

Instead, current recommendations support finding a "global-local" balance, described as the process of attending to cultural and contextual factors when assessing, designing or adapting, and implementing projects (Kidd et al., 2016; Kirmayer & Pedersen, 2014; Patel, 2014). This is largely achieved by closely collaborating with local community experts, including service users, who are best poised to articulate how to integrate global scientific knowledge and local community context (Campbell & Burgess, 2012; Jock et al., 2013; White, Jain, & Giurgi-Oncu, 2014). Berry (2013) describes this as a derived etics approach, such that it is an "imposed etic approach (the use of Western psychology in other cultures), followed by an emic search for local phenomena… and finally the use of derived etic approach [that] create[s] a global psychology that is valid for that concept or topic" (p. 59). Additional emphasis on local concepts that describe and define mental illness is also important for developing subsequent screenings and interventions that are contextually appropriate (Summerfield, 2008). In part, this may require deeper adaptations to interventions in order to account for cultural, spiritual/religious, and historical aspects of societies that influence mental illness (Bernal, 2009; Castro, Barrera, & Holleran Steiker, 2010). Growing evidence supports that enhanced effectiveness of interventions that are appropriately adapted and contextualized as compared to those that conceptualized as a "one size fits all" approach (Benish, Quintana, & Wampold, 2011; Maura & Weisman de Mamani, 2018).

In any setting, understanding contextual variables is a key aspect of successful delivery of psychotherapy and may be especially critical in LMICs, where psychotherapies developed in high-income countries (HICs) are often adapted to meet local needs (Divan, 2017). A growing body of work demonstrates the effectiveness of this practice (Meffert et al., 2016; Murray et al., 2013; Singla et al., 2017), with common adaptations including altering therapy content (e.g., addition or adaptation of certain information) and/or the form of program delivery, such as changing the location of therapy or changing the type of providers (Castro et al., 2004). However, adaptation first requires expert knowledge of a given local context, in order to inform necessary modifications.

Difficulties associated with initiating psychotherapy interventions are present in HICs, yet they are disproportionately present and more challenging in LMICs (Saxena et al., 2007). Examples include lack of specialized mental health professionals (Divan, 2017; Hanlon et al., 2016), limited task-shifted worker confidence in the ability to deliver care (Padmanathan & De Silva, 2013), and lack of private space for mental health interventions (Mendenhall et al., 2014; Padmanathan & De Silva, 2013). For patients, long wait times at clinics (Topper et al., 2015), lack of familiarity with psychotherapy and psychotherapeutic approaches (Mayston et al., 2015), and transportation issues (Chatterjee et al., 2008) may challenge typical Western psychotherapy models of weekly therapy sessions. Though not an exhaustive list, these are types of variables and associated challenges that may necessitate psychotherapy adaptations.

The aim of our study was to evaluate the cultural and healthcare context in a rural setting in Ethiopia. Data collection was designed to improve understanding of current health service utilization and service delivery, as well as barriers and facilitators to implementing psychotherapy in Ethiopian primary care. For this study, context is considered to be the setting in which the psychotherapy intervention will be implemented in the future (i.e., the primary care clinic), in addition to the broader cultural environment (Kitson, Harvey, & McCormack, 1998; Nilsen & Bernhardsson, 2019).

Method

Design and Setting

A qualitative study was undertaken using semi-structured interviews with key stakeholders. In Ethiopia, there are very few mental health providers (e.g., only one psychiatrist per two million people), and mental health services are sparsely available outside of the capital, though primary care is available throughout the country (Federal Democratic Republic of Ethiopia Ministry of Health, 2012). In rural settings, such as in this study, primary care clinics are staffed by health officers and nurses with little training in mental health (Abera et al., 2014). Rural populations commonly face barriers to primary care, including low literacy rates and large distances to clinics (Lund et al., 2012). Sodo district, the setting for this project, is located south-central Ethiopia and is located approximately 100 kilometers (62.137 miles) from the capital. Subsistence agriculture is the main economic activity in the region (Kebongo, 2011).

To begin meeting countrywide need for increased access to mental health care, researchers in Ethiopia previously conducted a multi-country research program entitled the PRogramme for Improving Mental health carE (PRIME), which investigated the implementation of integrated care in primary care for people with priority mental health conditions. The goal of PRIME was to generate evidence on the implementation of packages of care for priority mental disorders in primary and maternal health care contexts in Ethiopia, India, Nepal, South Africa, and Uganda (see Lund et al., 2012 for further details on the development of PRIME and additional goals, such as capacity building). In PRIME, a participatory process was followed to develop district level mental health care plans (Fekadu et al., 2014; Fekadu et al., 2016; Lund et al., 2012). Task-shared care for people with SMI in PRIME included diagnosis, initiation of medication, basic psychosocial support, ongoing follow-up and community support. Through this program, community health workers were trained in the WHO mhGAP project, which offers training in delivering mental health and substance use treatment to non-mental health professionals (WHO, 2013b) and increased their exposure to individuals with mental illness.

Participants

Purposive sampling was used to recruit stakeholders from the catchment area of eight Sodo district primary care clinics in rural Ethiopia. All mental health service users (MHSUs) were drawn from a pool of individuals who had previously participated in the PRIME study. Eligibility for this qualitative study included participants being at least 18 years old, able to provide informed consent, able to complete procedures in Amharic, and having

no suicidal or homicidal ideation or a suicide attempt within the past 30 days. MHSUs were further required to receive treatment at a Sodo district primary care clinic or primary hospital, be able to participate in 30 to 60-minute long interview, and provide informed consent to audiorecord that interview. Caregiver participants were identified by MHSU as a close family member or friend, aged 18 years or older, who was involved in supporting MHSU participants. Health care provider participants included those working at district health facilities or in community-based care who engaged in tasks including providing care for or supervising the care of MHSU with mental health concerns. Community and religious leader participants were members of the PRIME community advisory board or were identified through the PRIME project's traditional and faith healer mapping (Selamu et al., 2015). After providing informed consent, each MHSU and caregiver participant in this nested qualitative study was compensated 100 ETB (equivalent to $4.80) for their time and reimbursed for travel costs.

Forty-eight participants enrolled in this study (see Table 1 for demographic characteristics), including MHSU with severe mental illness (SMI) ($n = 13$), caretakers of individuals with SMI ($n = 13$), health care providers ($n = 13$), and community and religious leaders ($n = 9$). All participants were from the catchment area of eight Sodo district primary care clinics in rural Ethiopia. Participants identified a variety of factors associated with integrating psychotherapy into primary care in Ethiopia. Themes were clustered broadly into systems, community, and individual levels. Please see Tables 2 and 3 for descriptive examples of each theme.

Data Collection Procedures

Depending on literacy, written or verbal consent was gained from participants. Interview guides were developed based on existing literature and preliminary studies conducted by the authors. Several community members and local staff (i.e., Ethiopian psychiatrists and public health professionals, as well as an international psychologist and psychiatrist) with expertise in mental health research provided feedback on the interview guide protocols. The interview guides were developed to assess mental health symptoms, health service utilization, and barriers and facilitators to implementing psychotherapy in Ethiopian primary care. Four interview guides were developed (caregiver, MHSU, provider, and community member) (see Appendix). The semi-structured interviews included open-ended questions to facilitate inductive analyses and more specific probes related to *a priori* clinically- and culturally-relevant characteristics, and MHSU-, provider-, and facility-level barriers to, or facilitators of, implementation of psychotherapy. While additional questions were asked about specific experiences related to trauma, this manuscript focuses only on the implementation of psychotherapy broadly into the existing health care system (i.e., is not specific to trauma-focused interventions). All interviews were conducted in Amharic by an interviewer bilingual in English and Amharic at primary health care centers in Sodo and South Sodo districts in Ethiopia. Interviews were audio-recorded, transcribed, and translated verbatim into English by bilingual translators. Each week, the transcripts were reviewed to identify emerging themes, to modify the interview guide as needed, and to assess theoretical saturation. Data were collected from November 2, 2017 through May 18, 2018. All study

procedures were approved by the Addis Ababa University College of Health Sciences Institutional Review Board (IRB) and the Boston University Medical School IRB.

Data Analytic Procedures

We followed guidance from the Reporting Standards for Qualitative Research (JARS–Qual Working Group) to collect, analysis, and report data from this study (Levitt et al., 2018). Data analysis was an iterative process and followed descriptive qualitative thematic content analysis procedures (Bernard, 2011; Hsieh & Shannon, 2005). This qualitative study was a descriptive category study with the goal of formulating descriptive categories of barriers and facilitators based on inductive content analysis. Methods included using both a "conventional" inductive approach and a "directed" a priori approach to the content analysis in order to facilitate analyses related to the central research questions (Hsieh & Shannon, 2005). Concepts that emerged from the data were used to develop a codebook consisting of a label, a definition, and illustrative quotes from the data. Data analyses were completed in NVivo 12.0. Initially, coders coded at least five interview transcripts collaboratively and assessed inter-rater reliability. Building upon previously identified themes, coders re-coded interviews with specific focus on implementation barriers and facilitators. Final themes were agreed upon in consultation with fellow authors. Data was examined in ongoing discussions to allow for further theorizing and making connections between research questions, coding categories, and raw data.

The coding team was comprised of researchers from the United States and Ethiopia, several members of the team had extensive lived experience in Ethiopia or were Ethiopian. The team's educational background ranged from bachelor-level students to PhD-level clinicians and researchers, with specific expertise in psychology, psychiatry, and public health. To ensure that our respective backgrounds and perspectives were appropriately managed and were not inappropriately impacting data analysis, we routinely met as a team to discuss our coding process. This opportunity allowed us to discuss any differing cultural perspectives or varying understandings of the texts, as well as check for any personal or professional biases that may have colored our coding process.

Results

We identified relevant themes at the healthcare system, community, and individual levels. In this analysis, the healthcare system level includes any factor associated with the provision of professional services (and may include variables associated with individual providers or broader issues, such as appointment timing). Community level factors were conceptualized as issues that are common or generalizable to the general population and have impacts beyond a single individual (e.g., poverty). Finally, individual level factors were considered to be variables associated with personal experiences or preferences (i.e., they are unique to individuals).

Identified Barriers

Systems level.—Participants identified a variety of healthcare system variables with specific implications for the provision of psychotherapy. Typically, these factors were in

reference to healthcare workers and indicated practices that may challenge establishing a strong psychotherapeutic working alliance. Examples included concern about healthcare worker approach ($n = 5$), including poor listening skills ("professionals… have a gap in developing listening" (Healthcare Worker)) or using a harsh tone with patients.

Participants ($n = 15$), including healthcare workers and community members, described that while healthcare workers had received some education or training related to mental health treatment, there is an ongoing perception that healthcare worker current knowledge is not adequate.

> I don't think I have enough knowledge on the area. When I was in school, we learned about psychotherapy but didn't get to practice it. In schools, we are concerned about the grades only, so we only focused on the theory. I am working now, not by the knowledge acquired from school, but from the work experiences we get. So, I don't think the knowledge is adequate.
>
> (Healthcare Worker)

Healthcare workers ($n = 6$) described concern about possible job strain that might occur if conducting therapy was added to their current roles.

> It important to know that psychotherapy spend[s] a lot of time. If a heath officer gives more focus on it, he or she spends a lot of time, and this leads to not making himself accessible, and not [doing] what needs to be done to others. Since there is a shortage of health officers, this [does] not fulfill the targets.
>
> (Healthcare Worker)

Finally, participants also described logistical issues in the healthcare system that may make it challenging to provide confidential, comfortable, or convenient psychotherapy services. Most commonly, concerns related to lack of space ($n = 6$), waiting times ($n = 5$), or the location of services ($n = 5$), were noted.

> There are conditions in the hospital which are not convenient. The area where it is located is not that convenient. His room is not convenient. (*The psychiatric nurse's?*) Yes. The room is not that convenient for his service. I think it would be better if he is given a separate place.
>
> (Healthcare Worker)

Community level.—Participants identified community level factors, including conflicting beliefs about the cause or treatment of mental illness, mental health related stigma, and poverty, that could inhibit psychotherapy-seeking behaviors. Participants ($n = 12$) described possible conflict between formal mental health treatment and religious or spiritual practices, often due to beliefs that causes of mental illness are associated with sin or evil spirits. Additionally, interactions between these beliefs were also perceived to result in heightened mental-health related stigma. Participants ($n = 17$) indicated that attempts to minimize stigma often resulted in efforts to hide individuals with mental illness, rather than seek treatment.

> There is this tendency to hide the issue and sit on it… it might be not even thinking that it is something that can be cured or treated. So, what should be done is [helping] the people into the thought that they should come to a medical solution. I don't think hiding it is good, because when [people with mental illness] need to be treated but are made to stay at home locked up. Many people are growing up without anyone else knowing they exist.
>
> (Community Advisory Board member)

Respondents ($n = 5$) also described challenges to seeking mental health treatment that stem from financial worries, including deep poverty, which may be a barrier to seeking routine treatment.

> First of all, the place where therapy is given might determine it [if people are able to seek routine therapy]. For example, if it's only here at the center that therapy is given, and the patient is in a far away remote sub-district ['*kebele*'], one is unlikely to come. Often times, those families who have a mental health problem are also living in poverty, and they might also need to care and give support to them.
>
> (Community Advisory Board member)

Individual level.—Individual-level barriers to seeking psychotherapy were also identified, particularly associated with treatment-related variables, such as worries about confidentiality, discomfort disclosing problems or lack of belief in psychotherapy. Some participants ($n = 5$) described past experiences of having personal information shared with others, resulting in reticence to share mental health concerns with providers.

> If I tell what has happened to me to one person, that person will tell that to the other person, and then the information will be disseminated. Thus, there is no need of talking or consulting people. They might talk about things that I didn't say and they will finally judge me for what has happened to me.
>
> (MHSU)

> I told something to a friend I love, and we are the only two people who knows the story, but I heard it from someone else. My friend told [this] to another guy, and that guy told to the guy who told me the story, so I decided to keep things to myself from that moment on.
>
> (MHSU)

Other participants ($n = 8$) provided examples of discomfort that MHSUs may feel when disclosing mental health concerns to providers, particularly due to distress in re-living difficult past memories or lack of willingness to modify problematic behaviors.

> When he gets asked about his past, he says he doesn't like to be asked about his past… there was time he suffered a lot. Times he walked with the hyena day and night, times he get bitten; he had a car accident. He says he doesn't want to talk about this now; he is fine.
>
> (Family Caretaker)

> We talk to them as friends, not to make them irritated… but sometimes they didn't feel comfort[able] when asked [about] their back history. They didn't like to remember the situation.
>
> (Healthcare Worker)

> Most of the time they [MHSUs] are not open to answer these questions…. they try to hide certain things, like their drinking habits. Even when you ask their families, they will tell you a different answer that is contrary to the patient's statement. But the patient tries to hide these things… it is probably from fear that we are going to push them not to drink anymore, and they do not think it is for their own good.
>
> (Healthcare Worker)

Finally, some respondents ($n = 9$) described negative thoughts that MHSUs or their families have about seeking formal treatment for mental illness. Related beliefs included little faith that talk therapy offered much benefit in treating mental illness or a general lack of trust in the services provided.

> According to our country, most of the people come to a health facility to get a medication for their problem. They don't believe that the problem can be solved by a counseling service.
>
> (Healthcare Worker)

Identified Facilitators

Systems level.—Multiple participants described existing factors within the healthcare system that may facilitate initiation of psychotherapy. Several healthcare workers ($n = 12$) discussed their recent experiences with delivering broader mental health care, reflecting on how this exposure challenged their former perspectives on working with individuals with mental illness and reinforced their willingness to continue providing treatment.

> [Now] we all have trained in mhGAP, and we are providing mental health services. I personally had a different view about mentally ill persons. As we have been hearing things about mentally ill persons since our childhood…. I had a vague view about the illness. Even after I started working in this profession, I assumed that it would be difficult and challenging to provide the service with our capacity. But after we started providing the service, there are very good things…if we can treat mentally ill persons [in a] friendly [way], I understand that we can help them just like other physical illnesses, and they are not different from other people. They need proper treatment. Within this short period of time, I am able to understand that we can make a change.
>
> (Healthcare Worker)

This shift in perspective suggests openness to continued education and training, possibly paving the way for future delivery of psychotherapy or similar practices (e.g., providing psychoeducation).

> I think it is the way to treat a patient side by side with a drug; that is what I think about psychotherapy. In fact, it is like without the side effects; it is a tool by

which we treat people. So when giving psychotherapy, we need to include many things, like we shouldn't focus on one thing only… we are dealing with social life, spiritual life, personal life, and just basically everyday life of the individual… it is a tool that enables us, and it is a tool by which we are able to solve and tell the solution for the problem that is there.

(Healthcare Worker)

Further, though frequently lacking in formal training in psychotherapy, healthcare workers and MHSUs ($n = 16$) described a variety of counseling skills that are routinely used. Commonly cited examples included asking about: symptoms, medication compliance, past history (including obtaining getting collateral information from family or other supports); observing body language; giving homework; and providing psychoeducation. Some healthcare workers ($n = 4$) also noted past exposure to different theories of psychotherapy during their training. Participants reflected that this background offered an existing platform to build further targeted psychotherapy skills.

In addition to these existing strengths that may provide a pathway to integrating psychotherapy into existing work duties, some providers ($n = 4$) also indicated that inclusion of therapy as a work task would be a manageable addition to existing workflow, though it may depend on the number of MHSUs that are seen at a given clinic.

Community level.—Community level facilitators of note included compatibility of spiritual beliefs with psychotherapy practices, existing practices similar to therapy (i.e., advice giving), and increased mental health knowledge among community members. First, participants ($n = 6$) described ways that faith beliefs and practices can augment one another. Of note, some respondents indicated that religious or community leaders may even advocate for participation in both traditional religious treatment-seeking behaviors and formal healthcare treatments.

The major thing is, there is a place for everything. If the person is religious, no one prohibits [them] from going to modern treatment…. thus, the religious institutions give value to the modern treatment. But the major problem is there is not a system of collaborative work…. how can we harmonize both of them?… So, there is a need to work together in partnership. Both of them have acceptance.

(Community Advisory Board member)

Participants ($n = 14$) also described increased mental health knowledge observed within their communities. In turn, respondents felt that negative impacts from mental health stigma, while still present, may generally be improving, leading to increased acceptability of seeking mental health services.

But, on the contrary, as I have mention earlier, some of the community members might try to treat them [individuals with mental illness] as much as they can. There are families and community members who try to take different options to make the person get out of stress. The community might also try to get the sick person to health professionals.

(Community Advisory Board member)

Finally, respondents (*n* = 5) described practices that overlap with types of psychotherapy, particularly psychoeducation. Participants frequently noted that seeking advice is a common practice within the community, which may serve to facilitate treatment seeking at a medical facility.

> *(In this society, if someone is in some sort of problem or if he/she is in a bad feeling, usually where do they prefer to go to get the help they need?)* In our society, advice is the first thing… they will go to the nearest person and take an advice. If it is possible, they will solve it immediately.
>
> (Community Advisory Board member)

Individual level.—Participants identified concepts related to willingness to seek counseling, a sense that counseling leads to positive outcomes, and an acceptability of the timing and frequency of mental health appointments. Regarding openness to help-seeking, respondents (*n* = 31) identified benefits associated with past counseling and their perspectives on the importance of sharing concerns with health professionals.

> Regarding the service, it's advantageous. First of all, you will get to learn [about] your mind. Some ideas you will take from it and [take] with you… I, for one, would be happy if you are able to answer when I am on the wrong track. Come here - it is like this, do this and that. I need a person who does this for me.
>
> (MHSU)

> There is no problem that cannot be solved if you share it with someone. If someone went to the doctor and did not tell his symptoms, the doctor will not do anything for him. If he tells his symptoms, like I have a headache or I have abdominal cramps, he will help him. If he went to the doctor and sat silently, what could the doctor [do for] him?
>
> (Community Advisory Board member)

Respondents (*n* = 10) endorsed positive attitudes towards healthcare activities that shared overlapping features with traditional psychotherapy (e.g., asking questions about medication compliance and symptoms; providing psychoeducation).

> We both come here. Sometimes they give us advice about the problems she might face daily, and in the future, they are not causing harm. They [healthcare workers] are very cooperative. She survived till now with their support. *(What do you feel when they ask you questions like: how is your life; is she taking her medication properly; how do you feel when she is talking?)* It's ok; it's not so bad.
>
> (Family Caretaker)

> I am taking tablets. They are also giving counseling and they are coming to our village to educate us many times.
>
> (MHSU)

Overall, participants (*n* = 15) also described that engaging in formal healthcare activities, including activities similar to psychotherapy, offered benefits and assisted in recovery.

(What is the advantage and disadvantage of having the counseling service with the health professionals?) It doesn't have any disadvantage. I told you what I have in mind, and you will advise me things, so that I will get calm. For example, I just told you what I feel, and you advise me a good advice…obviously, you don't advise me a bad thing, right? Since you are talking to me patiently, I have also told you about my personal issues. I will be getting back home feeling relaxed because I talk to you about my personal issues

(MHSU)

Previously, I couldn't even walk alone. I couldn't speak; I was like crazy. I walked alone without any reason. But now, after I heard their advice, I am fine. They told me that when I get upset at home, I should go to my neighbor's house to say something. I am fine now.

(MHSU)

(What did you tell them about?) The problems I face in life, and the up and downs in my life. *(What is it like when you tell them?)* When I talk to them, I got relieved. I stopped getting worried and being stressed. I get relief from my stress… I feel like I have someone that shares my problems, and I am not alone. I feel relieved because they share my worries.

(MHSU)

Finally, participants ($n = 9$) confirmed that concurrently seeking medical treatment and faith-based interventions are not incompatible with one another. Discussants ($n = 17$) also noted availability to seek routine mental health care, including psychotherapy.

Discussion

This study offered insights into the current context in a rural Ethiopia community, specifically as it relates to future delivery of psychotherapy in a primary care setting. Overall, results indicate that, while challenges to the adaptation and implementation of psychotherapy in this setting, strong facilitators offer possible pathways upon which to build. We have identified adaptations that may be useful or required to ensure compatibility of the new intervention with the existing system. Though this study was conducted in Ethiopia, many of the same challenges related to accessing mental health care exist across low- and middle-income countries, and also in high-income countries (Singla et al., 2017), reflecting the sentiment that "in the context of mental healthcare, all countries are 'developing' to some extent" (Patel & Saxena, 2019). Mental illnesses affect individuals worldwide, and yet many individuals (including those in the United States) lack access to mental health care. Counterflows of knowledge, whereby lessons learned in low- and middle-income countries (LMICs) inform care in high-income countries, are identified as a key tool for improving knowledge about the impact of sociocultural factors on mental well-being among diverse populations (White, Jain, & Giurgi-Oncu, 2014). Investigating strategies to improve access to care in any underserved setting, including in LMICs such as Ethiopia, may offer insights into novel mechanisms to improve quality care access for individuals domestically and globally.

Factors related to service providers emerged as significant themes, suggesting areas that require preparatory intervention (e.g., provider lack of training in mental health, use of aversive counseling methods), as well as indicating existing facilitators that may allow for a smooth transition into service delivery (e.g., provider openness, provider use of skills similar to those used in psychotherapy). Particularly related to further education, similar variables have been identified in other LMICs (e.g., Gwaikolo et al., 2017), suggesting that attention to these constructs is needed in a variety of settings. To meet these needs, possible adaptations, such as modifying therapy manuals to have a greater emphasis on foundational counseling skills or providing an enhanced background explaining the concepts underlying procedures in the manuals, are warranted. Task-sharing with non-specialized healthcare workers to deliver psychotherapy and other health-related counseling is a common practice in both HICs and LMICs (Barnett et al., 2018; Hoeft et al., 2018; Kakuma et al., 2011; Padmanathan & De Silva, 2013; Van Ginneken et al., 2011) and has been identified as a mechanism to close the treatment gap globally (Patel et al., 2018; Singla et al., 2017). The considerations highlighted in this data underscore the need to bolster training to account for variations in service provider backgrounds. At the same time, healthcare workers are well-integrated in the communities that they serve, which may facilitate their role as mental health care providers. By being embedded in communities, health care workers tend to be viewed as trustworthy by MHSUs and can easily identify, assess, and offer care to those with low mental health literacy or who are reluctant to seek treatment (Petersen et al., 2011).

One area of particular note refers to the function and utility of counseling in a novel context; namely, what does formal psychotherapy mean for individuals who have minimal exposure to this concept? Some of the practices endorsed by MHSUs and community advisory board members, such as disclosing problems and seeking aid from others in the community, parallels aspects of clinical counseling. However, questions remain about the extent to which individuals grasped the concept of psychotherapy, as commonly described in Western contexts; in turn, healthcare worker understanding of formal psychotherapy remains under-explored. For example, while many participants (MHSUs, family caretakers, community advisory board members) in this study referenced "advice giving" when discussing common practice in meeting with healthcare providers or when asked about current services received. While advice giving is typically not a mainstream approach in Western psychotherapy, it appears that this approach is often well-received by MHSUs in Ethiopia. Familiarity with receiving information and directive advice has parallels with psychoeducation, which is commonly employed with success in LMICs (Singla et al., 2017), and other literature has similarly noted that counseling outside of Western contexts has a greater emphasis on didactic instruction (Hurley et al., 2017). Similarly, in HICs, psychoeducation is not an uncommon practice, and frequency of its use often reflects the theoretical orientation of practitioners (e.g., psychodynamic versus cognitive behavioral therapy). Nevertheless, there is difference between advice giving and didactic teaching; comfort with more directive counseling versus insight-oriented therapy may also reflect cultural variations regarding preference with level of directness in communication (Bolton et al., 2003). Considerations of how these approaches, which may have more local relevance, are both similar and different from existing Western practice may need to be further explored.

Constructs related to the process of psychotherapy may also be areas for adaptation. In this sample, some MHSUs reported discomfort disclosing problems to providers or a general lack of belief in psychotherapy to affect change. Other work in Ethiopia has similarly found that MHSUs and their caregivers question the competence of mental health clinical staff or psychotherapy's lack of tangible benefits (Mayston et al., 2015), which may affect responses obtained in this study. Further, some of these beliefs, endorsed by both MSHUs and community advisory board members, seemed to be associated with explanations about the etiology of mental illness (including beliefs that mental illness is rooted in spiritual causes). Conversely, other MSHUs and their families felt that counseling provided benefit and had positive outcomes, while also suggesting ways that mental health treatment may be integrated into other community forms of coping (e.g., religious institutions). Interventions that are culturally adapted and are accommodating of differences in beliefs about mental illness etiology and symptoms result in improved outcomes for racial and ethnic minority clients in HICs (Benish et al., 2011). Similarly, such adaptations that specifically focus on integrating psychotherapy with indigenous forms of coping (e.g., collaboration between healthcare providers and community traditional healers; educating on the strengths and limitations of both traditional healing and psychotherapy; and respecting, or even encouraging, concurrent use of psychotherapy and indigenous coping methods) may result in improved outcomes across settings.

MHSUs and community advisory board members also highlighted community-level factors, such as poverty and stigma, which may affect psychotherapy attendance and reach. Notably, these types of structural variables are not discretely contained within a community level, but rather may also impact both family and individual level variables. Furthermore, concerns about community-level stigma impacted family and individual disclosure of mental illness. As such discrimination is an important barrier to accessing mental health services even when they are available. Currently, efforts are underway to target health worker stigma toward mental health for primary care integration of care in LMICs (Kohrt et al., 2018). Also, studies that have targeted communities in HICs with interventions aimed at decreasing stigma both through education and contact with people who have mental illnesses have shown encouraging outcomes (Semrau et al., 2015). As such, adaptations to Western psychotherapies may require greater attention to both providers and community or group interventions aimed at reducing stigma and increasing mental health literacy, not simply a focus on individual effects of mental illness (Egbe et al., 2014; Fernando, 2012).

Other factors, such as the delivery location of services, may need to be considered. Some MHSUs and family caretakers noted that the location of treatment creates difficulty in attending routine treatment, due to either transportation issues or cost associated with lost time; however, other MHSUs expressed openness to attending weekly psychotherapy. Considerations of different locations (i.e., decentralized clinics or providing services that are more proximate to MHSUs) may make psychotherapy more relevant to participants (Mendenhall et al., 2014; Rathod et al., 2017); indeed, other work indicates that a combination of primary and community-based care delivery of psychological therapy offers advantages for detecting and treating individuals with mental illness (Jordans et al., 2017). These types of adaptation in location of service delivery may prove equally necessary in HICs, though may be somewhat challenging for Western practitioners who have been

"professionally socialized" about the boundaries and form of psychotherapy (Gallardo et al., 2009). Other adaptations may include flexibility in the frequency or timing of visits to better accommodate MHSUs.

Limitations

The findings reported here should be understood within their limitations. Themes related to implementation determinants were based on the views of study participants and may be skewed or missing essential determinants in this setting. Furthermore, the lack of direct experience with psychotherapies means that participants drew on anticipated facilitators and barriers rather than those that had been experienced. However, the perceptions of key-stakeholder groups and themes that emerged across participants are important, given that they are likely to be representative of the views of those who will receive or provide these services within primary care in their community. In addition, themes of barriers and facilitators identified in this study are likely valid since they are aligned with implementation determinants from other studies on integrating mental health services into primary care in LMICs (Miguel Esponda et al., 2019).

Another limitation to these findings is that interviews were translated from Amharic to English and coded for themes in English. It is possible that some local meaning was lost during the translation process that may have impacted selected themes. To mitigate this concern, Ethiopian researchers were an integral part of data collection and analysis.

Finally, participants mentioned other broad-scale, systemic issues of note, such as the lack of governmental funding for mental health services. As this concept was not specific to psychotherapy (e.g., lack of psychotropic medication was commonly referenced), they were not included as main areas of focus in this manuscript. However, this is not to suggest that psychotherapy is exempt from impacts of such concerns. Rather, it is important to further assess the specific ramifications of such broad-scale factors as they relate to the provision and sustainability of psychotherapy.

Future Directions

Future work will utilize information from this formative evaluation to identify critical steps that are necessary to integrate mental health services for MHSUs into primary care in rural Ethiopia. After treatment adaptation, the preliminary psychotherapy intervention will be pilot tested to evaluate preliminary effectiveness and implementation outcomes to assess impact on care delivery. Ongoing efforts to understand the extent to which interventions can be adapted, while still ensuring fidelity and treatment success, are required. Developing a robust body of literature to support this work is critical, as few parts of world have access to evidence-based therapies psychotherapy as often designed in HICs.

Additional studies that evaluate systems level factors (e.g., training) and its impacts on psychotherapy in non-Western settings would provide further data to inform treatment adaptation and capacity building efforts. In this paper, the term "systems" was used to highlight different levels (individual, family, community, etc.) where barriers or facilitators may exist. Future work that further investigates drivers of these systems level factors, such as training methods, would add depth to the current body of literature.

Lastly, though interview data was provided by a variety of types of participants (i.e., MHSUs, caregivers, community members, providers), there was great commonality of responses across groups. While our coding team looked for notable differences by group, little variation emerged, which helpfully suggests that the use of this data in future work will result in a meaningful adapted treatment. Nevertheless, additional evaluation of perspectives of psychotherapy among different types of participants may further elucidate questions about understanding and beliefs of Western interventions among non-Western populations.

Acknowledgements:

Appendix.: Interview guides for MHSUs, caregivers, community members, and providers.

MHSU Interview Guide

1. I would like to start by asking you a few questions about your recent health care. What services have you received at the health clinic for your health problem? Who provided the services? How long have you been receiving the services?

2. What is your view of talking with the clinic workers about your problems and your life?

3. Have any staff at the health center talked with you about your thoughts, feelings, or day-to-day activities or behaviors?

   a. (*If yes*) What was that experience like for you? What were the good things about it? What were the not so good things about it? What was helpful? What was not helpful? What would have made it a better experience for you?

      Probe: Who talked to you? Was anyone else, like your family member or friend with you? What was that like? What types of things did you talk about? How did the person speak to you?

   b. (*If no*) What do you think that would be like? What would you want to talk about? What would be the good things about it? What would be the not so good things about it? What would be helpful? What would not be helpful?

4. One of the things we are interested in is how to help people cope with difficult situations in their lives. I would like to ask you some questions about experiences

in your life. I am going to read you a list of difficult or stressful things that sometimes happen to people. Let me know if the event applies to you. The event could have happened to you or a close family member or friend, or you could have witnessed it happening to someone else. You can also tell me if you are not sure if it applies to you. Be sure to consider your *entire life* (growing up as well as adulthood) as we go through the list. [*Administer Life Events Checklist for the DSM-5 Standard Self-Report + Restrained Item*].

5. (*If the participant answers "yes" to "Any other very stressful event or experience"*) If you feel comfortable, would you share what the other very stressful event was?

6. If you feel comfortable, would you please tell me which experience has been the most difficult or painful for you? What has made this particularly hard for you?

7. Sometimes people with mental illness are chained or isolated when they are ill. Can you tell me about your experiences with that?

8. What do you think would help stop people from being chained or isolated?

9. Tell me about your relationships with other people in your life now. Are you currently experiencing anything that is painful or difficult? How do you keep yourself safe from other people? In what ways do people keep you safe?

10. What do you do to cope with these difficult experiences? What was helpful? What was not helpful?

11. What have other people done to help you cope with these difficult experiences? What was helpful? What was not helpful?

12. Do you want help addressing these problems? (*If yes*) What sort of help would you want? (*If no*) What would make you more likely to seek help?

13. Sometimes people feel bad or change their behavior after something difficult happens. What have you noticed about changes in people's thoughts, feelings, or behavior after something bad happens?

14. I am going to read you a list of problems that people sometimes have in response to a very stressful experience. Please consider each problem carefully and then tell me how much you have been bothered by that problem in the past month. [*Show response card and say*] You can point or say "Not at All," "A little bit", "Moderately", "Quite a bit", or "Extremely." [*Administer The PTSD Checklist for DSM-5*].

15. Are there any other reactions that you or someone else has experienced after a difficult event that I did not ask about?

16. In what ways, if at all, do these reactions interfere with your ability to work, interact with others, or engage in your day-to-day activities?

17. What do you do to help yourself when you are experiencing these reactions? Where do you go for help when these things happen? What sort of help do you receive?

18. What could other people do to help you when you are experiencing these reactions?

19. Why do you think people have these reactions? What do you think these reactions are?

20. What types of things make these reactions worse?

21. The health centers are thinking about providing services to help people who have experienced difficult situations. What do you think about that?

22. What is the need for such an intervention?

23. What, if anything, would you like your health center providers to do if they learn that you or another patient has experienced a difficult situation? What might be helpful? What might be harmful?

24. What would you expect and want from such an intervention? What do you think the intervention would change? What do you think you would do during the intervention? How much time do you think it would take?

25. What would make an intervention like this acceptable? What would make it unacceptable?

26. Who would you like to deliver the intervention? What characteristics or training would be important?

27. Who would you want involved in your care, if anyone? [Probe: family, friends, community members]

28. What if anything would make it difficult or easy for you to participate in this intervention?

29. If you needed to attend regular appointments at the health center to improve your wellbeing, how would that be? What about once a week? What about once a month?

30. The intervention that the health clinics are considering takes about three sessions. The patient would meet with a trained health center worker who would provide information about the ways that difficult or stressful situations can impact the body, the mind and behavior. The health center worker would also teach the patient ways of using his/her breathing and body to help reduce stress.

31. What do you think about the services I described? What do you like about it? What do you not like about it? What would make it better? What would make you more likely to use it? What would make you less likely to use it?

Caregiver Interview Guide

1. I would like to start by asking you a few questions about [patient's] recent health care. What services has [patient] received at the health clinic for his/her health problem? Who provided the services? How long has [patient] been receiving the services?

2. What is your view of talking with the clinic workers about your problems and your life? What about [patient] talking with clinic workers about his/her problems or life?

3. As far as you know, have any staff at the health center talked with you or [patient] about your thoughts, feelings, or day-to-day activities or behaviors?

    a. (If yes) What was that experience like for you or [patient]? What were the good things about it? What were the not so good things about it? What was helpful? What was not helpful? What would have made it a better experience?

        Probe: Who talked to you or [patient]? Was anyone else, like [patient] a family member or friend with you? What was that like? What types of things did you talk about? How did the person speak to you or [patient]?

    b. (If no) What do you think that would be like? What would you or [patient] want to talk about? What would be the good things about it? What would be the not so good things about it? What would be helpful? What would not be helpful?

4. One of the things we are interested in is how to help people cope with difficult situations in their lives. I would like to ask you some questions about experiences in your life and [patient's] life. I am going to read you a list of difficult or stressful things that sometimes happen to people. Let me know if the event applies to you or to [patient]. The event could have happened to you, [patient], or a close family member or friend, or you could have witnessed it happening to someone else. You can also tell me if you are not sure if it applies to you or [patient]. Be sure to consider your entire lives (growing up as well as adulthood) as we go through the list. [Administer Life Events Checklist for the DSM-5 Standard Self-Report + Restrained Item].

5. (If the participant answers "yes" to "Any other very stressful event or experience") If you feel comfortable, would you share what the other very stressful event was?

6. If you feel comfortable, would you please tell me which experience has been the most difficult or painful for you? What has made this particularly hard for you?

7. If you feel comfortable, would you please tell me which experience has been the most difficult or painful for [patient]? What has made this particularly hard for [patient]?

8.   Sometimes people with mental illness are chained or isolated when they are ill. Can you tell me about your and [patient's] experiences with that?

9.   What do you think would help stop people from being chained or isolated?

10.   Tell me about your relationships with other people in your life now. Are you currently experiencing anything that is painful or difficult? How do you keep yourself safe from other people? In what ways do people keep you safe?

11.   Tell me about [patient's] relationships with other people in his/her life now. Is [patient] currently experiencing anything that is painful or difficult? How do you keep [patient] safe from other people? Do you worry about patient harming other people? [If yes] In what ways do you keep other people safe from [patient]?

12.   What do you do to cope with these difficult experiences? What was helpful? What was not helpful?

13.   What have other people done to help you cope with these difficult experiences? What was helpful? What was not helpful?

14.   Do you want help addressing these problems? (If yes) What sort of help would you want? (If no) What would make you more likely to seek help?

15.   Sometimes people feel bad or change their behavior after something difficult happens. What have you noticed about changes in people's thoughts, feelings, or behavior after something bad happens?

16.   I am going to read you a list of problems that people sometimes have in response to a very stressful experience. Please consider each problem carefully and then tell me how much you have been bothered by that problem in the past month. [Show response card and say] You can point or say "Not at All," "A little bit", "Moderately", "Quite a bit", or "Extremely." [Administer The PTSD Checklist for DSM-5].

17.   Are there any other reactions that you or someone else has experienced after a difficult event that I did not ask about?

18.   In what ways, if at all, do these reactions interfere with your ability to work, interact with others, or engage in your day-to-day activities?

19.   What do you do to help yourself when you are experiencing these reactions? Where do you go for help when these things happen? What sort of help do you receive?

20.   What could other people do to help you when you are experiencing these reactions?

21.   Why do you think people have these reactions? What do you think these reactions are?

22.   What types of things make these reactions worse?

23.   The health centers are thinking about providing services to help people who have experienced difficult situations. What do you think about that?

24. What is the need for such an intervention?

25. What, if anything, would you like your health center providers to do if they learn that you, [patient], or another patient has experienced a difficult situation? What might be helpful? What might be harmful?

26. What would you expect and want from such an intervention? What do you think the intervention would change? What do you think you would do during the intervention? How much time do you think it would take?

27. What would make an intervention like this acceptable? What would make it unacceptable?

28. Who would you like to deliver the intervention? What characteristics or training would be important?

29. Who would you want involved in your or [patient's] care, if anyone? [Probe: family, friends, community members]

30. What if anything would make it difficult or easy for you or [patient] to participate in this intervention?

31. If you or [patient] needed to attend regular appointments at the health center to improve your wellbeing, how would that be? What about once a week? What about once a month?

32. The intervention that the health clinics are considering takes about three sessions. The patient would meet with a trained health center worker who would provide information about the ways that difficult or stressful situations can impact the body, the mind and behavior. The health center worker would also teach the patient ways of using his/her breathing and body to help reduce stress.

33. What do you think about the services I described? What do you like about it? What do you not like about it? What would make it better? What would make you more likely to use it? What would make you less likely to use it?

Community Member Interview Guide

1. What is your view of how community members would view talking with primary care clinic workers about their problems and their lives?

2. What do you think that experience would be like? What would be the good things about it? What would be the not so good things about it? What would be helpful? What would not be helpful?

3. One of the things we are interested in is how to help people cope with difficult situations in their lives. I would like to ask you some questions about experiences that people in your community may have had. I am going to read you a list of difficult or stressful things that sometimes happen to people. Let me know if you think the event applies to members of your community. The event could have happened to someone in the community, or someone could have witnessed it happening to someone else. You can also tell me if you are not sure if it applies

to anyone in your community. [*Administer Life Events Checklist for the DSM-5 Standard Self-Report + Restrained Item*].

4. (*If the participant answers "yes" to "Any other very stressful event or experience"*) If you feel comfortable, would you share what the other very stressful event was?

5. If you feel comfortable, would you please tell me which experiences are the most difficult or painful for people in this community? What makes those experiences particularly hard?

6. Sometimes people with mental illness are chained or isolated when they are ill. Can you tell me about experiences with that in your community?

7. What do you think would help stop people from being chained or isolated?

8. How do people in the community help keep people with mental illness safe? What would be better ways to keep people safe, if any?

9. Do people in the community worry about people with mental illness harming other people? *[If yes]* In what ways do people do to keep themselves safe? What would be better ways to keep people safe, if any?

10. What do people in the community do to cope with difficult experiences? What is helpful? What is not helpful?

11. What, if anything, could the health centers do to help with these types of difficulties?

12. Sometimes people feel bad or change their behavior after something difficult happens. What have you noticed about changes in people's thoughts, feelings, or behavior after something bad happens?

13. In what ways, if at all, do these reactions interfere with people's ability to work, interact with others, or engage in their day-to-day activities?

14. What do people do when they are experiencing these reactions? Where do they go for help when these things happen? What sort of help do you receive?

15. What could other people do to help them when you are experiencing these reactions?

16. What types of things make these reactions worse?

17. Why do you think people have these reactions? What do you think these reactions are?

18. The health centers are thinking about providing services to help people who have experienced difficult situations. What do you think about that?

19. What is the need for such an intervention?

20. What, if anything, would you like your health center providers to do if they learn that you or another community member has experienced a difficult situation? What might be helpful? What might be harmful?

21. What would you expect and want from such an intervention? What do you think the intervention would change? What do you think you would do during the intervention? How much time do you think it would take?

22. What would make an intervention like this acceptable? What would make it unacceptable?

23. Who would you like to deliver the intervention? What characteristics or training would be important?

24. Who would you want involved in your care, if anyone? [Probe: family, friends, community members]

25. What if anything would make it difficult or easy for you or another community member to participate in this intervention?

26. If you or another community member needed to attend regular appointments at the health center to improve your wellbeing, how would that be? What about once a week? What about once a month?

27. The intervention that the health clinics are considering takes about three sessions. The patient would meet with a trained health center worker who would provide information about the ways that difficult or stressful situations can impact the body, the mind and behavior. The health center worker would also teach the patient ways of using his/her breathing and body to help reduce stress.

28. What do you think about the services I described? What do you like about it? What do you not like about it? What would make it better? What would make you more likely to use it? What would make you less likely to use it?

Provider Interview Guide

1. I would like to start by asking you a few questions about your job. Tell me about your role/work here in the health center.

2. Tell me about the clinic and the environment you work in. What are some strengths or positive things about the environment you work in?

3. How about any challenges you face? Time constraints, pressures etc.? What would make it even better?

4. Tell me about your work with people with mental illness? How many people do you work with? What sorts of concerns do they have? How do you diagnose them? How do you treat them? How well are they doing?

5. How comfortable and confident are you in treating people with mental illness? What has helped you feel comfortable and confident? What would make it even better?

6. Do you or does someone on your team currently do any counseling or psychotherapy? If so, what does it look like? Which patients receive psychotherapy? What type of training and supervision do you and your staff

receive to provide this counseling? If someone in your team had to be trained to deliver psychotherapy, who do you think it should be? Why that person?

7. What are the positive and negative things about providing psychotherapy at the health center? What are things that could make psychotherapy easier to provide? What would make it more appealing to patients?

8. What is your view of talking with the patients with mental illness about their problems and their lives?

9. Have you ever talked with patients about their thoughts, feelings, or day-to-day activities or behaviors?

    a. (*If yes*) What was that experience like for you? What were the good things about it? What were the not so good things about it? What would have made it a better experience for you?

    Probe: Was anyone else involved in the discussion, like patients' family members or friends? What was that like? What types of things did you talk about?

    b. (*If no*) What do you think that would be like? What would you want to talk about? What would be the good things about it? What would be the not so good things about it? What would be helpful? What would not be helpful?

10. What is your view of how patients would view talking with primary care clinic workers about their problems and their lives? What would be the good things about it? What would be the not so good things about it?

11. Sometimes patients experience very difficult or painful things. One of the things we are interested in is how to help people cope with difficult situations in their lives. What types of difficult or painful things have the patients you've known experienced?

12. I am going to read you a list of difficult or stressful things that sometimes happen to people. Let me know if you think the event applies to patients that you treat at the health center. The event could have happened to them, or they could have witnessed it happening to someone else. You can also tell me if you are not sure if it applies to any of your patients. [*Administer Life Events Checklist for the DSM-5 Standard Self-Report + Restrained Item*].

13. (*If the participant answers "yes" to "Any other very stressful event or experience"*) If you feel comfortable, would you share what the other stressful events are?

14. What experiences do you think are the most difficult or painful for patients? What do you think makes those experiences particularly hard?

15. Sometimes people with mental illness are chained or isolated when they are ill. Can you tell me about experiences you have seen like that?

16. What do you think would help stop people from being chained or isolated?

17. How do people with mental illness keep themselves safe? How do people in the community help keep people with mental illness safe? What would be better ways to keep people safe, if any?

18. Do people in the community worry about people with mental illness harming other people? *[If yes]* In what ways do people keep themselves safe? What would be better ways to keep people safe, if any?

19. What do people in the community do to cope with difficult experiences? What is helpful? What is not helpful?

20. What, if anything, does the health center do to help with these types of difficulties? What do you currently do when you learn about these things? What is the standard of care in the clinic? What would improve care in this area? What could the health center do?

21. Is there any screening for difficult or traumatic experiences or the consequences of those experiences in the clinic? [*If yes*], what is the screening like? [*If no*] what do you think about this type of screening?

22. Do you discuss these things with your patients? What, if anything, are patients disclosing to you or the other staff members about these difficult experiences?

23. How do you feel about the patients who have had these difficult experiences?

24. What do you think about health center workers addressing these experiences and their effects on patients? DO you think there is a need for these services in the health center? Why or why not?

25. Sometimes people feel bad or change their behavior after something difficult happens. What have you noticed about changes in people's thoughts, feelings, or behavior after something bad happens?

26. I am going to read you a list of some reactions people have reported after experiencing a difficult event. Please tell me if you have noticed any of these symptoms in your patients [*Administer PTSD checklist*]. Are there any other things you have noticed that patients experience after a difficult event that are not listed here?

27. In what ways, if at all, do these reactions interfere with people's ability to work, interact with others, or engage in their day-to-day activities?

28. Why do you think people have these reactions? What do you think these reactions are?

29. What do patients do to help themselves when they are experiencing these reactions? What could other people do to help them when you are experiencing these reactions? Where do patients go for help when these things happen? What sort of help do they receive?

30. What could other people do to help them when you are experiencing these reactions?

31. What types of things make these reactions worse?

32. In your clinic, whose role, if anyone, is it to address issues such as negative effects of painful or traumatic experiences? Whose role do you think it should be? What is your role (in this respect and in relation to others). What challenges do you face in your role with respect to addressing these issues?

33. The health centers are thinking about formally providing services to help people who have experienced difficult situations. What do you think about that?

34. What is the need for such an intervention?

35. If the clinic were to do an intervention to address the effects of traumatic experiences, what should these interventions look like? Would you change anything if the intervention were provided to people with mental illness?

36. What would you expect and want from such an intervention? What do you think the intervention would change? What do you think you would do during the intervention? How much time do you think it would take?

37. What would make an intervention like this acceptable? What would make it unacceptable?

38. Who on your team would you like to deliver the intervention? What characteristics or training would be important?

39. What if anything would make it difficult or easy for you or another health care provider to participate in this intervention? What would work – why? Explore length, number of sessions, venue for interventions, who would deliver, how fit into process of care, whether to focus on a single substance or multiple substances)

40. If patients needed to attend regular appointments at the health center to participate in this intervention, how would that be? What about once a week? What about once a month?

41. The intervention that the health clinics are considering takes about three sessions. The patient would meet with a trained health center worker who would provide information about the ways that difficult or stressful situations can impact the body, the mind and behavior. The health center worker would also teach the patient ways of using his/her breathing and body to help reduce stress.

42. What do you think about the services I described? What do you like about it? What do you not like about it? What would make it better?

43. Do you think this kind of intervention could work in your health center? Do you think your clinic would be able to provide such an intervention (skill and time/ resources)? What would make it easier? What are the challenges or barriers?

44. Would such an intervention be acceptable to you? Would such an intervention be acceptable to your patients? What would make it more acceptable?

45. Who would be most likely to provide this intervention? What types of training would they need? What type of supervision? What barriers would they face? What would help overcome those barriers?

46. Are there any particular characteristics of staff and/or the clinic as a whole that are needed to make this intervention work?

47. What kinds of patients do you think this intervention would be most suitable for (e.g more severe cases)? What types of patients would not benefit from this type of intervention?

48. In your opinion what are the positives and negatives of implementing this intervention? What, if anything, would you change?

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Clinical Impact Statement

- Question: What are important factors that may affect future integration of psychotherapy into the Ethiopian healthcare system?

- Findings: Findings indicate that both strengths and challenges to psychotherapy integration exist on healthcare system, community, and individual levels.

- Meaning: Based upon these results, it appears that initiating evidence-based psychotherapy in primary care settings in Ethiopia is appropriate, though adaptations may be needed to ensure culture relevance when using Western psychotherapies in a novel setting.

- Next Steps: Future directions include testing and trialing psychotherapies, in accord with the adaptations, to assess impact on care delivery.

Table 1

Participant Demographic Characteristics

	MHSUs (n = 13)		Caregivers (n = 13)		Health Workers (n = 13)		Community Leaders (n = 9)	
	N	%	N	%	N	%	N	%
Age (mean)	35.15	15.18	37.38	9.99	29.77	7.46	47.00	17.55
Gender (%)								
Female	6	46.15	7	53.85	5	38.46	2	22.22
Male	7	53.85	6	46.15	8	61.54	7	77.78
Ethnicity								
Gurage	13	100	12	92.31	10	76.92	13	100
Oromo	0	0	1	7.69	2	15.38	0	0
Unknown	0	0	0	0	1	7.69	0	0
Education								
No formal	5	38.46	7	53.85	0	0	0	0
Primary	7	53.85	5	38.46	0	0	2	22.22
Secondary	1	7.69	1	7.69	1	7.69	0	0
University (i.e., BA equivalent)	0	0	0	0	12	92.31	7	77.78

Table 2

Possible Barriers to Integrating Mental Health Services into Primary Care in a Psychotherapy-Naïve Setting

Node	Description
Healthcare System	
1. Counseling Approach	Health care workers use a counseling approach that is a deterrent to MHSUs.
2. Facilities	Factors about healthcare facilities that make implementing therapy challenging.
3. Lack of Education	Health care workers feel a lack of education inhibits their ability to conduct therapy.
4. Location of Services	Distance or geographical factors that make seeking therapy difficult.
5. Job Strain	Factors that would cause additional strain or add burden to existing workload.
6. Wait Times	Wait times negatively impact desire for treatment.
Community	
1. Conflicting Beliefs	Conflicting beliefs (e.g., spiritual reasons) that may prevent individuals from seeking mental health care.
2. Poverty	Economic reasons why individuals may have difficulty seeking or attending treatment.
3. Stigma and Lack of Knowledge	Stigma or lack of knowledge in the community about mental health that inhibits treatment-seeking behaviors.
Individual	
1. Concerns about Confidentiality	MHSUs may not be interested in therapy due to concerns about confidentiality.
2. Discomfort	MHSUs are uncomfortable disclosing mental health symptoms and illness.
3. Frequency or Length of Visits	Timing or length of visits conflicts with community norms and would prove difficult in terms of engaging MHSUs in treatment.
4. Treatment Beliefs	MHSUs do not believe that "talk therapy" will improve mental health.

Table 3

Possible Facilitators to Integrating Mental Health Services into Primary Care in a Psychotherapy-Naïve Setting

Node	Description
Healthcare System	
1. Exposure to Mentally Ill MHSUs	Health care worker's prior exposure to MHSUs with mental illness that increases openness to work.
2. Manageable Work Load	Perception that conducting mental health treatment (possibly including therapy) does not add undue stress to workload.
3. Openness to Conducting Therapy	Health care worker's willingness to engage in therapy (or similar activity) with MHSUs.
4. Past Mental Health Education	Past mental health education that health care worker has received benefits work.
5. Positive View of Mental Health Care's Benefits	Health care worker's perspective that mental health care benefits MHSUs.
6. Use of Counseling Skills	Familiarity and use of skills similar to counseling skills.
Community	
1. Compatibility of Spiritual Beliefs	Spiritual beliefs and mental heath care are not in conflict with one another and may support each other. Faith institutions may offer opportunity to increase knowledge and acceptance.
2. Existing Practices Similar to Therapy	Advice giving and similar practices that occur in the community.
3. Increased Knowledge and Decreased Stigma about Mental Health	Positive changes in the community due to increased knowledge and changed beliefs about mental health.
Individual	
1. Engagement in Similar Services	Participant already engages in services that have some similarity to psychotherapy.
2. Integration with Beliefs	Use of mental health services, in conjunction with religious and cultural beliefs, aid in treatment engagement.
3. Openness to Counseling	Participant expresses willingness to engage in practice similar to therapy (e.g., disclosing symptoms, receiving feedback).
4. Positive Outcome from Mental Health Treatment	Participant believes that mental health treatment (including therapy) has a positive outcome and reduces distress.
5. Timing or Frequency of Visits	Timing and length of visits would not prohibit seeking treatment.