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Cultural Adaptation of Scalable Interventions

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It is known that 65 million people are currently displaced by war, based on data from the United Nations High Commissioner for Refugees (UNHCR, 2017), and millions of people in low- and middle-income countries are affected by poverty, political instability, and daily violence. As a consequence, high prevalence rates of *posttraumatic stress disorder* (PTSD) and other common mental disorders such as depression and anxiety have been reported in populations affected by violent conflicts (Charlson et al., 2016; de Jong, Komproe, & Van Ommeren, 2003), as well as other adversities such as gender-based violence (Ellsberg, Jansen, Heise, Watts, & García-Moreno, 2008). At the same time, evidence suggests that there are cultural differences in the way emotional distress is expressed (Kohrt et al., 2014) and in beliefs about how best to deal with stress (Kuo, 2011). Such cultural differences with regard to the symptomatology of PTSD and ways of overcoming adversity have been highlighted in previous chapters of this volume.

In view of this evidence, the global mental health movement is faced with the conundrum of high prevalence rates of mental disorders in settings where resources for providing treatment are constrained, hence an urgent need to develop affordable evidence-based interventions that can reach as many people as possible on a global scale, but without disregarding the cultural and contextual differences in these settings. Successful efforts to deal with this conundrum have been reported in the past decade. Different research groups around the globe have developed and tested interventions specially designed for the challenging surroundings of low-resource and humanitarian settings. The present chapter describes examples of such interventions. Evidence from such studies in part informed the development of guidelines produced by the World Health Organization (WHO) under its mental health Gap Action Programme (mhGAP; WHO, 2008) which aims at scaling up mental health services in low- and middle-income countries.

Interventions may be considered potentially scalable if they are brief, easy to understand, delivered by trained nonspecialists or in self-help formats (e.g., books, audio material, or online), and can easily be adapted to different cultures and contexts. We say "potentially scalable," because little experience exists with actual scaling-up of such interventions outside research contexts. The present chapter features examples of such interventions tested in research – that is, the Friendship Bench programme in Zimbabwe (Chibanda et al., 2015), group interpersonal psychotherapy (IPT) in Uganda (Bolton et al., 2003), and potentially scalable interventions developed by WHO, with the aim of identifying relevant aspects that may be important when adapting and delivering interventions to large numbers of people affected by symptoms of distress in low- and middle-income

countries. The examples presented in this chapter are not limited to PTSD but deal with the broader concept of common mental disorders, as this is the focus of a number of potentially scalable interventions.

This chapter first describes the evidence on *cultural concepts of distress* (CCD) and their relevance for psychological interventions, followed by the above-mentioned examples of potentially scalable interventions that were culturally and contextually adapted to diverse local settings. Based on these examples, key challenges with regard to cultural and contextual adaptation of (potentially) scalable interventions will be discussed, and future lines of research will be outlined.

Culture, Context, and Psychological Interventions

Since the beginning of cross-national epidemiological studies – for example, the WHO Collaborative Study on Psychological Problems in General Health Care (Üstün & Sartorius, 1995) – cultural psychiatrists and ethnologists have questioned the validity of Western diagnostic categories for other cultural groups (Kleinman, 1977). In the World Mental Health Surveys, prevalence rates of common mental disorders varied, with some countries showing comparatively low prevalence of depression, anxiety, or PTSD (e.g., China or Nigeria). These figures indicate that the validity of Western-defined diagnostic criteria for PTSD may be limited in some cultural contexts. Research has increasingly brought forward emic descriptions of CCDs, which have been summarized in an extensive literature review (Kohrt et al., 2014). The authors of this review looked at associations between CCD and Western categories of psychiatric disorders, defined by the odds of experiencing a Western-defined diagnosis when endorsing a particular CCD. Results showed that more rigorous and culturally appropriate studies revealed lower associations between CCD and Western categories of psychiatric disorders. The authors concluded that studies of higher quality may capture unique cultural phenomena that differ from Western diagnostic categories. Hinton and Bui (2019; Chapter 2 in this volume) describe one such CCD: the *khyâl attacks* among Cambodian refugees.

Despite the convincing evidence that the phenomenology of emotional distress differs across cultures, psychological interventions for the treatment of PTSD or depression as defined by Western criteria have been successfully applied in very diverse cultural contexts. A systematic review and meta-analysis of PTSD identified 18 clinical trials in culturally diverse low- and middle-income countries (Morina, Malek, Nickerson, & Bryant, 2017). Results revealed a large aggregated within-group effect size when comparing baseline versus follow-up assessments in active conditions (Hedges's $g = 1.75$). The aggregated effect size for comparison between intervention and control condition at follow-up was also large ($g = 0.93$). Six of these studies have assessed functional impairment, showing large pre-post and pre-follow-up effect sizes ($g = 0.73$ and 0.97, respectively). And a recent systematic review and meta-analysis including 32 randomized controlled trials (RCTs) of depression treatments in low- and middle-income countries found a large effect size ($g = 1.10$) when comparing psychotherapy with a control condition, using Western symptom assessments such as the Beck Depression Inventory or the Hamilton Rating Scale for Depression (Cuijpers, Karyotaki, Reijnders, Purgato, & Barbui, 2018). Functional disability was not addressed as an outcome in this review.

This evidence indicates that core psychological interventions such as behavioral activation or problem solving that are based on Western psychiatric concepts of PTSD and depression (and using corresponding outcome measures) can successfully be implemented in very diverse cultural settings, with small adaptations, leading to a considerable symptom reduction. Most interventions applied in low- and middle-income countries share common elements such as empathy, active listening, and normalizing symptoms or treatment, which might be perceived as helpful by many people around the world (Singla et al., 2017). Thus, on the one hand, there is *emic* research showing large variety in CCD, and on the other hand, clinical trials testing the effectiveness of

interventions that are based on *etic* assumptions on psychiatric disorders. Tol et al. (2014) point to a paucity of evidence on the effectiveness of interventions for CCD, and little is known regarding whether and how Western psychological interventions address CCD (Hall, Ibaraki, Huang, Marti, & Stice, 2016). But results for functional impairment indicate that the interventions worked beyond the reduction of symptoms as conceptualized with Western psychiatric categories, and they addressed psychopathology in a broader sense.

Our chapter argues that transferring interventions from one cultural context to another uncritically may be unhelpful and reduce the effectiveness or meaningfulness of the intervention, or could even potentially create risks of harm. On the other hand, conducting ethnographic research to identify CCDs for each cultural group before implementing an intervention, and testing the effectiveness of this intervention with a culturally specific outcome measure, would require extensive resources that are often not available. We suggest that a careful balance is needed – and possible – in finding the "proper dose" of cultural adaptation in large-scale interventions.

Aside from cultural adaptation, it is vital to consider other contextual factors when developing interventions for low- and middle-income countries. Most interventions identified in the systematic review by Morina et al. (2017) were relatively complex, high-intensity interventions – for example, eye movement desensitization and reprocessing (EMDR) or cognitive processing therapy – and thus required a high level of training and supervision. In humanitarian settings and low- and middle-income countries in general, lack of resources and trained specialists hinders the up-scaling of such high-intensity interventions (WHO, 2005). Moreover, in these settings, people affected by symptoms of distress are often unable to attend more than a few sessions due to other problems they face. And finally, stigma related to mental illness prevails in most countries of the world (Semrau, Evans-Lacko, Koschorke, Ashenafi, & Thornicroft, 2015), and people are often reluctant to utilize mental health services, even if they exist. In response to such cultural and contextual challenges, a variety of interventions have been developed and tested in recent years.

Scalable Psychological Interventions

Interventions that are potentially scalable are designed from a public health perspective, with the aim of reaching as many people in need as possible. The aim of reaching as many people as possible is a response to the "treatment gap" in most low- and middle-income countries. Epidemiological data on the prevalence of PTSD and other common mental disorders among populations affected by war and torture vary. Larger and more rigorous epidemiological studies generally show lower prevalence rates than smaller studies of lower quality (Steel et al., 2009). But even considering these lower prevalence rates, the number of people in need of psychological treatment is still enormous. Silove, Ventevogel, and Rees (2017) get to the heart of this when they state: "There is no realistic prospect, therefore, of formal mental health services, whether generic or specialized, meeting the mental health needs of refugees, noting that the majority reside in low-income countries" (p. 132). Therefore, innovative approaches are needed to increase coverage of mental health interventions for host and refugee populations in low- and middle-income countries.

According to WHO (2017), (potentially) scalable interventions include brief, modified, evidence-based psychological treatments (e.g., behavioral activation, problem solving, or IPT) that can be delivered by specialists, nonspecialists, or in a self-help format. Scalable interventions are of lower intensity, encompassing a limited number of sessions, and tend to be structured using manuals to ensure fidelity and utility. Lower intensity interventions have proven to be effective for different levels of symptom severity (Bower et al., 2013). Moreover, many scalable interventions use transdiagnostic approaches, targeting a broad range of symptoms as opposed to one particular diagnostic category such as PTSD or depression (Barlow, Allen, & Choate, 2004). Transdiagnostic approaches may address different kinds of CCD; however, little evidence exists regarding this assumption.

Scalable interventions can be delivered by specialists or nonspecialists. In response to the lack of specialist mental health workers (WHO, 2005), many low- and middle-income countries have increasingly embarked on training lay community health workers and other groups of nonspecialists in taking on limited tasks in the care of people with mental disorders, such as case detection, referral to primary care, and providing psychosocial support (Keynejad, Dua, Barbui, & Thornicroft, 2017). This *task-sharing* approach (Patel, 2009), in which care of people with mental disorders is transferred from specialists to primary care and community health workers, has yielded positive results. A Cochrane systematic review (van Ginneken et al., 2013) identified 38 studies from seven low- and 15 middle-income countries, most of which addressed depression and PTSD. Results were promising, showing possible benefits for people suffering from depression, anxiety, and PTSD, among others. However, most of the evidence was of low or very low quality, which limited possible conclusions about the specific effectiveness of the different interventions.

Cultural Adaptation of Scalable Interventions

Stammel (2019; Chapter 11 in this volume) introduced different theoretical frameworks for cultural adaptation of psychological interventions. Meta-analytic evidence on face-to-face treatments indicates that culturally adapted interventions are more effective than unadapted ones (Benish, Quintana, & Wampold, 2011; Hall et al., 2016) and that their effectiveness increases with the number of implemented adaptation elements according to the Bernal framework (Smith, Domenech Rodríguez, & Bernal, 2011). In addition, one meta-analysis including 21 direct comparison studies showed that adaptation of illness concepts was the sole moderator of superior outcomes of culturally adapted psychotherapy (Benish et al., 2011). However, a more recent meta-analysis looked at psychological interventions for the treatment of depression in low- and middle-income countries (Cuijpers et al., 2018). This study found that whether the intervention was culturally adapted or not was not a moderator of the effect size. Thus the extent to which cultural adaptation is related to the effectiveness of an intervention is still the subject of current research.

Evidence on the cultural adaptation of potentially scalable interventions is scarce. One meta-analysis identified eight studies on minimally guided interventions (e-mental health interventions and bibliotherapy) implemented in low- and middle-income countries and with immigrants in high-income countries. Results showed that the number of cultural adaptation elements was associated with higher effectiveness (Harper Shehadeh, Heim, Chowdhary, Maercker, & Albanese, 2016). However, no study was identified which directly compared adapted and unadapted interventions.

In the following, we describe examples of scalable interventions that were culturally and contextually adapted to diverse settings in low- and middle-income countries. This selection of interventions is not intended to be exhaustive but attempts to illustrate different kinds of experiences with cultural and contextual adaptations of scalable interventions.

Interpersonal Psychotherapy in Uganda

Verdeli et al. (2003) adapted *interpersonal psychotherapy* (IPT) to be delivered by nonspecialists in Uganda, a country that is severely affected by the *human immunodeficiency virus* (HIV) epidemic. According to the authors, prevalence rates of depression are higher (24%) than in neighboring Rwanda (16%). The local adaptation was based on ethnographic fieldwork on the phenomenology of common mental disorders in this region (Wilk & Bolton, 2002). Free listing and key-informant interviewing were used to collect data from 50 local people (from 10 different villages). Free listing revealed 30 problems that affect people as a result of HIV, eight of which could be classified as symptoms of disorders described in the *Diagnostic and Statistical Manual of Mental Disorders,*

fourth edition (DSM-IV; American Psychiatric Association, 1994) – for example, loss of hope, worry, social isolation, and suicide. Furthermore, two CCDs were identified, namely *yo'kwekyawa* (self-loathing) and *okwekubaziga* (self-pity), both of which share common symptoms with depression but include other symptoms that are locally relevant (e.g., not responding when greeted, hating the world, being unappreciative of assistance).

According to the local descriptions, yo'kwekyawa appeared to be the more severe syndrome, with symptoms including suicidal thoughts, hopelessness, loss of interest, criminal or reckless behavior, hating the world, and feelings of severe suffering and pain (Wilk & Bolton, 2002). The authors interpreted this syndrome as being similar to the "DSM-IV concept of a major depressive episode with mood-congruent psychotic features" (Wilk & Bolton, 2002, p. 396). Okwekubaziga seemed to correspond to a less severe major depressive episode, as it did not include hopelessness or suicidal thoughts. PTSD symptoms were not mentioned by key informants, despite the fact that many of them were affected by intense grief and loss.

In Uganda, IPT was adapted to respond to these CCDs and to locally shared cultural values (Verdeli et al., 2003). In IPT, individuals examine to what extent their interpersonal context is linked to their depression, and how they could change their interactions to reduce symptoms. The authors considered this approach to be consistent with local values in Uganda: "In these cultures people tend to see themselves as part of a family and community unit before they see themselves as individuals" (Verdeli et al., 2003, p. 115). In qualitative research, the authors explored to what extent the four interpersonal problem areas of IPT (i.e., grief, interpersonal disputes, role transitions, and deficits) would be triggers of depression in Ugandan communities. Local lay workers were trained to deliver IPT, and they were also the main source of information for adapting the manual.

In a first step, the intervention was simplified to be used by nonclinicians. Moreover, the language was slightly adapted – that is, "grief was called death of a loved one; disputes were called disagreements; transitions became life changes; and interpersonal deficits became loneliness and shyness" (Verdeli et al., 2003, p. 116). Three problem areas were considered to be relevant by the lay trainers; however, the fourth problem area, loneliness and social isolation, was not recognized as being relevant for the community. Poverty was repeatedly brought up as a trigger of depression. The authors decided to conceptualize poverty as a risk factor and focused on interpersonal events associated with it.

Regarding the therapeutic relationship, facilitators had to explain repeatedly that the group leader would not provide material goods. Instead, they explained that leaders and group members would mutually identify situations that potentially contributed to their depression, and discuss how group members could deal with these situations to feel better. Moreover, people in the community, government, and nongovernmental organizations were identified who could provide financial or other assistance, and group members were encouraged to seek help from these institutions for their financial problems.

Furthermore, a contextual adaptation was made with regard to the group setting. When the guiding principle of confidentiality for group meetings was introduced, group members were worried that other community members could "think that we are starting a new political movement or that we are encouraging women to use birth control" (Verdeli et al., 2003, p. 116). Therefore, some general information about the purpose of the group was given to the community. In addition, meetings had to be flexibly organized around community events such as funerals or weddings, in which the whole village participated. Several adaptations were also made to the content of the intervention. As an example, the IPT task for a person to say directly what they expect of another person was perceived as inappropriate and disrespectful. Culturally more appropriate options for resolving disputes were identified.

A cluster RCT was then implemented, including 30 villages in Uganda with a total of 248 participants. The primary outcome measure was a locally adapted Hopkins Symptom Checklist. The mean reduction in depression severity was almost five times higher in the intervention when

compared with the control group. After the intervention, 6.5 % in the intervention and 54.7 % in the control groups met the criteria for major depression. In the meantime, IPT was scaled up in several countries – for example, Ethiopia and Lebanon. In 2016, WHO published a generic field trial version of an IPT manual (WHO, 2016).

The Friendship Bench Program in Zimbabwe

Twenty years of research have shaped the Friendship Bench program for the treatment of common mental disorders among people living with HIV in Zimbabwe. Patel, Gwanzura, Simunyu, Lloyd, and Mann (1995) conducted a qualitative study on the phenomenology and explanatory models of common mental disorders, including 100 attendees of primary health care centers and traditional healers. The authors assessed both emic CCD and etic criteria of common mental disorders. Somatic symptoms were very prevalent among study participants, but most of them agreed that their mind or soul was the source of the illness, including spiritual causes such as being bewitched. Many of the reported symptoms corresponded with etic phenomena, but others did not have an etic equivalent, such as "veins/nerves pulling," "thinking too much," or unusual chest complaints (e.g., "pricking pain in my heart" or "if there is an electric shock in my chest"). Based on these results, a Shona (local language in Zimbabwe) questionnaire for detecting common mental disorders in primary care was developed (Patel, Simunyu, Gwanzura, Lewis, & Mann, 1997). This questionnaire, which is the first indigenous measure of common mental disorders developed in sub-Saharan Africa, includes 14 items which represent a mixture of emic and etic phenomena. It showed good psychometric properties and has been used for evaluating the effectiveness of the Friendship Bench program.

The CCD of "thinking too much" (*kufungisisa* in the local language) has been shown to be a core concept of common mental disorders in many other countries and has been included in the *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5; (American Psychiatric Association, 2013). Later qualitative research in Zimbabwe (Kidia et al., 2015) also revealed the local idiom of *moyo unorwadza* (i.e., burdened heart). In this study, the main stressors that caused symptoms of distress in the view of study participants were poverty, stigma related to HIV, and marital problems. Participants were then asked how an intervention should look if it were to be helpful for them. As poverty was the most significant challenge for most of them, they suggested that the intervention should be combined with an income-generating activity, and that they would need financial assistance for transport costs to participate in such an intervention. They also mentioned that privacy was a major priority to discuss personal matters individually with health workers without being overheard.

Based on these results, a pilot intervention was developed (Chibanda et al., 2011). The Friendship Bench (*Chigaro Chekupanamazano*) was locally adapted from problem-solving therapy and delivered by trained and supervised female lay workers, commonly referred to as *ambuya utano* (grandmother health provider). The Friendship Benches, made by local craftsmen, were placed in the clinic grounds in discrete areas under a tree within sight of the lay workers' office. Those referred or who self-referred were directed by nursing or reception staff to sit on the Friendship Bench, and the lay worker on duty would approach the bench after a potential client sat on it. After screening for inclusion and exclusion criteria, the intervention was delivered. The intervention consisted of a locally adapted problem-solving therapy (Abas, Broadhead, Mbape, & Khumalo-Sakatukwa, 1994). The first session includes three components called opening the mind (*kuvhura pfungwa*), uplifting (*kusimudzira*), and strengthening (*kusimbisa*), and the subsequent sessions build on the first one (Abas et al., 2016).

Moreover, participants most in financial need were referred to two local income-generating projects (peanut butter making; recycling). The intervention further included home visits by the lay health workers. In these home visits, lay workers encouraged participants to carry out activities

that really mattered to them and made their life more rewarding. Home visits also included 15–30 min of prayer delivered by the lay worker to provide comfort to the family.

In view of planning the cluster RCT and scale-up of the intervention, eight theory of change workshops were implemented for contextual adaptation (Chibanda, Verhey, Munetsi, Cowan, & Lund, 2016). Securing political support by local stakeholders was identified as key for a successful implementation. Furthermore, human resources, infrastructure, and supervision were identified as critical needs. Specific features were discussed, such as the use of WhatsApp as an alternative way of providing support, or the use of tablet computers for the assessments. One lay worker commented on the use of tablet computers as follows: "You see, for old people like me to move around with shiny fancy gadgets like these, people will place a spell on me for having this, and also I will be a target with the thieves" (Chibanda, Verhey, et al., 2016, p. 6). Further, a randomization exercise was done with workshop participants to make sure clinic managers and nurses understood the random allocation of clinics to the intervention or control condition.

A cluster RCT was implemented including 24 primary health care clinics and almost 600 study participants (Chibanda, Weiss, et al., 2016). The control condition encompassed enhanced usual care, consisting of brief support counseling and option for medication, psychoeducation, and referral to specialized psychiatric care if needed. Participants in the control condition also received two or three supportive short messages, the last message being a reminder to attend the 6-month follow-up assessment. Primary outcome was the results on the Shona Symptom Questionnaire (Patel et al., 1997). Participants in the intervention group showed a significantly lower symptom level than participants in the control condition at 6-month follow-up on the Shona Symptom Questionnaire (adjusted mean difference = −4.86) and the Patient Health Questionnaire, 9-item version (adjusted mean difference = −6.36).

To the best of our knowledge, this was one of the first RCTs on scalable interventions that included a measure of locally shared, emic CCD. Moreover, the inclusion of an income-generating activity goes along with the recognition of a vicious cycle between mental health problems and poverty, which can only be broken when addressing both factors at one time (Lund et al., 2010; Lund et al., 2011).

Problem Management Plus

In recent years, WHO has been working to develop a series of potentially scalable interventions (WHO, 2017). The first of these is a transdiagnostic intervention called Problem Management Plus (PM+; Dawson et al., 2015). PM+ can be used to help people experiencing psychological distress (e.g., symptoms of common mental health problems such as depression, anxiety, or stress), irrespective of whether exposure to adversity has caused the problem. PM+ is delivered face-to-face, either individually or in group format (the latter of which is currently being tested), and facilitated by trained lay workers who receive clinical supervision from a mental health specialist or other trained health workers. According to the authors, "The term 'problem management' is used rather than 'problem solving' to highlight that many practical problems encountered by people living in adversity may not necessarily be solvable" (Dawson et al., 2015, p. 355). Treatment components are based on the principles of cognitive behavior therapy and include basic psychoeducation, stress management (i.e., slow breathing), enhancement of social support, problem management, and behavioral activation, in accordance with WHO guidelines for the treatment of mental disorders in low- and middle-income countries (Dua et al., 2011). PM+ (individual format) has been tested in RCTs in two distinct settings: Among women affected by gender-based violence in suburban Nairobi, Kenya (Bryant et al., 2017; Sijbrandij et al., 2016), and in conflict-affected Peshawar, Pakistan (Rahman, Riaz, et al., 2016; Sijbrandij et al., 2015). After these successful RCTs, the PM+ manual was published on the WHO website in different languages (http://www.who.int/mental_health/emergencies/problem_management_plus/en/). Testing of group PM+ has been completed in Swat

Valley Pakistan (publication forthcoming), and a further RCT on the group format is underway in Nepal.

Kenya

In this example, PM+ was adapted for women affected by gender-based violence in Nairobi. The adaptation process started with a 2-day rapid qualitative community assessment method, as described in Schafer, Anjuri, and Ndogoni (2013). First, a free listing exercise with community members was done to assess common problems in the community. Three major problems were mentioned – that is, alcohol consumption, unemployment, and inadequate education. Mental health problems were frequently mentioned, as well, such as "having too many burdens on the mind" or "self-loathing." Mental health symptoms such as depressed mood, hopelessness, drug and substance abuse, suicidal behavior, or harming and showing hostility toward others in the family, were clearly associated with gender-based violence by community members.

After community assessment, the PM+ manual was read through by 18 community health workers (six groups consisting of three health workers each). Results of this process were documented in an unpublished document, and further information on the process was provided by Schafer (personal communication, 14 February 2018). According to these sources, discussions emerged around the terms *anxiety*, *stress*, and *worry*, which appeared to be difficult to translate to the local language. Problems were rather described in practical terms such as unemployment, poverty, housing, or education. Emotions such as anxiety or hopelessness seemed to be less "on the surface" than in other cultural settings and were talked about less. "Thinking too much" was, however, mentioned as a known symptom of a person experiencing mental health problems.

Smaller adaptations were made to the PM+ intervention, such as names of the main characters and the case studies, to make them locally meaningful. Religion and prayer were included as essential resources for alleviating the burden of distress in the local culture. Moreover, storytelling was identified as an important feature in Kenya and was therefore integrated into PM+. A further adaptation referred to the role of the family: It was recommended to develop a contract with family members on their role in the intervention process. Establishing a trusting relationship with the client and family in the first few sessions was considered essential to treatment compliance. An important adaptation was also made concerning stigma: Since gender-based violence is highly stigmatized, both women reporting gender-based violence and those not reporting it were randomized into the trial. Furthermore, the intervention was integrated into other existing health services to make sure participants were not directly identifiable as victims of violence.

Another challenge emerged with regard to the facilitators, who tended to give direct advice to participants instead of listening empathically. This inclination seemed to be congruent with a collectivist cultural bias toward advice giving as a means of support and the participants' tendency to describe concrete problems instead of emotions. Challenges also emerged with the problem management technique: For many women, solving their problem would have meant leaving their husband or making him leave, a solution that was not necessarily feasible or culturally acceptable for them. In the face of these challenges, a major focus of community health worker training was on establishing a good relationship with participants, to identify "solvable problems" and to support participants to solve their own problems, instead of demanding health workers offer direct advice. The PM+ intervention was adapted accordingly before being tested in an RCT.

For the RCT, participants (female only) were recruited in their homes in periurban areas of Nairobi (Bryant et al., 2017). For screening, assessors were instructed to interview one woman from every 10th household. Participants were included based on established cutoff scores for measures of psychological distress and impaired functioning. Following the above recommendation, all women with psychological distress and impaired functioning were randomized, regardless of history of violence, to make sure women who had experienced violence were not publicly singled

out. PM+ was delivered by health workers who had 10 years' school education and did not have prior training or experience in mental health care, and the sessions were done individually at participants' homes. In the RCT, participants ($N=421$) were assigned to either PM+ or enhanced usual care provided by community nurses who were provided with manualized nonspecific training (2 days) in counseling skills and psychological first aid. The dropout rate was acceptable at 19%. Results showed a significant moderate effect size in favor of PM+ for the primary outcome measure ($d=0.57$) and for a series of secondary outcome measures (Bryant et al., 2017).

Pakistan

PM+ was tested in two different sites: Individual PM+ was tested in Peshawar, and data analysis for group PM+ testing in Swat Valley is underway. Both sites have been heavily affected by violence and conflict during the past few decades, with severe consequences for mental health in the general population (Khalily, 2011). The cultural adaptation of PM+ was combined for both settings and is described in Chiumento et al. (2018). As in Kenya, a rapid qualitative assessment including free listing exercises was done, prior to the translation of the manual and the manual read-through by lady health workers (nonspecialist community health workers who assist maternal and child health care in communities). Adaptations were described along the lines of Bernal's eight elements of adaptation (Bernal & Sáez-Santiago, 2006; see Chapter 11 in this volume); however, a ninth aspect of "security" was included to account for complexities associated with the potential instability of humanitarian and dangerous contexts.

Concerning language, adaptations were made to the fact that Urdu language is more direct than English; therefore phrases such as "we are interested in finding out" became "we want to know." Moreover, the behavioral activation PM+ strategy "get going, keep doing" became "keep walking and keep doing" in both adaptations. Moreover, adaptations were made to the drawings in the intervention guide, the names of the main characters in the intervention, and regarding the examples of activities in the "get going, keep doing" exercise, to make these aspects more relevant for the cultural context. Somatic complaints mentioned in the free listing exercise such as "chest pain," "gas in stomach," and "heaviness in my head" were incorporated into the manual to ensure the terms used in the manual corresponded as closely as possible to those used by the community.

Culturally acceptable religious practices such as the use of local prayer beads, *malish* (massage with oils), and reference to Sufism when describing relaxation exercises were incorporated to increase the acceptability and local relevance of the exercises. The following example illustrates how religion can be used to motivate participants:

> Someone asked the Holy Prophet (peace be upon him) will ALLAH guard my camel if I leave it? The Prophet (peace be upon him) replied it is also essential to tie your camel with the rope before you depend on divine help to guard the camel. (Chiumento et al., 2018).

This story was used in Pakistan to stress participants' responsibility to manage their problems themselves, but with the aid of the facilitator (Chiumento et al., 2018).

As in Kenya, inclusion of the family into the intervention was essential, such as managing family expectations and providing information about the aims, the delivery, and particular aspects of the intervention to family members (i.e., the importance of regular attendance, completing homework, and the principle of confidentiality). And finally, due to the ongoing conflicts and complicated political situation in both Pakistani settings, it was important to first ensure the support of respected local elders to reduce potential risks to lay helpers resulting from community misperceptions about their role.

In Peshawar, a pilot trial was conducted first (Rahman, Riaz, et al., 2016), followed by a full RCT (Rahman, Hamdani, et al., 2016). In both trials in Pakistan, individual PM+ was tested against enhanced treatment as usual, consisting of consultations with a primary care physician who

received 1 day of basic training in treatment of common mental disorders. PM+ was delivered by a nonspecialist in five individual face-to-face sessions. The pilot trial explored the feasibility and acceptability of the intervention. In the full RCT, the sample ($N=346$) consisted of both male and female participants. The dropout rate was acceptable at 12%. A significant Group × Time interaction was found for the primary outcome measure with a moderate effect size ($d=0.88$), and small to moderate effects were found for the secondary outcome measures, as well (Rahman, Hamdani, et al., 2016).

Step-by-Step

Guided Internet- and mobile-based self-help interventions have been studied in high-income countries, providing effect sizes equal to face-to-face treatments in a large number of RCTs (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). These promising results have increased expectations about the use of such e-interventions in low- and middle-income countries (Muñoz, 2010), but evidence is still limited (Arjadi, Nauta, Chowdhary, & Bockting, 2015). Therefore, WHO has invested in developing and testing such an intervention for low-resource and humanitarian settings (Carswell et al., in press).

Step-by-Step is a five-session self-help or guided intervention delivered through smartphones or desktop computers. It was initially conceptually based on PM+ and therefore contains large parts of the original intervention. However, the problem management component was removed during the development process. Feedback from PM+ facilitators in different settings revealed that this was a difficult technique to teach, and it was considered to be overly challenging to be transmitted through a guided self-help intervention. The content of Step-by-Step (texts and illustrations) was developed in close collaboration with experts in psychological care, e-mental health, and global mental health and has gone through extensive peer review by over 30 external experts.

The main therapeutic focus of Step-by-Step is behavioral activation, an empirically supported therapeutic strategy for the treatment of depression (Dua et al., 2011; Ekers, Richards, McMillan, Bland, & Gilbody, 2011; Ekers et al., 2014). Additional therapeutic elements include stress management (i.e., slow breathing), positive self-talk, and increasing social support. However, the intervention has been designed in a way that additional components can be added in the future (Carswell et al., in press).

Step-by-Step uses a narrative approach with engaging illustrations of a person seeking help for depression. In the first part of each session, a "companion" tells their story in simple language, and users can either read the story or watch the video version, based on their literacy level and Internet connectivity. In the second part, an illustrated health worker provides additional information and small exercises. Completing each module takes approximately 30 min. Clients are then asked to practice the learned skills over the week. In the pilot setting, Lebanon, the intervention is supported by trained nonspecialist assistants (called "e-helpers") who have weekly phone- or message-based contact with users to provide support and guidance, lasting around 15 min per week. E-helpers are trained to use active listening and basic problem management, and also in the use of the user platform to provide technical guidance if needed. A generic English version of the intervention content was developed and then adapted for the first pilot test in Lebanon. A feasibility and a definitive RCT will be implemented in the coming months.

Lebanon

Step-by-Step has first been adapted for Lebanese nationals as well as Syrian and Palestinian displaced people. Lebanon has been heavily affected by the Syrian crisis. UNHCR (2018) reports 1 million registered Syrian refugees in Lebanon, and the number of unregistered refugees is likely

to be much higher. Displaced people themselves are a particularly vulnerable group for suffering symptoms of distress. Affordable and accessible mental health care is very limited in Lebanon. In 2015, the Ministry of Public Health launched a Lebanese National Mental Health Plan which, alongside other strategies, explicitly supports and advocates the use of innovative technologies such as e-mental health to increase coverage of services. According to the International Telecommunications Union (2017), a substantial proportion of the population has access to mobile phones (81 %) and the Internet (78 %), and the literacy rate is 88 % for adults and 96 % for youths. With regard to Syrian refugees, UNHCR reports 100 % Internet coverage among refugees in Lebanon, and 68 % of mobile ownership among refugees worldwide (UNHCR, 2016). These data suggest that many Lebanese and Syrian refugees have the means to access an e-health intervention.

The process of cultural and contextual adaptation of Step-by-Step in Lebanon is described in Abi Ramia et al. (2018). This process followed an (unpublished) WHO draft protocol for cultural adaptation and included several steps. Concerning contextual adaptation, one question was how clients would best access the intervention. The first version of Step-by-Step was programed as a website, and registering required having one's own e-mail address for account validation. In focus group discussions, it became evident that many potential users (particularly Syrians) would not be aware of their own e-mail address, even if they had one. Therefore, a system was installed in which e-helpers would hand out usernames and passwords for preregistered accounts.

A further crucial contextual adaptation was made with regard to the issue of privacy. Focus group discussions showed that in many Syrian families, one mobile phone was available for entire families. This meant extra care would have to be taken when e-helpers contacted participants to ensure confidentiality was maintained. This issue was particularly sensitive given concerns raised by stakeholders about intimate partner violence and whether the risk of violence might be increased should participation in the intervention be accidently disclosed. Therefore, different channels of communication were offered in the pilot study, such as in-site messaging and e-mail, WhatsApp, and phone calls. The study showed that all these different channels of communication were used, and some users did not wish any guidance at all.

Adaptations were also made with regard to the main characters of the intervention. The companion is tailored according to the gender of the client, and users can choose between characters that may resonate with some of the cultural groups in Lebanon (e.g., woman with or without a headscarf or man with or without a beard). Moreover, the text was written and illustrations were drawn in a generic manner to be as inclusive as possible for many different cultural groups or people in different living situations. Focusing on specific experiences, for example, being displaced, may increase relevance for one group while others may no longer feel addressed. In response to this challenge, the story does not provide detailed descriptions of experiences but refers to adversity and challenging life events in a more general manner, using images that may be relevant for people across many cultural groups and living situations (Carswell et al., in press).

Albanian-Speaking People in Switzerland

The war in Kosovo in 1998–1999 led to a massive stream of refugees into Europe, and Kosovar Albanian people are the second largest population of immigrants in Switzerland after Central Europeans. Step-by-Step is currently being culturally adapted for this group, which according to an epidemiological study suffers from high rates of common mental disorders (Schick, Morina, Klaghofer, Schnyder, & Müller, 2013). In this ongoing study, two versions of Step-by-Step will be tested against each other: One version will be culturally adapted according to the WHO draft adaptation protocol, similar to the Lebanon example. In focus group discussions, the intervention will be read through. Text and illustrations will be adapted to be consistent with Kosovar Albanian culture – for example, examples of pleasant activities or drawings of home situations. The second version will be adapted to Albanian cultural CCDs based on more intense ethnographic research.

This study aims to test whether adapting an intervention to CCDs has an effect on its efficacy and attrition rates. For this aim, a qualitative study was conducted including 20 Albanian-speaking participants in Switzerland (Shala, Morina, Salis Gross, Maercker, & Heim, 2018).

Preliminary results indicate that participants suffered from a broad range of premigration and postmigration stressors and psychological symptoms. A clear distinction emerged between expressions of the first and the second generation of immigrants. The younger generation tended to use Western concepts of distress such as *stress* or *anxiety.* Among the older generation, most of the participants expressed distress using the following culturally specific terms: *vuajtje* (suffering, misery), *brengë* (concern, care), *mërzi* (sorrow, grief, sadness), *nervozë* (tension, anger, fury), and *frikë* (fear, anxiety). These five idioms of distress appeared to be mutually linked, described as *zinxhirore* (like a chain). *Vuajtje* appeared to be an overarching term of suffering, encompassing the other terms. Brengë and mërzi are characterized by withdrawal and negative affect and differ in severity. Brengë describes constant worries about a specific problem – for example, family concerns, and is experienced by many people. It can be transient, but if persistent brengë may lead to mërzi, which in the authors' interpretation comes closest to the Western concept of depression. However, mërzi was not considered as a disorder in view of the participants, but illness in terms of somatic symptoms (e.g., strong fatigue, pain) can result if mërzi becomes very strong. Frikë and nervozë are characterized by externalizing behaviors and are therefore more similar to the Western concepts of anxiety and arousal.

Results further showed that Albanian-speaking immigrants in Switzerland would not seek professional help because of psychological distress, mostly due to fear of stigma and social exclusion. They described strategies of self-management and *durim,* a status of endurance, patience, and passive bearing. The term *durim* derives from a cultural belief in *fati* (destiny, fate), and the conviction that human suffering is part of life, and nothing can be done about it. Some participants had gone through a very long time of passive endurance and suffering, lasting from 1 year to more than 20 years. Medical treatment (e.g., medication, physiotherapy) is considered to be helpful in case of physical symptoms as a result of merzï, whereas psychological treatments are largely perceived as being unnecessary and limited to cases of severe mental disorders (e.g., severe depression).

Cultural adaptation to these CCDs will include the use of the respective idioms of distress – for example, *brengë* and *mërzi* for introducing the concept of behavioral activation and *nervozë* and *frikë* for stress-management techniques such as slow breathing. The most challenging aspect in this regard will be the strong cultural belief in fati and durim – that is, i.e. the conviction that suffering is part of life and has to be endured with patience, as well as the general mistrust in psychological interventions. One potential adaptation to meet this challenge could be to add a preliminary module for enhancing users' sense of self-efficacy. This could, for instance, be introduced through a story of Nasreddin, an important storytelling figure whose wise and philosophical tales are highly valued in Albanian culture. Social gatherings and meetings often start with one of Nasreddin's tales being told, followed by a discussion on the moral and philosophical meaning behind the story. For example, a story of Nasreddin to transmit the message that positive and health activity could have a positive effect on users' life would possibly increase engagement with the intervention.

Conclusions

This chapter has highlighted examples of cultural and contextual adaptations of potentially scalable interventions for different settings around the world. Cultural adaptation research has increased over the past decade. Meta-analytic evidence has provided mixed results, with two studies showing that culturally adapted evidence-based psychological interventions are more effective than unadapted ones (Benish et al., 2011; Hall et al., 2016), and one meta-analysis providing contrary evidence (Cuijpers et al., 2018). There is also little evidence about what specific aspects have to

be adapted, and to what extent. Chu and Leino (2017) differentiate between *peripheral* and *core* components of an intervention. Peripheral components encompass strategies of user engagement and treatment delivery, whereas core components refer to the main therapeutic ingredients of an intervention which lead to symptom reduction. Examples described in this chapter have addressed both aspects but differed in the profoundness of how this was done. Based on these examples, preliminary conclusions can be drawn regarding the cultural adaptation of (potentially) scalable interventions, but these conclusions go along with open questions that have to be addressed in future adaptation research.

First, although it seems essential to adapt peripheral components of an intervention, one can think about the thoroughness with which this has to be done. Adapting peripheral components of an intervention means finding an appropriate "packaging" by using culturally relevant language, case studies, examples of pleasant activities, or illustrations. Examples in this chapter highlighted the importance of these aspects. However, as described by Carswell et al. (in press) in the development of Step-by-Step, it may be possible to some extent to use illustrations and case examples that are generic enough to be meaningful for a very broad range of people affected by different kinds of adversities. The more a case example or an illustration is tailored to one specific group (e.g., displaced people), the more it may lose meaningfulness for other groups. Thus finding a proper balance in illustrations and examples being specific enough to be meaningful, but generic enough to address as many people as possible, may be crucial. These are assumptions, but could be empirically tested, particularly through the use of online interventions which allow for easier dissemination of multiple versions through one online system.

Concerning peripheral components, the examples highlighted in this chapter also showed the importance of adapting means of treatment delivery, including the many adaptations that were made with regard to treatment settings, privacy, scheduling and length of sessions, Internet connectivity in the case of e-interventions, and embedding the intervention in a mental health system – to mention only a few. Securing political support is without question one of the most critical aspects of a successful implementation of scalable interventions. Without exception, the examples showed how relevant authorities and stakeholders were involved prior to testing the intervention, which most probably will be a crucial step for later scale-up.

A second very relevant question refers to the extent to which the core components (Chu & Leino, 2017) of an intervention have to be adapted to be congruent with CCD. A large meta-analysis revealed the diversity of cultural conceptualizations of mental distress (Kohrt et al., 2014), but very little evidence exists on how to address such CCDs in the cultural adaptation of psychological interventions (Tol et al., 2014). In one meta-analysis, the adaptation of the illness concept was the sole moderator for superior effects of culturally adapted interventions (Benish et al., 2011). According to Bernal and Sáez-Santiago (2006), finding culturally appropriate ways of conceptualizing a client's problem and communicating it to them is very important. This includes somatic conceptualizations of common mental disorders and avoidance of psychiatric labels (Chowdhary et al., 2014). Furthermore, it seems important to choose interventions that correspond to local illness conceptions and values. The example from Uganda showed that IPT was congruent with local values, as people see themselves as part of a family and community (Verdeli et al., 2003). Formative research might help decision makers choose a therapeutic intervention based on how it aligns with such local values, but little evidence exists to support this assumption. Experiences with the different kinds of potentially scalable interventions that are currently being tested in diverse cultural contexts will hopefully provide more insights on this question.

Given the constrained resources in most settings, it does not seem realistic to conduct extensive ethnographic research to describe CCDs in each cultural group and then create a new intervention specifically for this group, particularly as there will then be a requirement to develop evidence for its effect. Instead, potentially scalable interventions are based on the assumption that core psychological interventions such as problem solving, stress management, or behavioral activation can be

used and quickly or easily adapted in different cultures, as they are simple and easy to apply, and people in many cultures may find them helpful. This was demonstrated in the PM+ trials in both Kenya (Bryant et al., 2017) and Pakistan (Rahman, Hamdani, et al., 2016). Therapeutic techniques can be adapted – for example, using a culturally appropriate form of support or stress management, as described by Hinton and Bui (2019; Chapter 2 in this volume). Moreover, potentially scalable interventions may be transdiagnostic, thus not targeting one narrow illness concept such as PTSD but a broader variety of symptoms. Transdiagnostic interventions are assumed to lead to a general symptom reduction and increased functioning.

And third, the question arises of how to measure outcomes of psychological interventions regarding CCDs. In a recent meta-analysis of culturally adapted evidence-based psychological interventions, Hall et al. (2016) concluded that the effects of culturally adapted and unadapted interventions on CCDs had not been studied so far. One study described in this chapter used a questionnaire to capture a local CCD in Zimbabwe, the Friendship Bench program (Chibanda, Weiss, et al., 2016). In this study, the Shona Symptom Questionnaire (Patel et al., 1997) was used as primary outcome measure, showing a significant symptom reduction. But again, considering the objectives of scalability and cost-effectiveness, it does not seem realistic to develop a specific questionnaire for each cultural group for which an intervention is planned to be adapted. The concept of functioning might be of crucial importance in this context. Including a measure of functioning in outcome assessments is a possible way of overcoming the problem with cultural variation in symptom expression. As an example, the WHO Disability Assessment Schedule (WHO, 1988) was developed in an interdisciplinary and culturally inclusive way with partners from all continents and might therefore reflect "functioning" in a broad sense that is valid in may different cultures.

In summary, we have aimed to show that cultural adaptation and potential scalability are not mutually exclusive, but rather go hand in hand. Given the pressing need for interventions to relieve psychological distress in underserved regions of the world that can be provided at scale, it is vital to find the "proper dose" of cultural adaptation, which can be seen as a balance between tailoring and generalizing. It remains one of the major challenges in history of psychotherapy research to develop interventions that are simple enough to be widely spread, that can speak to as many people as possible, but are still meaningful and helpful for very diverse cultural and social groups affected by adversity. Innovative attempts to meet this challenge have been outlined in this chapter, and results of studies that are currently implemented will provide very relevant insights on how this can be done in the future.

Acknowledgments

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