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RESEARCH PAPER

Common factors in psychological treatments delivered by non-specialists in low- and middle-income countries: Manual review of competencies

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Abstract Delivery of psychological and psychosocial treatments by non-specialists in low- and middle-income countries (LMIC) is a growing strategy to address the global mental health treatment gap. However, little is known about which competencies are essential for non-specialists to effectively deliver treatment. Psychotherapy research in high-income countries suggests that effective treatment requires competency in common factors. Therefore, our objective was to identify how common factors are described in evidence-supported non-specialist interventions in LMICs. To meet this objective, we identified and coded common factors by reviewing 16 evidence-supported manuals for psychological treatments delivered by non-specialists in LMICs. World Health Organization (WHO) manuals

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and other non-proprietary manuals, with positive randomized control outcomes, were included in the review. Fifteen common factors were identified and described in most manuals: 'promoting hope and realistic expectancy of change' and 'confidentiality' were described in 15 manuals (94%), followed by 'giving praise' and 'psychoeducation' (88% of manuals), and 'rapport building' (81% of manuals). Descriptions of common factors were similar across manuals, suggesting that training and competency evaluation approaches can be harmonized across interventions. Compiling these descriptions from the manuals can inform foundational training in common factors for diverse cadres of non-specialists around the world.
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Introduction

To reduce the burden of untreated mental illness, there has been a push for increased availability of psychological and psychosocial treatments around the world (Fairburn & Patel, 2014). There is increasing evidence that adequately trained and supervised non-specialists (e.g., community health workers, teachers, peers, etc.) can effectively provide support and deliver manualized psychological interventions for common mental and substance use disorders in low-resource settings, with a pooled effect size of .49 (95% CI = .36—.62) (Singla et al., 2017), with the most robust evidence for cognitive behavioral therapies and interpersonal therapies (Barbui et al., 2020).

Training for psychological interventions, whether for specialists or non-specialists, includes a combination of skill-building in common factors and treatment-specific factors. Typically, training in manualized psychological interventions is designed for specialists, and the manuals focus on treatment-specific factors, i.e., techniques and processes by which a particular intervention is theorized to produce a psychological benefit (Duncan, Miller, Wampold, & Hubble, 2010; Fonagy & Clark, 2015; Mulder, Murray, & Rucklidge, 2017). Examples of treatment-specific factors may include graded exposure in trauma therapy, cognitive restructuring to support changing unhelpful thought processes to adaptive thought processes in cognitive-behavioral therapy (CBT), or other techniques that are specific to a given treatment approach. Although treatment-specific factors in psychological interventions and psychotherapies may contribute to positive outcomes (Arch et al., 2012; Barth et al., 2013; Cuijpers, van Straten, Andersson, & van Oppen, 2008), the exact mechanisms for how these treatments work is often a subject of debate (Cuijpers, Reijnders, & Huibers, 2019).

These trainings for specialists are based on the assumption that trainees already have foundational knowledge and skills in common factors. Common factors refer to those techniques that are assumed to be universal for the delivery of any effective treatment and play an important role in generating effective outcomes, regardless of which treatment-specific approach is used (Mulder et al., 2017; Wampold, 2015). Common factors typically include skills that relate to building a warm, trustworthy relationship between the therapist and client, such as rapport-building, demonstrating empathy and genuineness, incorporating the client's explanations, using culturally-appropriate concepts for distress, and promoting hope that recovery is possible (Barth et al., 2012; Laska, Gurman, & Wampold, 2014). Common factors are framed as humanistic interactions that demonstrate beneficial impact within psychological treatments (Wampold, 2015).

Duncan et al. (2010) proposed a common factors model, which consists of four main elements: (1) client and extra-therapeutic factors; (2) models and techniques; (3) therapeutic relationship/alliance; and (4) therapist factors. Client and extra-therapeutic factors include those that highlight client attributes, incorporate the client's strengths, and her/his support system (e.g., family, community). Models and techniques are those that promote hope and expectancy of change, activate the client's positive and realistic expectancy for change, and motivate engagement in positive and healthy activities. Therapeutic relationship is the extent to which the therapist and client build trust between each other, and work collaboratively on the client's goals, i.e., therapeutic alliance. Therapist factors are those behaviors and skills of the therapist that support the alliance and delivery of treatment, such as empathy, genuineness, and encouragement (Duncan et al., 2010; Thomas, 2006).

Research in high-income settings suggests that common factors may be especially important for local non-specialists, particularly when building an alliance, because local non-specialist may share common concerns and can approach their provider role as a trusted peer (Faust & Zlotnick, 1995; Korfmacher, O'Brien, Hiatt, & Olds, 1999). Common factors have also been highlighted in reviews of evidence-based psychological treatments delivered by non-specialists in low- and middle-income countries (LMIC) (Brown, de Graaff, Annan, & Betancourt, 2017; Singla et al., 2017). Tools to measure common factor competency among non-specialists have been developed (Kohrt, Mutamba, et al., 2018; Kohrt, Jordans, et al., 2015; Kohrt, Ramaiya, Rai, Bhardwaj, & Jordans, 2015; Singla et al., 2014); though currently evidence is lacking on how and which common factors influence successful outcomes of these interventions delivered by non-specialists in LMIC.

Given that common factors are hypothesized to influence treatment outcomes, are shared across interventions, and are particularly important for treatment delivered by non-specialists, there is an opportunity and a need to find ways to harmonize training and evaluation of common factors to support the mission of globally scaling psychological interventions. Many non-specialist training manuals are adapted from specialist-based interventions, and therefore may not contain detailed information on common factors, i.e., when

training specialists there is an assumption that they would already have a foundation in common factors.

Consequently, our goal was to compile different examples of how common factors are described for non-specialists across a range of effective interventions in LMIC. We conducted a review of evidence-supported manualized psychological and psychosocial interventions delivered by non-specialists in LMIC. In this review, we identify which common factors are presented in these non-specialist manuals and how they are described. Compiling descriptions of common factors across effective interventions has the potential to improve future training materials and common factors competency evaluations.

This review is part of the World Health Organization (WHO) initiative Ensuring Quality in Psychological Services (EQUIP, https://www.who.int/mental_health/emergencies/equip/en/). EQUIP will be an open-access platform for resources and guidance to facilitate competency-based trainings and improve the assessment of competency for delivery of psychological and psychosocial interventions (Kohrt et al., 2020), with an emphasis on foundational skills including common factors.

Methods

Identification and selection of manuals

Following the principles of open science of health services, we limited our manual inclusion to materials that were freely available to the general public (Watts, van Ommeren, & Cuijpers, 2020). We obtained open access, non-proprietary and non-commercial (available online or by contacting the author) psychological and psychosocial manuals — distributed with no licensure or trainee user fees. In addition, we limited our inclusion to manuals that have proven effectiveness in randomized controlled trials (RCTs) when delivered by non-specialists in LMIC. Therefore, all manuals met the following inclusion criteria: (i) deliverable by non-specialist providers (i.e., not a licensed mental health professional such as a psychiatrist or psychologist); (ii) prior or current implementation in an LMIC according to World Bank country economic categories (The World Bank, 2018); (iii) available in an open-access format without fees to trainers and trainees; (iv) focus on a psychological and/or psychosocial therapy; and (v) evidence-supported, operationalized as at least one positive RCT. We also included manuals that were ancillary to included psychological interventions, i.e., manuals that were intended to be used alongside the primary content manual such as communication skills manuals (Fig. 1). The selected manuals are consistent with recommended psychological treatments in the WHO mental health Gap Action Program Intervention Guide (mhGAP-IG 2.0) and humanitarian version (mhGAP-HIG) (World Health Organization, 2015, 2016). The mhGAP-IG 2.0 and mhGAP-HIG recommend treatments that can be delivered by non-specialists, and include cognitive-behavioral therapy, trauma-focused cognitive behavioral therapy, interpersonal therapy, motivational enhancement, parent skills training, and problem-solving counseling. All psychotherapies referenced in mhGAP are drawn from reviewing the evidence-base in treatment outcomes, e.g., presence of RCTs with positive results.

For all manuals, target conditions could include common mental disorders, trauma-related disorders, substance use disorders, or generalized psychosocial distress. Manuals could vary on treatment-specific focus, such as emphasizing one treatment-specific approach for a given condition

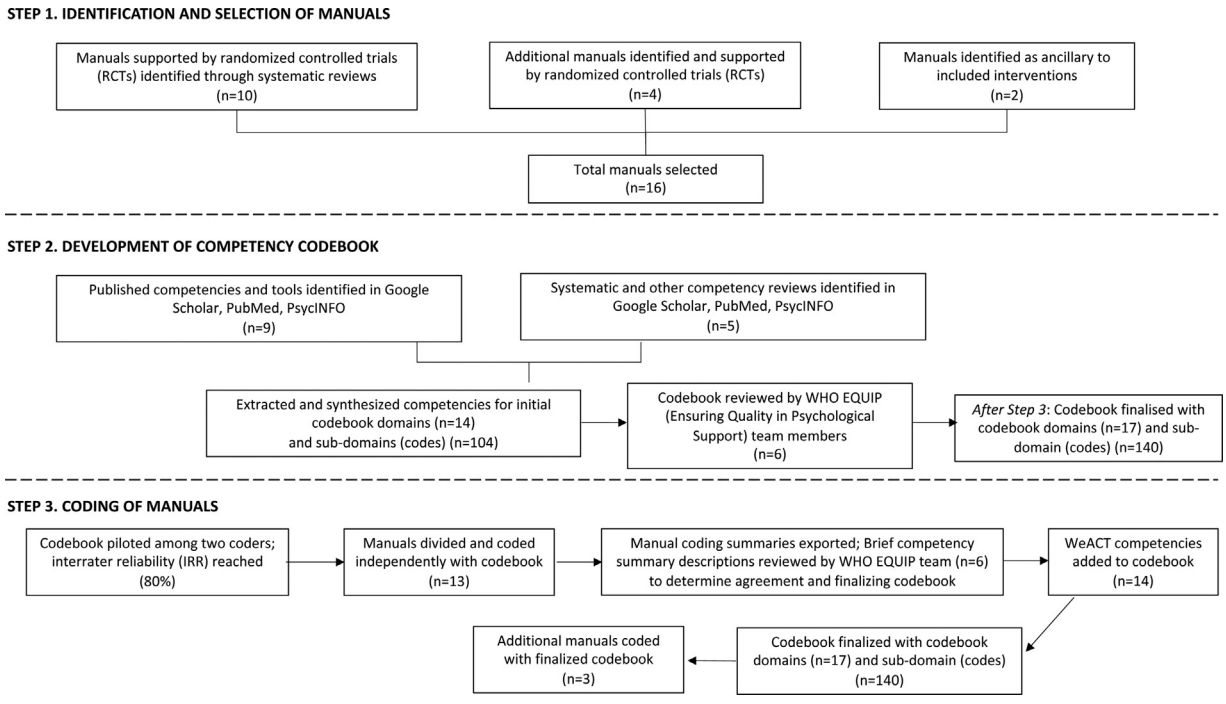

Figure 1 Methods for identification of manuals, development of competency codebook, and coding of selected manuals.

(e.g., cognitive behavioral therapy techniques for managing perinatal depression), incorporating multiple treatment-specific approaches for a single condition (e.g., motivational enhancement and problem-solving techniques for harmful drinking), or be identified as 'transdiagnostic' and offer a range of treatment-specific approaches for a range of conditions (e.g., different behavioral activation, cognitive, problem management, motivational enhancement, and trauma techniques may be tailored to whichever common mental disorder symptoms the client is experiencing). Manuals for child and/or adult interventions were included, as well as individual and group formats. Parenting manuals that did not include a child-focused mental health component were excluded. Manuals that were solely case management, social work services, or strictly school-based were not included in the current review due to additional site-specific or discipline-specific techniques that require further exploration in future reviews. Manuals that were not available online were only included if the author granted permission through email request.

It is important to note that this manual review does not intend to make claims about comparative contributions of common vs. treatment-specific factors, nor to distinguish relative importance among common factors. Intervention manuals may only represent one resource among many for training and supervising non-specialists in these RCTs, and we cannot claim whether presence or absence in a manual translated into competency for a common factor. Rather, the goal of this review is to compile descriptions of common factors for the evidence-supported initiatives to develop a more comprehensive resource for training on and evaluating common factors when working with non-specialists around the world.

Development of a codebook for competencies

We created a codebook for categorizing competencies described in the manuals. For code generation, a search for currently published competencies, competency frameworks, and systematic and literature reviews related to common factors and treatment-specific factors was conducted in April 2018. These sources were identified through searches in Google Scholar, PubMed, and PsycINFO using search terms, wildcards (e.g.*), and the Boolean operators AND and OR (search terms for PubMed: *review AND competency* and mental*; Search terms for PsycINFO: *review AND competency* AND TX mental AND health worker* OR lay health worker OR mental health worker OR health professional*; and *review AND competency* AND Tx mental*). In addition to the above search terms, ''competency framework'' was specified in Google Scholar to identify competency frameworks.

Identified published competencies and frameworks included the PracticeWise Psychosocial and Combined Treatments Coding Manual (Chorpita, Daleiden, & Weisz, 2005; Chorpita, Daleiden, & Weisz, 2008), Improving Access to Psychological Therapies (IAPT) competence framework (National Collaborating Centre for Mental Health, 2019), Yale Adherence and Competence Scale (YACS II) guidelines (Carroll et al., 2000; Nuro et al., 2005), Cognitive Therapy Scale-Revised (CTS-R) (Blackburn, James, Milne, & Reichelt, 2000), Let's Get Talking Practice Support: Competencies, training and supervision for talking therapies delivery (Te Pou o te Whaakaro Nui, 2016), Motivational Interviewing Rating Scale based on Miller and colleagues' (Miller, Moyers, Ernst, & Amrhein, 2003) manual for motivational interviewing, e-Problem Solving Therapy (e-PST) training and assessment tool (Cartreine et al., 2012), Global Social Service Workforce Alliance (GSSWA) competencies (Global Social Service Workforce Alliance, 2017), and the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale and its evidenced resources for item generation (Kohrt, Jordans, et al., 2015; Kohrt, Ramaiya, et al., 2015).

Two systematic reviews were selected, both which addressed evidence-based, low-intensity interventions being delivered in adult and child populations in LMIC, and which mapped out related competencies (Brown et al., 2017; Singla et al., 2017). Competencies and descriptions were extracted and synthesized from all included sources and resulted in a codebook of 104 competency codes with definitions, grouped in 14 domains (Common Factors, Engagement, In-Session Techniques, Other Techniques, Other Services, and Treatment-specific Techniques). The current analysis will focus on detailed descriptions of common factors.

Competency domain descriptions and sub-domain code definitions were combined from the different sources, with the common factor descriptions predominantly drawn from the PracticeWise manual (Chorpita et al., 2005; Chorpita et al., 2008), ENACT competency tool development codebook (2015), and Singla et al.'s systematic review (Singla et al., 2017). The codebook of domains, codes, and definitions were then reviewed by six EQUIP team members comprising three clinical psychologists with expertise in non-specialist psychological interventions (A.S., K.C., A.W.), two board-certified psychiatrists (including one with expertise in medical anthropology) (P.L., B.A.K.), and a masters-level researcher with expertise in psychological interventions and global mental health (G.A.P.). Cumulatively, the reviewers had experience in either delivering, training, or evaluating seven non-specialist interventions widely used in LMICs. The coders were not involved in the development of any of the manuals included in the review.

Coding of competencies

Codes and manual files were transferred into NVivo 12, a qualitative data analysis computer software package (QSR International, 2012). An initial two manuals were reviewed by two coders (G.A.P., P.L.) piloting the entire codebook and assessing inter-rater reliability (IRR); any code discrepancies were discussed with a third coder (B.A.K.). The two coders independently coded the same manual and repeated until 80% IRR was established. The two coders then divided 13 manuals and coded separately. Double coding was accepted if sections covered multiple competencies. Any notes on the coding process were recorded per manual and shared on a Google Doc in real-time to facilitate discussions and agreement as needed. Any discrepancies that could not be decided were then addressed by the third coder. Codes were collapsed when frequently double coded.

Competency codes for each competency were exported from NVivo, grouped, and then summarized into brief descriptions per manual into a shared document. The

competency summary descriptions from the manuals were then reviewed by the EQUIP team to determine agreement and decision on which additional competency codes may be collapsed. WeACT, a 14-item ENACT-based common factors assessment tool tailored for non-specialists and educators delivering treatment to children and adolescent populations, is currently being piloted by War Child Holland. To explore these items among child-caregiver manuals, the coders added the 14 items of WeACT to the codebook. After these last iterations, the final codebook was used to code an additional three manuals by one of the coders. At this stage, minor re-coding and refinements to the final codebook were completed. These methods were applied for all competencies (e.g., common factors, treatment-specific, other non-specific, etc.) across included manuals. In this paper, we only present the findings for common factors. Results for treatment-specific and other non-specific factors coded across the manuals will be presented in subsequent publications. The process for developing the codebook of competencies and coding competencies is displayed in Fig. 1.

Results

Reference lists of recent reviews (Brown et al., 2017; Pedersen et al., 2019; Singla et al., 2017) were initially searched to identify interventions. Ten were identified and fit the inclusion criteria, and they were available online or upon author approval. An additional four interventions with positive RCTs were identified. This resulted in a total of 14 interventions: Cognitive Processing Therapy (CPT), Counselling for Alcohol Problems (CAP), Common Elements Treatment Approach (CETA)-Adult, CETA-Youth, Friendship Bench (FB), Happy Families (HF), Healthy Activity Program (HAP), Group Interpersonal Therapy (Group-IPT), Problem Management Plus (PM+), Parenting Program Uganda (PPU), Screening and Brief Intervention for Harmful and Hazardous Drinking (SBI), Self-Help Plus (SH+), Thinking Healthy Program (THP), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Two additional manuals were identified as ancillary to the current collection of interventions and therefore included in the review: 1. Counselling Relationships (CR), which supports the teaching of basic counselling skills in tandem with CAP and HAP; and, similarly to CR, 2. Psychological First Aid (PFA), a manual that has been used in some instances to build supportive skills prior to commencing training in treatment-specific interventions. Ultimately, the review included 16 manuals: 14 treatment-specific manuals, plus 2 ancillary manuals (Table 1). All manuals included in this review were in English. Translated manuals, e.g., Spanish version of THP or Arabic version of PM+, were not coded for this review.

The final codebook included 140 codes in 17 domains (Common Factors, Engagement, In-Session Techniques, Other Techniques, Other Services, Relaxation, Behavioral Activation, Cognitive, Motivational Enhancement, Problem Management, Interpersonal, Trauma, Group Facilitation, Other Delivery Techniques, Supervision, Caregiver-Specific, and Child-Specific).

Table 2 lists the common factors coded in the manual and describes how each code was operationalized. The most frequent common factors were promoting hope and realistic expectancy for change, ensuring confidentiality, giving praise, psychoeducation, rapport building, empathy, incorporation of coping mechanisms, and collaborative goal-setting (Fig. 2). Less frequent competencies included family engagement, eliciting feedback, normalization, assessment of harm, non-verbal and verbal communication, and factors related to functioning. Fifteen of the manuals included treatment-specific techniques. Cognitive techniques and problem management techniques were the most commonly identified treatment-specific techniques, included in 8 (53%) of the 15 manuals (Fig. 3). Interpersonal techniques were identified in 7 manuals (47%); behavioral activation in 6 manuals (40%); and trauma and motivational enhancement techniques each in 4 manuals (25%).

Harmonization of common factor descriptions and concepts was possible across the manuals. However, the presentation of each competency varied in rate of occurrence (e.g., once versus multiple times throughout) and description across manuals. Examples of some of these variations in descriptions are given below for a selection of the common factors.

Promoting hope and realistic expectancy for change

Promoting hope and expectancy for change was present in 15 (94%) manuals. Each of these manuals included instructions for the non-specialist to be transparent and explain to the client a realistic expectation about what the program would offer, including the goals of the program. Instructions in manuals offered prompts for promoting hope for change, such as ''provide hope,'' ''give hope,'' ''provide reassurance and hope,'' ''communicate hope,'' ''instill hope,'' and ''express optimism'' to the client that the program will work. Manuals also included instructions for giving clients encouragement, such as by explaining how the program has helped others with similar problems.

Descriptions of promoting hope and realistic expectancy for change also referred to the need to be realistic, e.g., not to mislead the client, and clearly explain that joining the program will not ''make life's problems disappear'' (THP) or give false hope that ''everything will be fine after these sessions'' (Group IPT). Manuals (46%) also included explicit instructions for non-specialists to describe what not to expect. These instructions included how the non-specialist should manage expectations, given that a client might anticipate or seek monetary goods or employment in exchange for attendance. The manuals may also have simply instructed the non-specialist to explain the program and be ''honest'' about what the treatment would not provide.

Additionally, three manuals specifically instructed how to support the client when s/he is losing hope and feeling discouraged about how the program might be helpful, or if recovery is taking longer than initially expected. Prompts for the non-specialist included: ''No one can guarantee that any particular treatment will work, but now that you are here you could give this counselling a try and see if it helps you in any way,'' (CAP) and, ''Change doesn't come easily or quickly, even when one is trying hard'' (PPU).

Table 1 Manuals ($n = 16$) for psychological treatments delivered[a] by non-specialists in low- and middle-income countries.

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Cognitive Processing Therapy (CPT)	Cognitive Processing Therapy (CPT) aims to support people with mental health problems following traumatic events, including rape, domestic violence, combat, torture, and child sexual abuse. This manual was created for delivery by non-specialists in the Democratic Republic of Congo For additional information on CPT: https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/our-projects/by-intervention/	(Bass, Bolton, et al., 2013; Bass, Annan, et al., 2013)	Combination of individual and group sessions 12 sessions (1 individual and 11 group)	Manual (93 pp) Assessment and worksheets included within manual
Counselling for Alcohol Problems (CAP), Sangath	The Counselling for Alcohol Problems (CAP) was designed to deliver counseling to people with harmful or dependent drinking in primary care settings. It is meant to accompany the Premium Counselling Relationships manual during delivery (see below). CAP uses a mix of motivational approaches (motivational enhancement) with other approaches such as problem-solving steps and cognitive techniques to, ''help people change their thinking about, and behavior towards, drinking alcohol'' CAP materials are freely available online: http://www.sangath.in/premium-manual/	(Nadkarni et al., 2017; Patel et al., 2014)	Individual sessions with option to include significant other (SO) 2—4 sessions, each session lasting 30—60 min, delivered weekly Adaptable as needed	Manual (112 pp) Annex with assessments, glossary, referral pathways and medication descriptions (7 pp) Intended to be paired with Counselling relationships manual

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Common Elements Treatment Approach, For Adults (CETA, Adult)	Common Elements Treatment Approach (CETA) Adult is a transdiagnostic treatment to address symptoms related to common mental health problems such as trauma-related symptoms, depression, and anxiety. The manual was designed specifically for use in low-and middle-income countries and developed in a simple format to ensure those with ''little to no previous mental health training could learn and implement the components'' For additional information on CETA Adult: https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/our-projects/by-intervention/	(Murray et al., 2014a, 2014b; Weiss et al., 2015)	Individual or group sessions Roughly 8—12 sessions, 60 minutes each, delivered weekly Adaptable as needed	Manual—Session guide and step sheets only (83 pp) Assessments and worksheets included separately
Common Elements Treatment Approach, for Child and Caregiver (CETA, Youth)	Common Elements Treatment Approach (CETA) Youth is a transdiagnostic therapeutic approach incorporating nine therapies based on multiple treatment classes. It is meant to be delivered to individual children and adolescents (aged 7 to18 years), and their caregivers (if available). Caregivers may be treated in parallel with the child's treatment in order to teach caregiver therapeutic skills and help the caregiver support the child in using the skills from the sessions at home. There may be a combined child-parent therapy session, typically for dealing with traumatic events For additional information on CETA Youth: https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/our-projects/by-intervention/	(Murray et al., 2018)	Combination of Individual (or group) child and caregiver sessions, with some combined caregiver and child sessions Roughly 8—12 sessions, 60-minutes each, delivered weekly Adaptable as needed	Manual—Session guide and step sheets only, Child and Caregiver (126 pp) Assessments and worksheets included separately

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Friendship Bench (FB)	The Friendship Bench (FB) is a transdiagnostic treatment that uses cognitive behavioral therapy techniques specifically related to problem-solving and behavioral activation. It is written in English and Shona and was created to be supported by the use of tablets Friendship Bench materials are freely available online: https://www.friendshipbenchzimbabwe.org/project-resources	(Chibanda et al., 2011; Chibanda et al., 2016; Singh, 2017)	Individual sessions with some group meeting circles 6 structured sessions, 45 minutes each, delivered weekly	Manual - English (77 pp) Includes assessments, worksheets, handouts in English and Shona (30 pp)
Group Interpersonal Therapy (IPT) for Depression	The WHO Group Interpersonal Therapy (Group IPT) adapts traditional individual IPT therapy into a simplified version designed for group treatment of depression in a variety of settings. The therapy covers four main problem areas that are common to individual IPT including grief, disputes/conflict, life changes, and loneliness/isolation. This model teaches that one or more of these problem areas trigger depression WHO Group IPT Materials: https://www.who.int/mental_health/mhgap/interpersonal_therapy/en/	(Bass et al., 2006; Betancourt et al., 2012; Bolton et al., 2007; Bolton et al., 2003; Mutamba, Kane, et al., 2018; Mutamba, Kohrt, et al., 2018; Patel et al., 2011; Petersen, Bhana, Baillie, & MhaPP Research Programme Consortium, 2012; Verdeli et al., 2003; Verdeli et al., 2008; Verdeli et al., 2016)	Group format of 6—10 participants Groups typically separated for men and women, and/or for other characteristics based on context 8 sessions, 90 minutes each, delivered weekly Adaptable as needed	Manual (60 pp) Annex with case studies, assessments and worksheets (30 pp)
Healthy Activity Program (HAP), Sangath	The Healthy Activity Program was designed for counseling adults with moderate to severe depression in primary care settings. It should be accompanied by the Counselling Relationships manual during delivery HAP materials are freely available online: http://www.sangath.in/premium-manual/	(Chowdhary et al., 2016; Patel et al., 2017)	Individual sessions 6—8 sessions, 35 minutes each, delivered weekly Adaptable as needed	Manual (72 pp) Annex with assessment information, glossary (2 pp) Intended to be paired with Counselling Relationships manual

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Happy Families (HF)	The Happy Families (HF) caregiver and family skills intervention is meant for children (ages 7 to 15 years) and their caregivers. It was adapted from the Strengthening Families program and includes topics on parenting and skills for better family functioning. It was developed for implementation with Burmese migrant families displaced in Thailand For additional information on HF: https://www.rescue.org/report/building-happy-families-irc-research-brief	(Annan, Sim, Puffer, Salhi, & Betancourt, 2016; Puffer, Annan, Sim, Salhi, & Betancourt, 2017)	Group sessions (separate groups for children and parents with some combined parents and children groups) 12 sessions, 150 minutes each	Manual—Child session guide only (80 pp) Includes handouts within
Parenting Program Uganda (PPU)	Parenting Program Uganda (PPU) is aimed to encourage parents to adopt and practice parenting skills that support the healthy development of their children (''develop into strong, healthy, and smart people''). It comprises five main messages: (a) diversify the child's diet with animal-source foods and provide three to four meals daily; (b) hand-wash with soap and use latrines; (c) engage in two-way talk with the child using pictures; (d) provide home-available play materials; and (e) love and respect yourself, your child and your spouse For more information on PPU: https://www.plan-international.org/publications/parenting-impact-study-lira-uganda	(Singla & Kumbakumba, 2015; Singla, Kumbakumba, & Aboud, 2015)	Group sessions (some with both parents and children, some for mothers only, some for fathers only) 12 sessions	Manual (65 pp) Annex with handouts and worksheets (7 pp)

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Problem Management+(PM+)	Problem Management Plus (PM+) is a brief psychological intervention for adults with symptoms of depression, anxiety, or stress who live in communities affected by adversity. The approach involves problem management (PM) (also known as problem-solving counseling or problem-solving therapy) plus (+) selected behavioral strategies. Ordered PM+ Strategies: Managing stress, Managing problems, Get going, keep doing (behavioral activation), Strengthening social support and Relapse prevention WHO PM+ Materials	(Bryant et al., 2017; Chiumento et al., 2017; Dawson et al., 2015; Hamdani et al., 2017; Rahman, Hamdani, et al., 2016; Rahman, Riaz, et al., 2016; Sangraula et al., 2018; Sijbrandij et al., 2015; Sijbrandij et al., 2016)	Individual and group formats 5 intervention sessions, 90 minutes each, delivered on weekly basis (timing adaptable based on client's needs) Client should receive PM+ strategies in the order they are described	Manual (65 pp) Annex with assessments and worksheets (62 pp)
Premium Counselling Relationship Manual, Sangath	The Counselling Relationships manual was designed to guide those who have no formal training in counselling individuals with mental health problems. The Counselling Relationships manual teaches basic counseling skills ''required in a practical and simple-to-understand format'' PREMIUM Counselling Relationship Manual materials are freely available online: http://www.sangath.in/premium-manual/	(Chowdhary et al., 2016; Nadkarni et al., 2017; Patel et al., 2014; Patel et al., 2017)	N/A. To be used in addition with other manuals (e.g., CAP & HAP) for effective delivery of care	Manual (45 pp) Annex with glossary and suggested reading (2 pp)

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Psychological First Aid (PFA)	Psychological First Aid (PFA) is humane, supportive, and practical assistance to fellow human beings who recently suffered exposure to severe stressors. It involves non-intrusive, practical care and support, assessing needs and concerns, helping people to address basic needs (food, water), listening, but not pressuring people to talk, comforting people and helping them to feel calm, helping people connect to information, services and social supports, protecting people from further harm WHO PFA Materials: https://www.who.int/mental_health/publications/guide_field_workers/en/	(Fox et al., 2012; Snider, 2016)	N/A. PFA materials support a 4-hour to 1- or 2-day orientation to prepare helpers to support those that have been recently affected by a serious crisis/event. It is not intended to give participants (helpers) therapeutic counseling skills	Manual (59 pp) Annex with worksheets (12 pp)
Screening and Brief Intervention for Harmful and Hazardous Drinking (SBI)	Screening and Brief Intervention for Harmful and Hazardous Drinking (SBI) offers guidance physicians, nurses, community health workers, and a range of others to care for persons whose alcohol consumption may be or has become hazardous or harmful to their health WHO SBI Materials: https://www.who.int/substance_abuse/activities/sbi/en/	(Peltzer et al., 2013)	Initial screening is conducted using the Alcohol Use Disorders Identification Test (AUDIT) during routine clinical practice If a client needs intervention, one 15-minute session is described	Manual (53 pp)
Self Help Plus (SH+)	SH+ was developed to help people with high levels of stress and psychological distress (e.g., symptoms of depression, anxiety), especially in areas where there are many people needing support (i.e., a humanitarian setting), or where there are difficulties in the provision and/or supervision of psychological interventions. Facilitators and co-facilitators use pre-recorded audio, pictures, and support materials to conduct each session WHO SH+ Materials are currently being evaluated and will be made available pending results. The Juba Arabic version for use in South Sudan is available on request	(Brown et al., 2018; Epping-Jordan et al., 2016; Tol et al., 2018)	Group sessions no more than 30 people (separated by gender or other characteristics depending on context) 5 intervention sessions, 90 minutes each	Manual (includes 36 pp for facilitator manual; 104 pp for session guide) Annex with assessments and worksheets (48 pp)

Table 1 (*Continued*)

Intervention	Description	Relevant publications[b]	Session format, length, and related strategies	Details on Coded Material[c]
Thinking Healthy Program (THP)	Thinking Healthy Program (THP) is a psychosocial approach based on cognitive behavioral therapy (CBT) principles for managing perinatal depression. Three CBT-based steps are repeated throughout the program and include ''learning to identify unhealthy thinking,'' ''learning to replace unhealthy thinking with helpful thinking,'' and ''practice thinking and acting healthy.'' It is community-based and focuses on mother and infant wellbeing rather than directly treating depression WHO THP Materials: https://www.who.int/mental_health/maternal-child/thinking_healthy/en/	(Atif et al., 2017; Maselko et al., 2015; Rahman, 2007; Rahman, Malik, Sikander, Roberts, & Creed, 2008; Sikander et al., 2019; Sikander et al., 2015; Zafar et al., 2016)	Individual sessions typically delivered in the client's home 16 sessions within 6 modules, 3 sessions per module	Manual (125 pp) Annex with worksheets (47 pp)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is a treatment protocol for addressing the psychosocial sequelae of trauma exposure among children and adolescents (3—18 years), with a specific application for grief. Non-specialists can deliver it in low- and middle-income settings For additional information on TF-CBT: https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/our-projects/by-intervention/	(Dorsey et al., 2020; Dorsey et al., 2017; Murray et al., 2015; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013)	Individual or group sessions Roughly 8—12 sessions, 60 minutes each, delivered weekly Adaptable as needed	Manual—Session guide and step sheets only, child and caregiver (162 pp) Assessments and worksheets included separately Intended to be paired with book: Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)

[a] Included manuals involved either an RCT or were ancillary to an included intervention. Additional manuals which are currently being tested in an RCT were coded and can be found in the supplementary files.

[b] Relevant publications include any literature published related to the intervention (e.g., RCT, pilot studies, descriptive pieces, etc.) which support its evidence base, including descriptions that announce ongoing evaluation or planned RCTs.

[c] Materials coded include manual pages (Manual (pp #)); assessments, worksheets, and handouts were not coded in this process.

Table 2 Brief descriptions of common factors identified across number (%) of manuals ($n = 16$).

Common factor	Brief description	Number of Manuals (%), *n* (%)
Promoting hope and realistic expectancy for change	Building the client's positive and realistic expectancy for change by outlining what can and cannot be achieved through treatment, and encouraging the client that change is possible	15 (94)
Explaining and assuring confidentiality	Building trust with the client by clearly explaining confidentiality, as well as disclosing when confidentiality may be broken to assure client's safety (e.g., confidentiality exceptions for harm to self and others); and, adjusts topics based on private or non-private settings to maintain confidentiality	15 (94)
Giving praise	Praising the client for mental health-promoting behaviors, e.g., participating in the therapy, expressing emotions during therapy, completing homework and practice assignments	14 (88)
Psychoeducation	Explaining psychological distress and how the treatment works by incorporating the client's explanatory model, local concepts and terms; provides information about the client's problem and related treatment plan; checks that the client understands	14 (88)
Rapport building and self-disclosure	Using strategies that increase the quality of the relationship between the provider and client through socially appropriate interactions, making the client feel comfortable, and offering appropriate disclosure in the service of the client's needs	13 (81)
Empathy	Portraying a deep understanding of the client's perspectives by showing warmth, genuineness, and respect; the ability to understand psychological distress within the context of the client's worldview and experiences	12 (75)
Incorporating client's coping mechanisms	Identifying and incorporating the client's prior mental health-promoting behaviors; collaborative discussion with the client to re-evaluate potential unhelpful or harmful coping mechanisms	12 (75)
Collaborative goal setting	Supporting the client's autonomy, control, and ability to make choices; jointly selects treatment targets and path to achieve that objective; checks-in on goals throughout treatment, to see if the client has adjusted or redefined them	12 (75)
Family engagement	Involving family members and significant others; encouraging interaction between client and significant others when appropriate during the treatment process; promoting skills and strategies to facilitate the family's positive engagement in treatment	11 (69)
Eliciting feedback	Routinely checking for client's experiences of and perspectives on treatment progress, clinical decisions, and expectations	11 (69)
Normalization and validation of emotions	Showing acknowledgment of emotional responses, and when appropriate, explains that the client's feelings are expected for a person in her/his situation	11 (69)
Assessment of harm	Taking an assessment of harm to self, harm to others, and developing a collaborative response plan	10 (63)
Non-verbal communication	Showing culturally appropriate body language to communicate engagement, e.g., eye contact, facial expression, nodding head, sits at appropriate angle from the client and leans in to show interest, uses communications such as 'uh-huh,' 'hmm,' 'I see,' etc.	10 (63)
Verbal communication	Using open-ended questions, paraphrasing, reflective listening, and summary reflections	10 (63)
Connecting daily functioning and mental health	Connecting symptoms to functioning and impact on life, as well as pathway from functioning to symptoms; exploring with the client how to improve functioning when symptoms take time for abatement	7 (44)

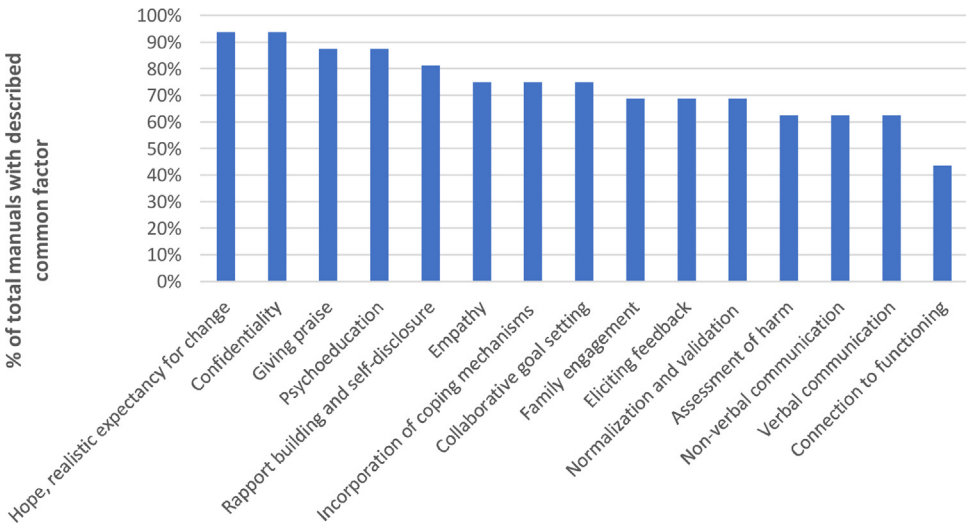

Figure 2 Common factors described in number (%) of total manuals ($n = 16$) for delivery by non-specialist providers in low-resource settings.

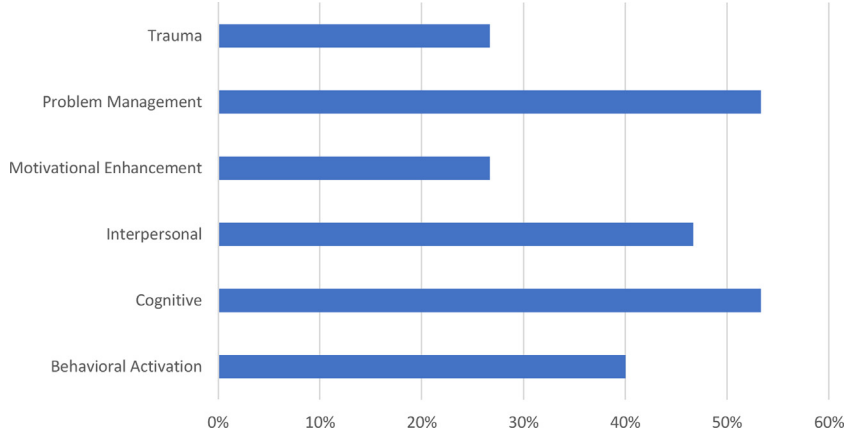

Figure 3 Treatment (Tx) specific domains across % of manuals ($n = 15$)*. * Psychological First Aid manual has no identifiable treatment specific domains and is not represented in this figure.

Empathy

Instructions for portraying empathy, warmth, and genuineness was present in 12 (75%) manuals. Typically, the instruction was given at the beginning of each manual and indicated as a ''must-do'' for the non-specialist throughout treatment. Empathy was most often included alongside non-verbal skills and active listening descriptions, with instructions for the non-specialist typically consisting of succinct phrases such as ''show respect,'' ''show sincere understanding'' ''try to understand,'' ''show concern,'' ''express warmth and genuineness,'' ''empathize with upset feelings,'' ''give accurate empathy,'' ''be non-judgmental,'' and ''show genuine interest.''

Some manuals (50%) provided examples or described what these actions meant, including why empathy is important during sessions. For example, the Friendship Bench described the power of showing empathy to the client: ''The client will feel taken more seriously when she gets the impression that the counselor is able to understand what the patient feels and why she feels the way she feels,'' instructing for the non-specialist to, ''Be genuine, ask before pretending to have understood. Avoid advising the patient to stay strong, not cry, etc. It is good to express emotions.'' Sangath's Counselling Relationships manual includes how ''expression of warmth'' should be done in a culturally appropriate manner, as it varies across different settings (e.g., laying a hand on a client's arm from a counselor may not be appropriate in some contexts). Counselling Relationships also explains the difference between empathy and sympathy, ensuring the counselor understands that empathy is ''putting oneself into another's shoes'' rather than having pity for the client.

It is important to note that empathy was identified as an explicit competency in manuals, regardless of whether treatment-specific competencies (e.g., cognitive, interpersonal, or trauma-focused) were a requirement for non-specialists to deliver the intervention (e.g., helpers learning skills from SH+ and PFA manuals are instructed to learn empathy but do not need treatment-specific competencies to deliver the treatment). The SH+ manuals include a list of Do's and Don'ts along with examples to support the non-specialist in portraying empathy: ''...it is important to acknowledge their emotions. Facilitators can do this

by describing the emotion clients may be experiencing, e.g., 'this seems really hard for you.''' The PFA manual also offers examples on how to show empathy, with instructions for those working with children and adolescents to ''relate on their eye level and use language they can understand... Remember they also have strengths.''

Another competency often found alongside empathy was normalization and validation, which was coded in 69% of manuals. Manuals included instructions such as ''normalize,'' ''validate/validation,'' or other instructions to remind the client that ''it is okay to experience...'' ''or it is normal...'' in response to the client's expressed emotions or problems. Typically, manuals repeated this instruction throughout sessions.

Psychoeducation

Psychoeducation was present in 14 manuals (88%). Each of the 14 manuals included psychoeducation in the beginning of the manual at treatment initiation, linking it to the overall goals of the program. Manuals also included psychoeducational components at the beginning of new activities to clearly explain how a new technique may target the general problem (e.g., depression in Group IPT, stress in SH+).

Although all of the manuals gave examples for how to deliver psychoeducation in lay terms (e.g., ''CPT is a therapy that works on thoughts and feelings. Traumatic experiences can change a person's thoughts about themselves, other people and the world. Sometimes the thoughts a person has are not actually true. CPT helps group members develop more accurate and balanced beliefs. When group members have more balanced beliefs, it can change how they feel,'' CPT), only a few manuals (21%) addressed the importance of incorporating culturally relevant terminology during psychoeducation. For example, Friendship Bench, a locally created manual in Zimbabwe, includes the Shona language terms and concepts throughout the manual, such as framing psychoeducation around *kufungisisa*, ''thinking too much,'' referring to the intervention as *kuvhura pfungwa*, ''opening up the mind,'' and explaining techniques such as making an action plan as ''uplifting'' (kusimudzira) and implementing the action plan as ''strengthening'' (kusimbisa).

Similarly, TF-CBT was adapted for use in Tanzania and Kenya and incorporated different Kiswahili terms during techniques. For example, the manual refers to *pole pole ndiyo mwendo* to have facilitators remind the children that it ''gets easier, and we take it slow'' (pp. 6). It also uses cultural references, such as instructing facilitators to ask children about feeling like uncooked and then cooked *bamia*, a local stew, when teaching them muscle relaxation (pp. 3). The THP manual instructs to, ''Discuss commonly held cultural beliefs about the baby's health with mother and family. Give medical explanations for common ailments, especially diarrhea in children'' (pp. 100). Some of the manuals, though not explicitly including specific idioms of distress or cultural adaptions, emphasized adapting elements. For example, in PM+, instructions described that the facilitator should be familiar with the local context and learn about local customs and beliefs to promote the delivery of care in a culturally appropriate way.

Some manuals (29%) included clear instructions on how facilitators could incorporate the client's problems or symptoms as the client had described them while delivering psychoeducation; or, how the facilitator might relate the program goals specifically to the client's described symptoms or problems. For example, the CETA manuals instructed facilitators to explain each CETA element in the context of the client's symptoms as they had been explained during assessment (CETA-Adult, CETA-Youth). THP instructs the non-specialist to ''not dictate'' the information when explaining maternal psychosocial well-being and the benefits of the program. The Group IPT manual takes into account the client's problems and symptoms; however, it only explains the symptoms, problems, and program in terms of ''depression'' and that the client assumes a sick role for depression. Six (43%) manuals instructed the facilitator to incorporate the client's significant other and/or family member's understanding of the problem during instruction for psychoeducation. All of the included interventions designed for both caregivers and their children or adolescents included the component of family member psychoeducation.

Communication skills

Instructions for non-verbal communication and active listening was present in 10 (63%) of the manuals. Each manual included this instruction towards the beginning, most often found within a designated section for learning how to be an effective facilitator (e.g., ''Style of a Counselor,'' ''An effective counseling relationship,'' or ''Basic helping skills''). Nine manuals included the directive to make or keep culturally appropriate eye contact, using statements such as, ''Where culturally accepted... make eye contact,'' ''maintain appropriate eye contact,'' ''look at the person when they are talking,'' and ''be aware of... eye contact.'' Nine of the manuals also highlighted the use of appropriate body language, seven of which suggested ''nodding'' the head as a way to communicate listening. Four manuals also made suggestions about body posture. These manuals instructed things like ''turn the upper body towards the client,'' be aware of ''the way you sit or stand in relation to the other person,'' or ''avoid crossing your arms and sitting with a stiff position.'' Forty percent of the manuals included instructions for the facilitator to use non-lexical utterances, including ''uh-huh,'' ''hmmm,'' ''okay,'' or ''I see.''

Similar to non-verbal communication, verbal communication was identified in a designated section of instructions on best facilitator practices. Manuals provided examples of open-ended questions such as ''What happened?'', ''Do you...,'' ''Are you...,'' and instructed readers to avoid closed questions or ones that may incite defensive reactions, such as, ''Did you like this?'' or ''Why not?''

Other common factors

Fewer than 70% of the manuals discussed in detail family engagement, eliciting feedback, normalization and validation, and relating to functioning. When manuals did include these factors, conceptual representation was similar. For example, with family engagement, manuals (69%) instructed facilitators to identify social support (e.g., significant other, family member) as a trustworthy source that may encourage

the client's participation throughout care. Family engagement was particularly emphasized in manuals that delivered treatment for substance use (e.g., CAP, CETA). Eliciting feedback (69%) consisted of instructions that prompted the facilitator to ask the client how they felt about a technique (e.g., likes, dislikes, confusion), including after learning it in session, when reviewing home practice, or when ending treatment.

Connecting daily functioning and mental health was the least frequently coded across manuals. Manuals that did include it (44%) instructed facilitators to ask how their concerns and symptoms are affecting their daily functioning (including relationships) with questions such as, ''What [symptoms] are interfering with your life the most? Which of your symptoms are affecting your family the most?'' (CPT) and ''What is the connection between what you do (or don't do) and how you feel and the problems/stressors in your life?'' (HAP).

Assessment of harm

Although not traditionally considered a common factor, assessment of harm has been identified as a competency needed for all non-specialists in global mental health (Kohrt, Jordans, et al., 2015; Murray, Skavenski, et al., 2014). Ten (63%) manuals incorporated instructions for assessment of harm, of which 7 manuals focused on assessment of self-harm or suicide risk, and three instructed assessment of both harm to others and harm to self. Five manuals included explanations to break common myths surrounding harm assessment (e.g., it is not true that talking openly or asking about suicide will cause the person to attempt suicide).

Discussion

This review compiled descriptions of common factors from psychological and psychosocial intervention manuals delivered by non-specialists in LMIC, which are supported by an RCT or which were ancillary to an included treatment. Manuals included a range of therapeutic targets (e.g., depression, stress, transdiagnostic), addressed both adult and youth populations and varied in session format (e.g., individual and group). Common factors were present in all manuals, and the harmonization of descriptions of those common factors and concepts was possible.

Overall, manuals covered most common factor competencies in detail, with 75% or more of manuals including instruction for 8 common factors: hope and expectancy for change, confidentiality, giving praise, psychoeducation, rapport building, empathy, incorporating coping mechanisms, and collaborative goal setting. These shared competencies in evidence-supported interventions suggest that these are likely foundational skills needed by non-specialists to deliver psychological treatments and psychosocial support effectively. Given similar framing used for these 8 domains, it is possible to create harmonized descriptions for future training material development as well as assessment approaches that can be used across interventions.

Elicitation of feedback from clients was only included in 2/3rds of the manuals. This finding potentially contrasts with what would be recommended given the evidence base for specialist delivered interventions in high-income settings. In a meta-analysis of active ingredients of change by Wampold (2015), the most significant potential for change is via mobilizing the client in therapy and promoting the client's participation through elicitation of feedback throughout treatment (Duncan et al., 2010). In the context of competencies for providers in LMIC, skills in eliciting feedback may deter the provider from didactic lecturing the client and his/her family, which has been identified as a concern in non-specialist delivered psychological interventions in LMIC (Kohrt, Jordans, et al., 2015). It should also be considered that eliciting feedback may be less present in brief manualized interventions that focus on a predetermined goal, which should be explored when considering bolstering existing manuals with this material.

Family engagement is another client-focused competency that was not as commonly present (69%). For the manuals in which it was discussed, family members were described as critical support in a variety of ways, including treatment adherence and helping the client create effective and realistic treatment plans. Gaining the client's consent to involve family member(s) is crucial. The benefit of involving family must be balanced with the risks, which include hindering the client's recovery if the family is not supportive of the treatment or harm the client's mental health in other ways. Moreover, family engagement holds great potential for creating change, particularly in LMIC, where families may be considered as an extension of self and social connections are so highly and culturally regarded (Hinton, Kohrt, & Kleinman, 2019; Kohrt, Asher, et al., 2018; Pedersen et al., 2019). Therefore, it is worth considering that working with families is a component of all non-specialist manuals going forward.

Few manuals detailed the process for assessment of harm (63%). Though typically not categorized as a common factor, assessment of harm and safety planning have both been found to be neglected during task-sharing approaches in LMIC (Murray, Skavenski, et al., 2014). This disregard may be due to research trial conditions in which study participants with self-harm are excluded from studies and/or assumptions that trainees already have skills in safety planning. However, in everyday practice, suicidality is likely to be encountered by non-specialists (Mutamba, Kane, et al., 2018; Mutamba, Kohrt, et al., 2018). When identifying universally needed skills for non-specialists, addressing the risk of harm was highlighted (Kohrt, Ramaiya, et al., 2015). As with other domains, the issue of self-harm may have been discussed in other training materials or ethical protocols; but, given the increasing use of off-the-shelf manuals, this could be considered a skill to be included in all future manuals for non-specialist training.

Connecting daily functioning and mental health was not a competency across most manuals in this review (present in 44% of manuals). This may be because it is considered a difficult skill, or it is perceived as relevant only in some interventions such as Group IPT. However, culturally relevant connections between symptoms and functional impairment may be beneficial for non-specialist skills training. For example, when exploring symptoms, it may be advantageous for the non-specialist to appropriately explore the client's idioms of distress and how those may impact life problems. Including nstructions on how to incorporate relevant idioms of distress (e.g., *kufungisisa* ''thinking too

much'') may improve identification of treatment needs, facilitate client engagement, and potentially reduce stigma surrounding participation in treatment (Cork, Kaiser, & White, 2019; Fairburn & Patel, 2014; Kaiser et al., 2015).

Limitations

Based on the methodology of this review, a number of limitations should be considered when interpreting the results. First, the length and style of the reference manuals differed substantially, with some manuals only including session-specific material (e.g., step sheets), while others included detailed descriptions for non-specialist providers. Manuals ranged from 45 pages to 162 pages. Second, the reviewers only coded original manuals released in English. Therefore, manuals adapted in different languages (e.g., Spanish version of THP), which may have included contextualized definitions or descriptions of common factors, were not coded.

Additionally, this review did not include manuals subsequently developed based on the original manual in our review. For example, THP has been adapted into a peer-delivered version (Fuhr et al., 2019; Sikander et al., 2019) as well as a technology-assisted cascade training and supervision model of THP (Rahman et al., 2019). These adaptations include additional modifications from the original material that may have added more non-specialists tailored common factors descriptions. This review presents results on manuals that are either supported by an RCT ($n = 14$) or are ancillary to interventions ($n = 2$) and therefore does not include coding results from WHO-based or other manualized interventions with ongoing efficacy trials. For example, the authors did not include common factor coding results in this review for Early Adolescent Skills for Emotions (EASE), a transdiagnostic manual intended for adolescents (10—14 years) and their caregivers living in low-and-middle-income countries and affected by adversity (e.g., armed conflict) (Brown, Steen, Taha, Aoun, Bryant, & Jordans, 2019; Dawson, Watts, Carswell, Harper, Jordans, Bryant, & van Ommeren, 2019), or for Caregiver Skills Training (CST), a program aimed to support families of children with developmental delays or disorders and intended for implementation in LMIC by non-specialists (Salomone et al., 2019).

The authors of this review coded common and treatment-specific competencies with a categorical approach (e.g., the manual either presented the competency or it did not). We did not code for competency ''intensity'' (e.g., how many times the competency was mentioned throughout one manual) because of concern that an intensity description could be misleading in the context of coding manuals and not actually observing the therapies and coding them in practice (which could be done in the future). Moreover, training approaches and supplemental material used by specific organizations or trainers may contain additional descriptions and instruction related to common factors. For example, it is likely most trainers describe verbal and non-verbal communication, even though it is not included in all manuals. We do not have information on which common factors are incorporated during training or which are used by the non-specialist during delivery of the treatment(s). Therefore, we cannot make any conclusions at this time on whether the number of common factors identified in a treatment manual equates with the effectiveness of the treatment.

As large-scale dissemination of these programs continues, observation of training programs is needed to understand what is being taught outside of, or along with, instructive manuals. These observations should highlight common factors, treatment-specific (e.g., problem-solving, cognitive, trauma, etc.) and non-specific factors (e.g., assigning homework, relaxation, ending sessions, etc.) that may or may not be taught during training.

Furthermore, the frequency of common factors identified across manuals in this review is not synonymous with the degree of importance of the factors as mechanisms of action. While it would be valuable for mental health and psychosocial support (MHPSS) training programs and projects to understand what factors are most effective, we cannot conclude, given the manuals alone, which common factors are most important for treatment outcomes. Additional work is needed to evaluate which common factors are most associated with client outcomes in LMIC (Ottman, Kohrt, Pedersen, & Schafer, 2020). In addition, although common factors may be a critical mechanism of action promoting change in client outcomes, competency in common factors should be evaluated alongside treatment-specific factors (e.g., problem-solving, cognitive, interpersonal techniques, etc.) and other non-specific factors (e.g., assigning homework, agenda-setting, relaxation, etc.) for a more accurate assessment of competency-related mechanisms of change (Cuijpers et al., 2019; Mulder et al., 2017).

Applications and recommendations

This review illustrates that common factors are central to the make-up of reference manuals for many psychological and psychosocial interventions being utilized globally. From an off-the-shelf perspective, some manuals could benefit from providing more detail when describing common factors and offering descriptions and examples of what they entail. The competencies identified through this review and how competencies for common factors are described will be used to inform the EQUIP platform's catalog of competencies and guidance on competency-based training and assessment. More work is needed to decide best which competencies are most important for designing training and supervision programs.

Conclusion

As the use of psychological interventions across low-resource settings is increasing, it is important to efficiently and effectively train persons lacking mental health professional backgrounds. Similar to psychological interventions provided by specialists, common factors likely play an important role in treatment effects in psychological and psychosocial interventions delivered by non-specialists. In this manual review, common factors were strongly represented across all evidence-supported interventions delivered by non-specialists in LMIC. Promoting hope and expectancy for change, assuring confidentiality, giving praise, rapport building, and culturally relevant psychoeducation were dominant common factors in training manuals. Further research is needed to determine which of the common factors identified

across the range of manuals in this review are most important for therapeutic change and predictive of treatment outcomes. The findings of this review provide a foundation for further research on training and client outcome studies needed to advance the global march to reducing the burden of untreated mental illness and psychological distress.

Disclosure of interest

The authors declare that they have no competing interest.

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Appendix A. Supplementary data

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References

Annan, J., Sim, A., Puffer, E. S., Salhi, C., & Betancourt, T. S. (2016). Improving mental health outcomes of burmese migrant and displaced children in Thailand: a community-based randomized controlled trial of a parenting and family skills intervention. *Prevention Science*, 1—11. http://dx.doi.org/10.1007/s11121-016-0728-2

Arch, J. J., Eifert, G. H., Davies, C., Plumb Vilardaga, J. C., Rose, R. D., & Craske, M. G. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology*, *80*(5), 750—765. http://dx.doi.org/10.1037/a0028310

Atif, N., Krishna, R. N., Sikander, S., Lazarus, A., Nisar, A., Ahmad, I., et al. (2017). Mother-to-mother therapy in India and Pakistan: adaptation and feasibility evaluation of the peer-delivered Thinking Healthy Programme. *BMC Psychiatry*, *17*(1), 79. http://dx.doi.org/10.1186/s12888-017-1244-z

Barbui, C., Purgato, M., Abdulmalik, J., Acarturk, C., Eaton, J., Gastaldon, C., et al. (2020). Efficacy of psychosocial interventions for mental health outcomes in low-income and middle-income countries: an umbrella review. *The Lancet Psychiatry*, *7*(2), 162—172. http://dx.doi.org/10.1016/s2215-0366(19)30511-5

Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., et al. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PLoS Medicine/Public Library of Science*, *10*(5), e1001454. http://dx.doi.org/10.1371/journal.pmed.1001454

Barth, R. P., Lee, B. R., Lindsey, M. A., Collins, K. S., Strieder, F., Chorpita, B. F., et al. (2012). Evidence-based practice at a crossroads: the timely emergence of common elements and common factors. *Research on Social Work Practice*, *22*(1), 108—119. http://dx.doi.org/10.1177/1049731511408440

Bass, J., Bolton, P., Kaysen, D., Griffith, S., Murray, S., Cetinoglu, T., et al. (2013). *Addressing sexual violence related trauma in eastern DRC with cognitive processing therapy*. Washington, DC: World Bank.

Bass, J., Neugebauer, R., Clougherty, K. F., Verdeli, H., Wickramaratne, P., Ndogoni, L., et al. (2006). Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes — Randomised controlled trial. *British Journal of Psychiatry*, *188*, 567—573. http://dx.doi.org/10.1192/bjp.188.6.567

Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., et al. (2013). Controlled trial of psychotherapy for congolese survivors of sexual violence. *New England Journal of Medicine*, *368*(23), 2182—2191.

Betancourt, T. S., Newnham, E. A., Brennan, R. T., Verdeli, H., Borisova, I., Neugebauer, R., et al. (2012). Moderators of treatment effectiveness for war-affected youth with depression in Northern Uganda. *Journal of Adolescent Health*, *51*(6), 544—550. http://dx.doi.org/10.1016/j.jadohealth.2012.02.010

Blackburn, I. M., James, I. A., Milne, D. L., & Reichelt, F. K. (2000). *Cognitive therapy scale - revised (CTS-R)*. pp. 15. http://dx.doi.org/10.1111/j.1365-246X1980.tb02634.x

Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., et al. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: a randomized controlled trial. *JAMA*, *298*(5), 519—527.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., et al. (2003). Grup interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *JAMA*, *289*(23), 3117—3124.

Brown, F. L., Carswell, K., Augustinavicius, J., Adaku, A., Leku, M. R., White, R. G., et al. (2018). Self Help Plus: study protocol for a cluster-randomised controlled trial of guided self-help with South Sudanese refugee women in Uganda. *Global mental health (Cambridge, England)*, *5*, e27. http://dx.doi.org/10.1017/gmh.2018.17

Brown, F. L., de Graaff, A. M., Annan, J., & Betancourt, T. S. (2017). Annual Research Review: Breaking cycles of violence—-A systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. *Journal of Child Psychology and Psychiatry*, *58*(4), 507—524. http://dx.doi.org/10.1111/jcpp.12671

Brown, F. L., Steen, F., Taha, K., Aoun, M., Bryant, R. A., Jordans, M. J. D., & on behalf of the S.-c. (2019). Early Adolescent Skills for Emotions (EASE) intervention for the treatment of psychological distress in adolescents: study protocol for randomised controlled trials in Lebanon and Jordan. *Trials*, *20*(1), 545.

Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Mulili, C., Ndogoni, L., et al. (2017). Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: a randomised clinical trial. *Plos Medicine*, *14*(8), e1002371. http://dx.doi.org/10.1371/journal.pmed.1002371

Carroll, K. M., Nich, C., Sifry, R. L., Nuro, K. F., Frankforter, T. L., Ball, S. A., et al. (2000). A general system for evaluating therapist adherence and competence in psychotherapy research in the addictions. *Drug & Alcohol Dependence*, *57*(3), 225—238.

Cartreine, J. A., Chang, T. E., Seville, J. L., Sandoval, L., Moore, J. B., Xu, S., et al. (2012). Using self-guided treatment software (ePST) to teach clinicians how to deliver problem-solving treatment for depression. *Depression Research and Treatment*, http://dx.doi.org/10.1155/2012/309094

Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high

prevalence of people living with HIV. *BMC Public Health*, *11*(1), 828.

Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., et al. (2016). Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe. A randomized clinical trial. *Jama-Journal of the American Medical Association*, *316*(24), 2618—2626. http://dx.doi.org/10.1001/jama.2016.19102

Chiumento, A., Hamdani, S. U., Khan, M. N., Dawson, K., Bryant, R. A., Sijbrandij, M., Rahman, A., et al. (2017). Evaluating effectiveness and cost-effectiveness of a group psychological intervention using cognitive behavioural strategies for women with common mental disorders in conflict-affected rural Pakistan: study protocol for a randomised controlled trial. *Trials*, *18*(1), 190. http://dx.doi.org/10.1186/s13063-017-1905-8

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: a distillation and matching model. *Mental Health Services Research*, *7*(1), 5—20. http://dx.doi.org/10.1007/s11020-005-1962-6

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2008). *Psychosocial and combined treatments coding manual*. P. LLC [Version 9/9/12 ed.].

Chowdhary, N., Anand, A., Dimidjian, S., Shinde, S., Weobong, B., Balaji, M., et al. (2016). The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. *British Journal of Psychiatry*, *208*(4), 381—388. http://dx.doi.org/10.1192/bjp.bp.114.161075

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford.

Cork, C., Kaiser, B. N., & White, R. G. (2019). The integration of idioms of distress into mental health assessments and interventions: a systematic review. *Global mental health (Cambridge, England)*, *6*, e7. http://dx.doi.org/10.1017/gmh.2019.5

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). *The role of common factors in psychotherapy outcomes*. pp. 1—25. http://dx.doi.org/10.1146/annurev-clinpsy-050718-095424

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). pp. 909—922. *Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies* (76) http://dx.doi.org/10.1037/a0013075

Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., et al. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry*, *14*(3), 354—357. http://dx.doi.org/10.1002/wps.20255

Dawson, K. S., Watts, S., Carswell, K., Harper, M., Jordans, M. J. D., Bryant, R. A., & van Ommeren, M. (2019). Improving access to evidence-based interventions for young adolescents: Early adolescent skills for emotions (EASE). *World Psychiatry*, http://dx.doi.org/10.1002/wps.20594

Dorsey, S., Lucid, L., Martin, P., King, K. M., O'Donnell, K., Murray, L. K., et al. (2020). Effectiveness of task-shifted trauma-focused cognitive behavioral therapy for children who experienced parental death and posttraumatic stress in Kenya and Tanzania: a randomized clinical trial. *JAMA Psychiatry*, *77*(5), 464—473. http://dx.doi.org/10.1001/jamapsychiatry.2019.4475

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., et al. (2017). Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of clinical child and adolescent psychology: the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *46*(3), 303—330. http://dx.doi.org/10.1080/15374416.2016.1220309

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change, second edition: delivering what works in therapy*. Washington, DC: American Psychological Association.

Epping-Jordan, J. E., Harris, R., Brown, F. L., Carswell, K., Foley, C., García-Moreno, C., et al. (2016). Self-Help Plus (SH+): a new WHO stress management package. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *15*(3), 295—296. http://dx.doi.org/10.1002/wps.20355

Fairburn, C., & Patel, V. (2014). The global dissemination of psychological treatments: a road map for research and practice. *American Journal of Psychiatry*, *171*(5), 495—498.

Faust, D., & Zlotnick, C. (1995). Another Dodo bird verdict? Revisiting the comparative effectiveness of professional and paraprofessional therapists. *Clinical Psychology and Psychotherapy*, 2(3), 157—167.

Fonagy, P., & Clark, D. M. (2015). Update on the Improving Access to Psychological Therapies programme in England: commentary on ... Children and young people's improving access to psychological therapies. *BJPsych bulletin*, *39*(5), 248—251. http://dx.doi.org/10.1192/pb.bp.115.052282

Fox, J. H., Burkle, F. M., Bass, J., Pia, F. A., Epstein, J. L., & Markenson, D. (2012). The effectiveness of psychological first aid as a disaster intervention tool: research analysis of peer-reviewed literature from 1990—2010. *Disaster Medicine and Public Health Preparedness*, *6*(03), 247—252. http://dx.doi.org/10.1001/dmp.2012.39

Fuhr, D. C., Weobong, B., Lazarus, A., Vanobberghen, F., Weiss, H. A., Singla, D. R., et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually randomised controlled trial in India. *The Lancet Psychiatry*, *6*(2), 115—127.

Global Social Service Workforce Alliance. (2017). *Para professionals in the social service workforce: guiding principles, functions and competencies*. http://www.socialserviceworkforce.org/resources/para-professionals-social-service-workforce-guiding-principles-functions-and-0

Hamdani, S. U., Ahmed, Z., Sijbrandij, M., Nazir, H., Masood, A., Akhtar, P., et al. (2017). Problem Management Plus (PM+) in the management of common mental disorders in a specialized mental healthcare facility in Pakistan; study protocol for a randomized controlled trial. *International Journal of Mental Health Systems*, *11*(1), 40. http://dx.doi.org/10.1186/s13033-017-0147-1

Hinton, L., Kohrt, B. A., & Kleinman, A. (2019). Enaging families to advance global mental health intervention research. *The Lancet Psychiatry*, *6*(365—367).

Kaiser, B. N., Haroz, E. E., Kohrt, B. A., Bolton, P. A., Bass, J. K., & Hinton, D. E. (2015). ''Thinking too much'': a systematic review of a common idiom of distress. *Social Science & Medicine*, *147*, 170—183. http://dx.doi.org/10.1016/j.socscimed.2015.10.044

Kohrt, B., Asher, L., Bhardwaj, A., Fazel, M., Jordans, M., Mutamba, B., et al. (2018). The role of communities in mental health care in low- and middle-income countries: a meta-review of components and competencies. *International Journal of Environmental Research and Public Health*, *15*(6), 1279. http://dx.doi.org/10.3390/ijerph15061279

Kohrt, B. A., Mutamba, B. B., Luitel, N. P., Gwaikolo, W., Onyango Mangen, P., Nakku, J., & Baingana, F. (2018). How competent are non-specialists trained to integrate mental health services in primary care? Global health perspectives from Uganda, Liberia, and Nepal. *International Review of Psychiatry*, *30* (1369-1627) (Electronic), 182-198.

Kohrt, B. A., Jordans, M. J. D., Rai, S., Shrestha, P., Luitel, N. P., Ramaiya, M., et al. (2015). Therapist Competence in Global Mental Health: Development of the Enhancing Assessment of Common Therapeutic Factors (ENACT)

Rating Scale. *Behaviour Research and Therapy*, *69*, 11–21. http://dx.doi.org/10.1016/j.brat.2015.03.009

Kohrt, B. A., Ramaiya, M. K., Rai, S., Bhardwaj, A., & Jordans, M. J. D. (2015). Development of a scoring system for non-specialist ratings of clinical competence in global mental health: a qualitative process evaluation of the Enhancing Assessment of Common Therapeutic Factors (ENACT) scale. *Global Mental Health*, *2*, e23. http://dx.doi.org/10.1017/gmh.2015.21

Kohrt, B. A., Schafer, A., Willhoite, A., van't Hof, E., Pedersen, G. A., Watts, S., et al. (2020). Ensuring Quality in Psychological Support (WHO EQUIP): developing a competency global workforce. *World Psychiatry*, *19*(1) http://dx.doi.org/10.1002/wps.20704

Korfmacher, J., O'Brien, R., Hiatt, S., & Olds, D. (1999). Differences in program implementation between nurses and paraprofessionals providing home visits during pregnancy and infancy: a randomized trial. *American Journal of Public Health*, *89*(12), 1847–1851.

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective. *Psychotherapy (Chic)*, *51*(4), 467–481. http://dx.doi.org/10.1037/a0034332

Maselko, J., Sikander, S., Bhalotra, S., Bangash, O., Ganga, N., Mukherjee, S., et al. (2015). Effect of an early perinatal depression intervention on long-term child development outcomes: follow-up of the Thinking Healthy Programme randomised controlled trial. *The Lancet Psychiatry*, *2*(7), 609–617. http://dx.doi.org/10.1016/S2215-0366(15)00109-1

Miller, W. R., Moyers, T. B., Ernst, D., & Amrhein, P. (2003). *Manual for Motivational Interviewing Skill Code (MISC)*.. Retrieved from https://casaa.unm.edu/download/misc.pdf

Mulder, R., Murray, G., & Rucklidge, J. (2017). Common versus specific factors in psychotherapy: opening the black box. *The Lancet Psychiatry*, *4*(12), 953–962. http://dx.doi.org/10.1016/S2215-0366(17)30100-1

Murray, L., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., et al. (2014). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice*, *21*(2), 111–123. http://dx.doi.org/10.1016/j.cbpra.2013.06.005

Murray, L., Skavenski, S., Bass, J., Wilcox, H., Bolton, P., Imasiku, M., et al. (2014). Implementing evidence-based mental health care in low-resource settings: a focus on safety planning procedures. *Journal of Cognitive Psychotherapy*, *28*(3), 168–185.

Murray, L. K., Hall, B. J., Dorsey, S., Ugueto, A. M., Puffer, E. S., Sim, A., et al. (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global mental health (Cambridge, England)*, *5*, e16. http://dx.doi.org/10.1017/gmh.2018.7

Murray, L. K., Skavenski, S., Kane, J. C., Mayeya, J., Dorsey, S., Cohen, J. A., Bolton, P. A., et al. (2015). Effectiveness of trauma-focused cognitive behavioral therapy among trauma-affected children in Lusaka, Zambia. *JAMA Pediatrics*, *169*(8), 761–769. http://dx.doi.org/10.1001/jamapediatrics.2015.0580

Mutamba, B. B., Kane, J. C., De Jong, J., Okello, J., Musisi, S., & Kohrt, B. A. (2018). Psychological treatments delivered by community health workers in low-resource government health systems: effectiveness of group interpersonal psychotherapy for caregivers of children affected by Nodding Syndrome in Uganda. *Psychological Medicine*, *48*(15), 2573–2583. http://dx.doi.org/10.1017/S0033291718000193

Mutamba, B. B., Kohrt, B. A., Okello, J., Nakigudde, J., Opar, B., Musisi, S., et al. (2018). Contextualization of psychological treatments for government health systems in low-resource settings: group interpersonal psychotherapy for caregivers of children with nodding syndrome in Uganda. *Implementation science: IS*, *13*(1), 90. http://dx.doi.org/10.1186/s13012-018-0785-y

Nadkarni, A., Weobong, B., Weiss, H. A., McCambridge, J., Bhat, B., Katti, B., et al. (2017). Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *Lancet*, *389*(10065), 186–195. http://dx.doi.org/10.1016/s0140-6736(16)31590-2

National Collaborating Centre for Mental Health. (2019). *The improving access to psychological therapies manual*. https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

Nuro, K. F., Maccarelli, L., Martino, S., Ball, S. A., Baker, S. M., Rounsaville, B. J., et al. (2005). *Yale Adherence and Competence Scale (YACSII) Guidelines. Yale University Psycotherapy Development Center, Manual-Guided Training Series No. 7.*

O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). *A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war-affected Congolese girls*, *52*(4), 359–369. http://dx.doi.org/10.1016/j.jaac.2013.01.013

Ottman, K. E., Kohrt, B. A., Pedersen, G. A., & Schafer, A. (2020). Use of role plays to assess therapist competency and its association with client outcomes in psychological interventions: A scoping review and competency research agenda. *Behaviour Research and Therapy*, *130*, 103531. http://dx.doi.org/10.1016/j.brat.2019.103531

Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., et al. (2011). Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months. *British Journal of Psychiatry*, *199*(6), 459–466.

Patel, V., Weobong, B., Nadkarni, A., Weiss, H., Anand, A., Naik, S., et al. (2014). The effectiveness and cost-effectiveness of lay counsellor-delivered psychological treatments for harmful and dependent drinking and moderate to severe depression in primary care in India: PREMIUM study protocol for randomized controlled trials. *Trials*, *15*(1), 101.

Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., et al. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *Lancet*, *389*(10065), 176–185. http://dx.doi.org/10.1016/s0140-6736(16)31589-6

Pedersen, G. A., Smallegange, E., Coetzee, A., Hartog, K., Turner, J., Jordans, M. J. D., et al. (2019). A systematic review of the evidence for family and parenting interventions in low- and middle-income countries: child and youth mental health outcomes. *Journal of Child and Family Studies*, *28*(8), 2036–2055. http://dx.doi.org/10.1007/s10826-019-01399-4

Peltzer, K., Naidoo, P., Louw, J., Matseke, G., Zuma, K., McHunu, G., et al. (2013). Screening and brief interventions for hazardous and harmful alcohol use among patients with active tuberculosis attending primary public care clinics in South Africa: results from a cluster randomized controlled trial. *BMC Public Health*, *13*, 699. http://dx.doi.org/10.1186/1471-2458-13-699

Petersen, I., Bhana, A., Baillie, K., & MhaPP Research Programme Consortium. (2012). The feasibility of adapted group-based interpersonal therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. *Community and Mental Health Journal*, *48*(3), 336–341. http://dx.doi.org/10.1007/s10597-011-9429-2

Puffer, E. S., Annan, J., Sim, A. L., Salhi, C., & Betancourt, T. S. (2017). The impact of a family skills training intervention among Burmese migrant families in Thailand: a randomized controlled trial. *PLoS ONE*, *12*(3), e0172611. http://dx.doi.org/10.1371/journal.pone.0172611

QSR International. (2012). *NVIVO qualitative data analysis software (Version 10)*. Doncaster, Australia: QSR International Pty Ltd.

Rahman, A. (2007). Challenges and opportunities in developing a psychological intervention for perinatal

depression in rural Pakistan — A multi-method study. *Archives of Womens Mental Health*, *10*(5), 211—219. http://dx.doi.org/10.1007/s00737-007-0193-9

Rahman, A., Akhtar, P., Hamdani, S. U., Atif, N., Nazir, H., Uddin, I., et al. (2019). Using technology to scale-up training and supervision of community health workers in the psychosocial management of perinatal depression: a non-inferiority, randomized controlled trial. *Global Mental Health (Cambridge, England)*, *6*, e8. http://dx.doi.org/10.1017/gmh.2019.7

Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., et al. (2016). Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan. A randomized clinical trial. *Jama-Journal of the American Medical Association*, *316*(24), 2609—2617. http://dx.doi.org/10.1001/jama.2016.17165

Rahman, A., Malik, A., Sikander, S., Roberts, C., & Creed, F. (2008). Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *Lancet*, *372*(9642), 902—909.

Rahman, A., Riaz, N., Dawson, K., Hamdani, U., Chiumento, A., Sijbrandij, M., et al. (2016). *Problem Management Plus (PM+): pilot trial of a WHO transdiagnostic psychological intervention in conflict-affected Pakistan (Vol. 15).*

Salomone, E., Pacione, L., Shire, S., Brown, F. L., Reichow, B., & Servili, C. (2019). Development of the WHO Caregiver Skills Training Program for Developmental Disorders or Delays. *Frontiers in Psychiatry*, *10* http://dx.doi.org/10.3389/fpsyt.2019.00769, 769-769

Sangraula, M., Van't Hof, E., Luitel, N. P., Turner, E. L., Marahatta, K., Nakao, J. H., et al. (2018). Protocol for a feasibility study of group-based focused psychosocial support to improve the psychosocial well-being and functioning of adults affected by humanitarian crises in Nepal: Group Problem Management Plus (PM+). *Pilot and Feasibility Studies*, *4*, 126. http://dx.doi.org/10.1186/s40814-018-0315-3

Sijbrandij, M., Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Ndogoni, L., et al. (2016). Problem Management Plus (PM+) in the treatment of common mental disorders in women affected by gender-based violence and urban adversity in Kenya; study protocol for a randomized controlled trial. *International Journal of Mental Health Systems*, *10*, 44. http://dx.doi.org/10.1186/s13033-016-0075-5

Sijbrandij, M., Farooq, S., Bryant, R. A., Dawson, K., Hamdani, S. U., Chiumento, A., et al. (2015). Problem Management Plus (PM+) for common mental disorders in a humanitarian setting in Pakistan; study protocol for a randomised controlled trial (RCT). *BMC Psychiatry*, *15*(1), 232. http://dx.doi.org/10.1186/s12888-015-0602-y

Sikander, S., Ahmad, I., Atif, N., Zaidi, A., Vanobberghen, F., Weiss, H. A., et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan. *The Lancet Psychiatry*, *6*(2), 128—139. http://dx.doi.org/10.1016/S2215-0366(18)30467-X

Sikander, S., Lazarus, A., Bangash, O., Fuhr, D. C., Weobong, B., Krishna, R. N., et al. (2015). The effectiveness and cost-effectiveness of the peer-delivered Thinking Healthy Programme for perinatal depression in Pakistan and India: the SHARE study protocol for randomised controlled trials. *Trials*, *16*(1), 534. http://dx.doi.org/10.1186/s13063-015-1063-9

Singh, M. (2017). *The friendship bench can help chase the blues away*. http://www.npr.org/sections/goatsandsoda/2017/01/10/508588401/the-friendship-bench-can-help-chase-the-blues-away

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology*, *13*, 149—181. http://dx.doi.org/10.1146/annurev-clinpsy-0328

Singla, D. R., & Kumbakumba, E. (2015). The development and implementation of a theory-informed, integrated mother-child intervention in rural Uganda. *Social Science & Medicine*, *147*, 242—251. http://dx.doi.org/10.1016/j.socscimed.2015.10.069

Singla, D. R., Kumbakumba, E., & Aboud, F. E. (2015). Effects of a parenting intervention to address maternal psychological wellbeing and child development and growth in rural Uganda: a community-based, cluster-randomised trial. *The Lancet Global Health*, *3*(8), e458—e469. http://dx.doi.org/10.1016/S2214-109X(15)00099-6

Singla, D. R., Weobong, B., Nadkarni, A., Chowdhary, N., Shinde, S., Anand, A., et al. (2014). Improving the scalability of psychological treatments in developing countries: an evaluation of peer-led therapy quality assessment in Goa, India. *Behaviour Research and Therapy*, *60*, 53—59. http://dx.doi.org/10.1016/j.brat.2014.06.006

Snider, L. (2016). *Psychological First Aid: Five year retrospective (2011—2016)*.. Retrieved from https://babeldc.gr/wp-content/uploads/2018/10

Te Pou o te Whaakaro Nui (Ed.). (2016). *Practice support: Competencies, training and supervision for talking therapies delivery*. Aukland, New Zealand: Te Pou o te Whakaaro Nui.

The World Bank. (2018). *Word Bank Country and Lending Groups*. https://www.datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

Thomas, M. L. (2006). The contributing factors of change in a therapeutic process. *Contemporary Family Therapy*, *28*(2), 201. http://dx.doi.org/10.1007/s10591-006-9000-4

Tol, W. A., Augustinavicius, J., Carswell, K., Brown, F. L., Adaku, A., Leku, M. R., et al. (2018). Translation, adaptation, and pilot of a guided self-help intervention to reduce psychological distress in South Sudanese refugees in Uganda. *Global Mental Health*, *5*, e25. http://dx.doi.org/10.1017/gmh.2018.14

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., et al. (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *2*(2), 114—120.

Verdeli, H., Clougherty, K., Onyango, G., Lewandowski, E., Speelman, L., Betancourt, T. S., et al. (2008). Group Interpersonal Psychotherapy for depressed youth in IDP camps in Northern Uganda: adaptation and training. *Child & Adolescent Psychiatric Clinics of North America*, *17*(3), 605—624.

Verdeli, H., Therosme, T., Eustache, E., Hilaire, O. S., Joseph, B., Sönmez, C. C., et al. (2016). Community Norms and Human Rights: Supervising Haitian Colleagues on Interpersonal Psychotherapy (IPT) with a depressed and abused pregnant woman. *Journal of Clinical Psychology*, *72*(8), 847—855. http://dx.doi.org/10.1002/jclp.22366

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270—277. http://dx.doi.org/10.1002/wps.20238

Watts, S., van Ommeren, M., & Cuijpers, P. (2020). Open access of psychological intervention manuals. *World Psychiatry*, *19*(2), 251—252. http://dx.doi.org/10.1002/wps.20756

Weiss, W. M., Murray, L. K., Zangana, G. A. S., Mahmooth, Z., Kaysen, D., Dorsey, S., et al. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. *BMC Psychiatry*, *15* http://dx.doi.org/10.1186/s12888-015-0622-7

World Health Organization. (2015). *Mental Health Global Action Programme Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and*

substance use conditions in humanitarian emergencies. http://www.who.int/mental_health/publications/mhgap_hig/en/

World Health Organization. (2016). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized settings: mental health Gap Action Programme (mhGAP)-version 2.0.*. Retrieved from Geneva, Switzerland: https://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

Zafar, S., Sikander, S., Hamdani, S. U., Atif, N., Akhtar, P., Nazir, H., et al. (2016). The effectiveness of Technology-assisted Cascade Training and Supervision of community health workers in delivering the Thinking Healthy Program for perinatal depression in a post-conflict area of Pakistan—study protocol for a randomized controlled trial. *Trials*, *17*(1), 188. http://dx.doi.org/10.1186/s13063-016-1308-2