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Title:

**A qualitative study assessing the feasibility of implementing a group CBT based intervention in
Sierra Leone**

Author names and affiliations:

Waterman, Samantha¹; Cole, Charles L²; Greenberg, Neil³; Rubin, G James³; Beck, Alison¹

1. South London and Maudsley NHS Foundation Trust
2. Division of Psychiatry; University College London
3. King's College London; Institute of Psychiatry, Psychology and Neuroscience

Corresponding Author: Samantha Waterman

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Abstract

Mental health support in Sierra Leone is sparse, and qualitative research into the feasibility of implementing psychological interventions is equally underdeveloped. Following the 2014 Ebola Virus Disease outbreak, South London and Maudsley NHS were commissioned to develop a psychological intervention that UK clinicians could train national staff with minimal psychological experience to deliver to their peers. Following the completion of the stepped care, group-based CBT intervention, qualitative interviews were conducted with the national team to identify key barriers and enablers to implementation and engagement with this intervention. This article describes the key themes that came out of those interviews, and discusses the implications of these findings for future clinical teams.

Key words

Group CBT, Ebola, engagement, anxiety, depression, Sierra Leone

Declaration of Interest

There are no declarations of interest from any authors.

Introduction

Mental health support in Sierra Leone is largely limited to support from families, local communities and traditional healers (Alemnu et al., 2012). There is no modern mental health legislation and no specific budget for mental health (WHO, 2015). Additionally, there are high levels of stigma surrounding mental ill-health.

During the 2014-15 Ebola Virus Disease (EVD) outbreak in West Africa, Ebola Treatment Centres (ETCs) were set up across Sierra Leone and staffed by a combination of national and international healthcare workers. These staff were exposed not only to significant risk of infection with the disease, which is highly contagious (Gulland, 2014), but also to traumatic scenes of human suffering on a daily basis (Paladino, 2017). There is a significant body of evidence that experiencing trauma increases a person's susceptibility to mental health difficulties (Thormar et al, 2013; West et al, 2008).

Following the EVD outbreak, South London and Maudsley NHS Trust trained a team of ex-ETC staff to deliver a group based Cognitive Behaviour Therapy (CBT) intervention targeting anxiety and depression, to support their peers from the ETCs. Qualitative interviews were later conducted with the facilitators to gain a more in-depth understanding of the barriers and enablers to engagement within this population.

Intervention and Setting

12 national ex-ETC staff were trained to facilitate the delivery of this intervention with their peers. All 12 CBT facilitators received weekly support and coaching from a UK based psychologist or psychotherapist via Skype.

The intervention developed was a six week group CBT programme for depression and anxiety based on the evidence-based low-intensity interventions delivered in the UK (Beck et al., 1979). 253 people were referred to the CBT programme, and 157 (62%) completed the full intervention. Although the majority of participants were literate, some were not and all written material was adjusted accordingly.

Participants

Due to the high level of consensus throughout the interviews it was agreed that data saturation had been reached after ten interviews. The participants were nine of the 12 CBT group facilitators, and one staff member responsible for assisting in the co-ordination of the project. Five were female (50%) and five were male (50%).

Procedure

Each participant was interviewed in English over Skype by one of two researchers based in the UK. Interviews lasted between 45 and 60 minutes. Ethical approval was received by the Medical Director of South London and Maudsley NHS. Participants were asked open questions designed to highlight the barriers and enablers of group CBT implementation, such as “what were the main challenges you as a facilitator faced during the intervention” and “what were the things you felt went well during the intervention”.

Data Analysis

The interviews were recorded and transcribed. These qualitative data were subsequently analysed by two researchers (CC, SW) using thematic analysis.

Results

Barriers

Lack of motivation to attend. Most of the facilitators agreed that there was a lack of external motivating factors for attending and engaging with the group CBT sessions. Being provided with treatment itself did not seem to be motivation enough; group participants expected refreshments, and although reimbursed for travel, this did not provide substantial motivation.

“Many of the participants...they don't have anything. They were used to being given refreshments...[they] were given transport costs instead, which were worthless... sometimes I had to beg people to attend sessions”.

Additionally, many of the participants viewed acquiring employment as their priority:

“The participants were more concerned about getting jobs than their mental health. [they were] paid lots for working in the treatment centres - but today they are unemployed”.

Low literacy levels. Although the materials were adapted for lower literacy levels, many participants still struggled to understand the workbooks. This meant that the sessions were often interrupted and some were less able to complete homework tasks and contribute to group discussion.

“It was very challenging to teach CBT to people that could not speak or read English... I had to give them a lot of assistance and sometimes they still wouldn't understand, even when I explained in the local language”.

Differing cultural conceptualisations of mental health problems. Within the Sierra Leonean culture, mental health problems are often conceptualised in ways that differ to the western bio-psycho-social model. This can include witchcraft, evil spirits, or curses (Yoldi, 2012, p. 62). Therefore, some participants found it challenging to integrate the novel concepts of CBT into these pre-existing conceptualisations:

“CBT is new here and many people struggled to understand the concepts that aren't things like black magic, witchcraft... some people didn't get the point in coming because they didn't see their problems in the same way we did”.

Resource constraints. Due to resource constraints the final four sessions had to be merged and the resulting two sessions were longer, but some of the content had to be condensed and facilitators were not able to explain the material in as much depth:

“The participants wanted to drop off because they couldn't understand the sessions. I had less time to explain some important parts”.

Enablers

Novelty of CBT. Taking part in a CBT programme was novel and exciting for some attendees, leading to heightened engagement.

“CBT was a new experience for them and a new process of learning... the more interested ones answered more questions and were faster to manage their depression”.

Social Networks. Many participants had already met each other in previous parts of this stepped intervention and formed friendships. This greatly enhanced group cohesiveness amongst some of the groups, a factor that has been shown to influence the effectiveness of group CBT, and the facilitation of a safe space to share (Whitfield, 2010).

“Participants got to make friends in the earlier phases...making them feel safe enough to be honest about their problems that they kept secret due to community stigma and shame”.

Discussion

This study suggested some key barriers, but also some enablers, to the implementation of a phased group-based CBT intervention in Sierra Leone. These results add qualitative information about the first hand challenges that face clinicians attempting to implement psychological interventions in Sierra Leone.

The people of Sierra Leone experience high levels of poverty and within the sample of the current study, 53.80% of participants were unemployed. According to Maslow’s hierarchy of needs theory (Maslow, 1943) it is understandable that ETC workers, who were unable to find jobs and ostracised from their communities, would prioritise their physical and safety needs above attending to their mental health. In other words they would lack the motivation to attend a group focusing purely on their psychological needs. However further investigation would be required involving consultation with the attendees to further isolate the individual barriers to engagement.

While this may be a continually present factor in countries like Sierra Leone where the poverty rate is 77.5% (United Nations Development Program, 2016), interventions should be implemented using a collaborative psycho-social approach, working with social agencies available in Sierra Leone to not only improve attendees mental health, but also to support them through their

social difficulties, including unemployment. Talking therapy interventions such as The Friendship Bench which also utilise lay health workers have been shown to be effective in other South African countries (Chibanda et al, 2016), demonstrating the perceived usefulness of talking therapies and the value of psychological approaches similar to this model.

Educating the population about the importance of good mental health and the far-reaching benefits of this may improve people's motivation to attend similar interventions in the future. Additionally, providing some form of sustenance such as a small snack may be beneficial in low-income countries where participants may be hungry, which could impact their concentration and ability to interact in the groups.

This study highlights the difficulties in implementing psychological interventions in sub-Saharan Africa. However, it also demonstrated some key enablers. The findings may be useful for future research projects and clinical teams to consider. There is some evidence which suggests that many non-Western cultures identify with a 'collective self' whereby the identity and sense of self of a person is defined by their relationships with others – in contrast to the Western 'individual self', in which identity is based on individual self alone (Luhman et al, 2015). This may explain the importance of social networks in this population, and offer understanding as to why networks were a key enabler to engagement.

There were two key limitations to this study. First, these data reflect the perceptions of the facilitators about what the group attendees were thinking, and without direct questioning of the group attendees themselves we cannot validate these results. Second, the intervention was implemented within a particularly niche sample. Group attendees had all worked at the ETCs during a traumatic, but specific, crisis so the barriers and enablers to engagement in a group CBT program discussed here may not apply to populations that have not recently experienced similar trauma.

Nonetheless, this study offers a unique insight into the barriers and enablers to implementing a group based CBT program in sub-Saharan Africa, which can be used by future teams to increase uptake in such interventions with this population.

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