

Understanding Community-Sourced Practices Used by Lay Counselors in a Family  
Therapy Intervention in Eldoret, Kenya

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## **Abstract**

The large global burden of mental health disorders calls for the development and implementation of contextually-appropriate mental health interventions that improve the wellbeing of children and families in low-resource settings. Tuko Pamoja is a family therapy intervention designed for delivery by lay providers in low-resource settings and pilot tested in Eldoret, Kenya. Improving the effectiveness of evidence-based interventions like Tuko Pamoja requires cultural and contextual sensitivity in implementation. One important step towards contextual sensitivity is gaining an understanding of the community-sourced practices used in interventions. Community-sourced practices refer to the ways in which counselors draw upon their own local understandings and norms to discuss and incorporate different supports, lessons, and explanatory models into the intervention. This paper identifies and describes the community-sourced practices utilized by lay counselors delivering Tuko Pamoja. Results include six primary community-sourced practices used by lay counselors: 1) providing metaphors and proverbs, 2) incorporating religion, 3) self-disclosure, 4) using examples and role models, 5) discussing interpersonal relationships outside of the family, and 6) referring to community dynamics and resources. The community-sourced practices described in this thesis can be used to inform and develop context-specific implementation guidelines and a comprehensive implementation model for scale up, improving the intervention's effectiveness in positively impacting child and family outcomes.

## Table of Contents

I. Abstract	2
II. Acknowledgements	4
III. Background	5
IV. Methods	15
V. Results	19
Metaphors and Proverbs	19
Religion	24
Self-Disclosure	30
Examples and Role Models	36
Interpersonal Relationships Outside of the Family	43
Community Dynamics and Resources	54
VI. Discussion: Implications and Limitations	58
VII. Conclusions	62
VIII. References	63

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## **Background**

### **Global Mental Health Burden**

Global mental health is an emerging priority in global health initiatives and policy (Whiteford et al., 2016). Mental disorders are a significant health and economic burden globally, but mental health care is scarce in low resource settings (Baingana et al., 2015). Global mental health research and treatment are critical given the high burden of mental health disorders, which account for approximately one-third of years lived with disability (YLDs) and 13% of disability-adjusted life-years (DALYs) (Vigo et al., 2016). The World Health Organization (WHO) estimates that 450 million people worldwide experience a mental disorder, which accounts for nearly 12% of the global burden of disease (WHO, 2011). Common mental disorders cost the global economy \$1 trillion in lost productivity annually, a loss that is projected to worsen (Chisholm et al., 2016). However, psychological interventions can decrease the high cost and high prevalence of mental health disorders. A meta-analysis of randomized controlled trials found that mental health interventions reduce the burden of depression by 20% (Van Zoonen et al., 2014). The WHO has found that approximately every \$1 invested in scaling up treatment for common mental health disorders leads to a \$4 return in the form of better health and productivity in the workplace (Chisholm et al., 2016).

Despite the evidence for effective treatments in low-resource settings, approximately 90% of individuals who need mental health treatment do not receive it (Wang et al., 2007). The significant lack of available treatments to meet the need for mental health care is worst in low and middle income countries (LMICs), where the burden of mental health disorders is greatest. The treatment gap is predominantly due to a lack of mental health care professionals, especially in low income countries and in rural regions within countries (Saraceno et al., 2007). There is a

shortage of 1.2 million health workers needed to provide mental health services in LMICs (Kakuma et al., 2011). Filling the treatment gap in LMICs is necessary to reduce the global burden of mental health, improving the wellbeing and quality of life for all who experience mental health disorders throughout the world.

### **Kenyan Context**

Research shows that between 4% and 10% of adults in Kenya have a common mental disorder, including anxiety and depressive disorders (Jenkins et al., 2012; Marangu et al., 2014). Mental, neurological and substance use disorders account for 16% of the disease burden in Kenya, with depression accounting for the highest burden (Institute for Health Metrics and Evaluation, 2014). Conflict, poverty, unemployment, displacement and HIV all contribute to the mental health burden (Puffer et al., 2011).

In addition to the high mental health burden, there is a shortage of mental health workers. With a population of almost 50 million, Kenya only has approximately 500 mental health professionals, including 54 psychiatrists, 418 trained psychiatric nurses and very few psychologists (Marangu et al., 2014). This contrasts sharply to the levels of mental health care providers in high-income countries, such as the United States, where there were 552,000 mental health professionals in 2010 (Grohol, 2011). Low levels of mental health literacy amongst health workers at all levels of the health care system compound the problem of a shortage of providers (Marangu et al., 2014). Brain drain, or the phenomenon of trained health care providers moving from low-income countries to high-income countries for work, is also a problem in Kenya (Marangu et al., 2014). Of the 418 trained psychiatric nurses, only 250 currently provide mental health services in Kenya; others have left the country or work for non-governmental organizations (Marangu et al., 2014).

Mental health care has received limited attention in Kenyan health reform and remains a low policy priority (Marangu et al., 2014). Mental health's low prioritization in Kenyan policy is partially due to other competing health priorities, including infectious diseases like HIV and malaria, and increasingly non-communicable diseases like cardiovascular disease and diabetes (Marangu et al., 2014). Human resources, financial resources and political motivation are all currently inadequate to address the high mental health burden in Kenya.

In the city of Eldoret, near the site of the current study, Moi Teaching and Referral Hospital provides some psychiatric care services, including inpatient care and limited outpatient care. Moi University is also located in this area and provides undergraduate training in medical psychology. The available psychiatric care services and psychology training focus mostly on treatment for adults with serious mental illness, and very little family-specific or child-focused training or treatment is available (Puffer et al., 2018).

### **Task Sharing as a Solution to the Treatment Gap**

Although the global health burden of mental disorders is highest in LMICs, where treatments and health professionals are most scarce, research shows that mental health treatments can be effectively implemented by non-specialist workers in different cultural contexts (Javadi et al., 2017). Given the gap in mental health care in LMICs and the high potential positive impact of treatment on quality of life and the global economy, it is essential to develop mental health interventions that are sustainable and scalable, culturally and contextually relevant, and feasible given limited resources (Betancourt & Chambers, 2016; Jordans et al., 2013; Lund et al., 2012). Current research points to the potential of task sharing, or task shifting, to fill the gap in mental health professionals in LMICs (Murray et al., 2011). In task sharing, specific interventions are delivered by those with little to no previous mental health training or experience, utilizing the lay

counselor workforce to address the lack of mental health services (Murray et al., 2011). Task sharing interventions can be delivered by community health workers, primary care providers or lay counselors.

A large body of research and a range of randomized clinical trials suggest that evidence-based mental health interventions can be successfully adapted across cultural contexts and implemented through task sharing to achieve positive mental health outcomes (Patel et al., 2011). For example, in Uganda, interpersonal psychotherapy was effective in reducing the burden of depressive symptoms among adolescents living in internally-displaced camps, as well as in adults affected by HIV (Bolton et al., 2007; Bass et al., 2006; Verdeli et al., 2003). A cognitive-behavioral therapy (CBT) intervention for maternal depression in Pakistan has been effective in improving depressive symptoms and infant health (Rahman et al., 2008). In conflict-affected, rural Nepal, a classroom-based psychosocial intervention was found to reduce psychological difficulties and aggression among boys, improve prosocial behavior among girls, and increase hope in older children (Jordans et al., 2010). In studies where follow-up assessments were conducted several months after intervention completion, outcomes were maintained (Rahman et al., 2008; Bass et al., 2006). Without an emphasis on the lay counselor workforce, scaling up mental health services for population-level impact would be unrealistic due to the limited number of mental health specialists in LMICs (Wang et al., 2007).

Although research has shown the effectiveness of mental health interventions through task sharing in low-resource settings, ineffective translation of evidence-based treatments to local contexts is a significant barrier to the implementation of mental health care. Contextual sensitivity is necessary to effectively implement interventions across cultures (Lund et al., 2012; Betancourt & Chambers, 2016). Most research on adapting psychological treatments to new



cultural settings does not clarify whether or how the intervention achieved cultural and contextual sensitivity, which is necessary to optimize improvements in mental health. As evidence for the effectiveness of specific mental health interventions accumulates, health entities, such as NGOs and Ministries of Health, would benefit from information to inform implementation guidelines for the effective translation of mental health interventions in varied global contexts (Betancourt & Chambers, 2016).

### **Family-Based Interventions Delivered through Task-Sharing**

Although there is a solid evidence base for the effectiveness of task sharing in reducing mental health symptoms, there is a relative lack of task sharing of family-based interventions for child mental health needs. Family-based interventions can positively impact the mental health of both children and caregivers, improving the wellbeing of the family as a whole. Additionally, family environments continue to affect children into early adulthood and potentially for the rest of their lives. Interventions that target these family dynamics increase the likelihood of sustainable, long-term improvements in the emotional wellbeing of children and their caregivers (Puffer et al., 2016). There is a growing body of family-based work targeted towards parents and children separately, but there are limited treatments that incorporate caregivers and children together in the intervention. Existing programs have demonstrated effectiveness for childhood and adolescent disorders, but very few of these interventions, which are created in high-resource settings like the United States, have been adapted and tested in other cultural contexts (Kaslow et al., 2012). In poverty, families face concurrent challenges, including a lack of basic needs, limited access to health care and education, the multifaceted effects of disease, unemployment, and uncertainty about the future (Mejia et al., 2012). Despite heightened distress and

disconnectedness, families can also be a source of resilience and support in the context of poverty (Puffer et al., 2016).

One example of a family-based mental health intervention that has been used successfully in low-resource settings is the Collaborative HIV Prevention and Adolescent Mental Health Family Program (CHAMP). CHAMP has been adapted and implemented with HIV-positive youth in South Africa and in the United States (Bhana et al., 2014). Multiple randomized controlled trials of CHAMP have shown that the intervention results in significant improvements in family functioning and child mental health, with high acceptability among caregivers and youth. Additionally, the “Let’s Talk!” intervention was adapted from Talking Parents, Healthy Teens, a US-based program that led to improved parent-child communication about sex. “Let’s Talk” was implemented in workplaces in South Africa and showed similar improvements in the South African context (Bogart et al., 2013). As this progress in adapting family-based approaches to LMIC settings has shown, improved development and implementation of family-based approaches in low-resource settings is needed; these approaches should incorporate family members together (Puffer et al., 2016).

### **Tuko Pamoja: Family-Based Approach within Existing Social-Structures in Kenya**

*Tuko Pamoja*, which means “We are together” in Kiswahili, is a community-based family therapy intervention in Eldoret, Kenya (Puffer et al., 2018). Tuko Pamoja is designed to decrease family conflict and improve family functioning in ways that lead to improve caregiver and child mental health and reduce child risk behavior (Puffer et al., 2018). Tuko Pamoja is appropriate for families who are experiencing marital conflict, parent-child conflict or general family disorganization and families with a child showing emotional distress or concerning behaviors. Task sharing interventions typically train health care providers who deal with large workloads,

but Tuko Pamoja aims to avoid this problem by involving those who are already spending their time providing informal care in the community (Puffer et al., 2018). Because community leaders are already trusted and sought out for support, Tuko Pamoja increases acceptability and expands evidenced-based treatment beyond the formal health system.

Tuko Pamoja was developed from evidence-based treatments and culturally informed through qualitative work (Puffer et al., 2018). A qualitative study on family dynamics in Eldoret identified negative patterns associated with adolescent emotional and behavioral problems, including incomplete communication processes when problem-solving and disorganization due to unclear roles and responsibilities. Evidence-based practices that best fit these cultural norms and needs were selected and adapted to align with identified common family processes in the Kenyan context (Puffer et al., 2018). These included solution-focused family therapy, behavioral skills training in communication, parenting skills and cognitive-behavioral therapy. The combination of systems, solution-focused and behavioral approaches are proven to reduce mental health symptoms among children and caregivers (Sprenkle 2012; Carr et al., 2016). The Tuko Pamoja approach identifies problematic interaction patterns, facilitates the process of families creating solutions to achieve their goals and directs behavioral skills practice.

Tuko Pamoja is made up of six modules, as shown in Table 1, to address different domains of family functioning, which the counselors can match to the needs of the families. A mobile phone tool guides counselors during sessions and provides video demonstrations of skills. The lay workers who delivered the intervention were recruited based on their current community roles as informal counselors. As a family-based intervention delivered through a community-based task sharing approach, Tuko Pamoja has shown high promise of increasing mental health outcomes of whole families in low-resource settings.

Table 1: Tuko Pamoja Intervention Outline

Module (“Somo”)	Evidence-Based Strategies
Introduction	Family engagement Psychoeducation (counseling purpose; systems understanding of family) Systems-focused problem assessment
A: Building Stronger Parent-Child Relationships A1: General relationship concerns A2: Severe behavioral problems	10 Core Steps* (solution-based and systems-focused family therapies) Parenting skills training <i>Includes child-only, parent-only, and joint sessions</i>
B: Building a Stronger Marriage	10 Core Steps* (solution-based and systems-focused family therapies)
C: Building an Organized and United Family	10 Core Steps* (solution-based and systems-focused family therapies)
D: Coping with Caregiver Distress	Brief cognitive behavioral coping skills training <i>Individual caregiver sessions</i>
E: Coping with Child/Adolescent Distress	Brief cognitive behavioral coping skills training <i>Includes individual child sessions and a parent session</i>
F: Sexual Risk Behavior (special session)	Parent-child communication skills practice related to risk behavior; <i>incorporates knowledge-based questions about HIV transmission and pregnancy risk and brief discussion of positive sexuality</i>
Transition Sessions <i>(after completion of each module)</i>	Solution-focused Progress Tracking Systems-based assessment of remaining needs <i>(can include brief individual adolescent assessment)</i> Choice of next module or graduation
Graduation Session	Solution-focused Progress Acknowledgement and Planning <i>(includes identifying ongoing sources of community/family support)</i>
<b>*10 Core Steps</b> (drawn largely from solution-based and systems-focused family therapies)	
1. Get the story (Understand the family system)	
2. Scaling question (Assess severity of the problem)	
3. Positive Communication Skills (didactic, modeling, and practice components)	
4. Build Empathy (Share thoughts and feelings)	
5. Identify Previous Solutions	
6. Identify Exceptions (Times/circumstances when problems do not occur)	
7. Miracle Question (Envision life if problems were solved; Describe behavioral changes)	
8. Set Specific Relationship Goal	
9. Develop Action Plan	
10. Track Progress and Continue Change	

The Tuko Pamoja intervention has no fixed time limit. Its length is based on the individual family's needs and progress towards their goals. It includes different modules, or "somos", meaning lessons in Kiswahili, related to marriage, parent-child relationships, family organization, child mental health, caregiver mental health and child risk behavior. Most modules follow a similar 10-step process that begins with examining the family system and moves towards goal setting, planning and enacting solutions. Families receive the therapy modules that they express a need for based on their specific challenges. Therapy is free for families, and counselors receive no compensation except for research-related activities. They are asked to not spend more time in counseling than they had already been spending while informally supporting families.

### **Present Study Goal**

A feasibility pilot study of Tuko Pamoja was completed from 2015 to 2016, which provides the data for this study. Effective implementations of evidence-based interventions require cultural and contextual sensitivity, and attaining this sensitivity requires an understanding of the community-sourced practices used in interventions. This thesis aims to identify and describe the community-based practices used by lay counselors in the pilot family therapy intervention. Community-based practices refer to the ways in which counselors draw upon their own local understandings and norms to discuss and incorporate different supports, lessons and explanatory models into the intervention. As part of the pilot study, counselors were trained in effective pedagogical and therapeutic strategies, but they were also encouraged to exercise a degree of flexibility in how they delivered the intervention. The study's findings are based on the assumption that providers naturally adopt different community-sourced elements in their own therapeutic strategies that fit local understandings and norms. These contextual adaptations,

practices and ways of explaining content are not part of the manualized Tuko Pamoja intervention but arise naturally among local providers to fit community paradigms.

In the present study, therapy session transcripts from the pilot trial were analyzed to identify and describe the community-sourced practices used by counselors while delivering the intervention. The identified community-based practices could be explored in future studies to understand which practices and strategies best promote acceptability, fidelity, and effectiveness and inform a context-specific implementation plan and updated Tuko Pamoja protocol, better integrating mental health treatment into its real-world settings and application.

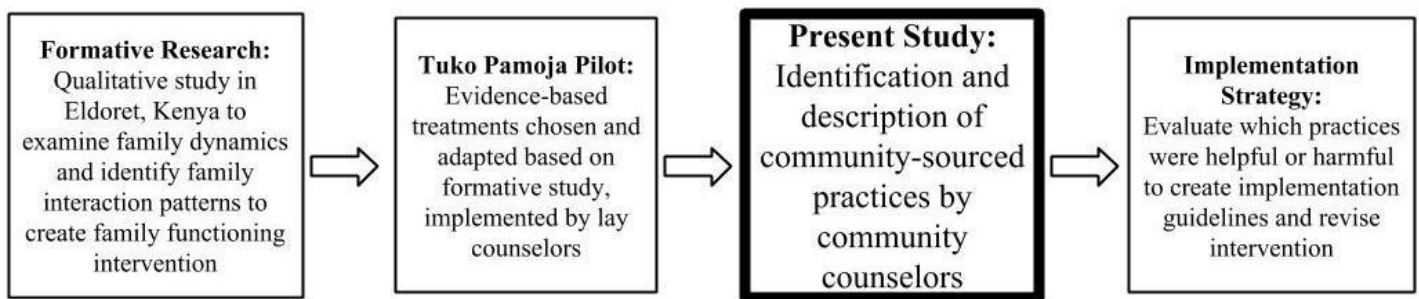


Figure 1: The present study in relation to overall development and evaluation of Tuko Pamoja

## **Methods**

### **Setting**

The Tuko Pamoja pilot trial took place in two peri-urban communities near Eldoret, Kenya, located in the Rift Valley Province in the Western part of the country. Eldoret had a population of 289,380 in 2009 and is growing quickly (USAID, 2012). The family therapy sessions took place predominantly in families' homes.

### **Participants**

To recruit lay counselors, community leaders identified 23 trusted individuals in the communities who were acting as “natural counselors,” meaning that they already provided informal counseling in their community (Puffer et al., 2018). These individuals were serving as sources of support for distressed families either as a component of their official position, such as a pastor or community leader, or informally through a social structure, such as a youth program volunteer at a church. Despite having no formal counseling training, these individuals were routinely sought out by families for advice, conflict mediation, or encouragement. They helped families deal with conflicts, addressed domestic violence and child abuse, and gave guidance regarding children's behavioral and emotional problems. The Tuko Pamoja study team interviewed the cohort and selected fourteen individuals to participate in training. After training, nine were selected as counselors to deliver the intervention based on their present role in the community, education level and performance in training, natural clinical skills and understanding of the therapy. Counselors were selected to create variability in these characteristics. They reported spending an average of 13.8 hours conducting informal counseling per week (Puffer et al., 2018).

The counselors then recruited eighteen families from their own communities. Eligible families were both (1) experiencing persistent distress and dysfunction at the family level and (2) had a child between the ages of 12 and 17 with emotional distress or concerning behaviors. The counselors first approached the family to explain the intervention, inquire if they were interested and ask for permission for the research team to contact them. If the family confirmed interest, then a research staff member visited the family to explain the study and obtain consent, as well as parental permission and assent for the child. Of the eighteen families referred for treatment by the counselors, fifteen consented to treatment, fourteen initiated, and ten completed treatment. The fourteen families who initiated therapy are included in the present study because there are recorded and translated transcriptions of their therapy sessions. Each family had a female caregiver, male caregiver, and child between the ages of 12 and 17 participate. Of the eight counselors selected to deliver Tuko Pamoja, four worked with two families each, two counselors were married and worked with one family together, and two other counselors worked with one family together. Six identified primarily as serving in religious roles, and one identified primarily as a policymaker.

Table 2: Lay Counselor Demographics (Puffer et al., 2018)

Counselor #	Gender	Age	Education	Community Role
1	M	48	Some secondary	Mosque Elder
2	M	43	Completed secondary	Policy maker
3	F	36	Post-secondary vocational	Church member / Counselor
4 5 (Married Pair)	M F	46 43	Some secondary Completed primary	Catechist Wife
6	M	36	Completed primary	Sunday school teacher
7	F	52	Some primary	Church Chairlady
8	F	53	Some secondary	Church Chairlady



## **Procedures**

The counselors' training on the intervention lasted ten days. Training was led by one clinical psychologist from the United States and one clinical psychologist from Kenya. Training focused on general therapeutic skills and treatment-specific skills and content, with a heavy focus on clinical role plays and peer feedback. After six months, the treatment manual was revised based on counselor feedback and the completion of initial cases. Revisions included increasing clarity of concepts and changing the order of some steps. After revisions to the treatment manual were made, counselors had a brief five-day refresher training focused on practicing the revised portions of the manual and improving general therapeutic skills.

Supervision was also an important part of the Tuko Pamoja pilot trial, which used a tiered supervision model (Murray et al., 2011). Four local supervisors, including third year undergraduate students studying medical psychology at Moi University and receiving practicum training hours for their participation, oversaw the counselors and their cases. In addition to participating in the counselor training, supervisors received five extra days of training on the program. Supervision was provided to the counselors after every session, either in person or via phone calls. Local supervisors had weekly phone calls to discuss counselors and their cases with the US-based psychologist via Skype. All therapy sessions were audio recorded. Research staff members or local supervisors listened to the recordings in Swahili and transcribed them into English.

Families received a mean of twelve therapy sessions, ranging from one session to twenty-two sessions. For families who completed treatment, the mean was fifteen sessions over an average span of 30 weeks, ranging from fifteen weeks to 46 weeks. The intervention is intended

to be delivered through weekly sessions, but scheduling difficulties led to longer overall courses of treatment.

All study procedures were approved by the Duke University Institutional Review Board and the Institutional Research and Ethics Committee at Moi University in Kenya.

## **Analysis**

I used thematic analysis to identify and describe types of community-sourced practices. Thematic analysis is a method for identifying, analyzing and reporting patterns within data (Braun and Clarke, 2006). I collaborated with another researcher (Dr. Bonnie Kaiser) to identify themes and apply codes, and I developed descriptions of themes. We used an inductive approach in our theme identification, meaning that the themes we identified are linked to the data themselves, and not a pre-existing theoretical framework (Patton, 1990). However, it is important to note that we could not free ourselves of our theoretical background knowledge. Our identification of community-based practices is therefore grounded in the data, and also inherently informed by our existing academic training and professional experience with anthropology, global health, and psychology.

We actively read several transcripts from different families and different counselors, searching for patterns and making notes of potential community-based themes. We developed these into codes, then iteratively edited and added to the initial list of codes and definitions by reviewing additional transcripts until saturation was reached, meaning that no new themes emerged from the data. We independently coded several transcripts, one at a time, and compared our coding until we reached sufficient inter-coder reliability.

We randomly selected six transcripts from each of the ten families who completed therapy. We selected all transcripts from the four families that had fewer than six therapy

sessions. Two families had only three sessions, one family had two sessions, and one family had one session. A few families had ten or more sessions; thus the six randomly selected ones represented just over half of their total sessions, while other families had closer to eight sessions, meaning the six randomly selected sessions represent most of their therapy. We split up the transcripts between the researchers, with transcripts for a given family always assigned to the same researcher, and coded the data using NVivo Version 11.

## **Results**

Results illustrated that counselors integrated a diverse array of community-based practices in the course of delivering the intervention, made up of supports, examples and explanatory models that were informed by their own backgrounds and experiences. Six primary community-based practices used by lay counselors were identified: 1) providing metaphors and proverbs, 2) incorporating religion, 3) self-disclosure, 4) using examples and role models, 5) discussing interpersonal relationships outside of the family, and 6) referring to community dynamics and resources.

### **Metaphors and Proverbs**

Counselors used metaphors<sup>1</sup> and proverbs to explain the intervention's concepts to family members. Proverbs or cultural and environmental metaphors were used to support lessons or counseling strategies. Commonly used metaphors included steering a car to represent family functioning, building a house to represent solving family problems, and the provision of specific Swahili sayings and stories. In Tuko Pamoja, a tree is used as an analogy for the family, and different parts of the tree represent different components of the family system. Since the tree

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<sup>1</sup> Many of these examples are similes, personification, or other literary devices, but we use the term metaphor throughout for simplicity's sake.

metaphor is a core tenet of the intervention program, it does not represent a community-based practice in and of itself. However, counselors used other community-based practices as explanatory models for explaining the tree metaphor, which will be discussed in later sections.

**Building a house or a wall.** Several counselors used an analogy of a wall to describe the importance of keeping the family firm and together. A counselor compared holes in the wall to problems in the family, telling the father to “look at the hole that you can seal while we are talking to make the wall firm.” Notions of strengthening and solidifying extended across metaphors and analogies throughout all families. One counselor used a metaphor of building a house:

“The most important thing is that you are the ones to build this house. You are ones to build this house to stand. I have repeated this many times that again you are the ones destroying it. So you have two activities; to build and to destroy are the two activities. Sit down and talk and note the places where there are holes [and] seal them.”

The counselor told the family that they could either build or destroy their house, reminding them that they are the ones who have control over their family. The counselor also told them to discuss amongst themselves where the holes are and how to fix them. Another counselor explained:

“As the Swahili saying goes; ‘If you don’t repair a crack on the wall, you will build a new wall.’ When you see a crack on the house and do not mend it you will build the whole wall which is expensive than mending a crack.”

This counselor used a common proverb to emphasize that prevention is important to avoid exacerbating problems.

**Driving a car and gender roles.** Only one counselor used the metaphor of driving a car as an analogy for family functioning, but the counselor used it throughout multiple sessions. The metaphor reflected gender roles, such as explaining that the husband “steers the car in the driver’s seat” and thus has many responsibilities in the family, stating, “As a driver you have lots of work to ensure that the bus is moving well. Does it have concerns or it is stable?” The

counselor also asked the mother how the father handled his duties, questioning, “How do you think when the father is on the steering? He is the governor, are there any challenges?” Then the counselor seemed to try to remind the mother that she has a role in the car as well, telling her that the husband cannot know “how much he drives the car.” The part of the metaphor focused on the father’s duties was clear, but the role of the mother in the car was more confusing, potentially muddling the caregivers’ intended point. The counselor said to the mother:

“You look at this vehicle and appreciate it, and if any rectification is there to be made, do it. It is the big important task for you.”

Through the car metaphor, the mother’s responsibilities are to identify and fix the family’s problems, which are not specific or actionable. The counselor was critical of the father and told him he had been sleeping at the wheel. The counselor also asked the father what he would do if the car drove into a ditch because he had dozed off, making the metaphor more confusing. The counselor used the car analogy in a variety of ways, discussing the different gears of a car and how, when one is overwhelmed, they must shift gears. If one gear does not work, one must shift gears again. He also compared individuals to cars:

“The human life is like a car. It needs service and sometimes talking and eating food together and doing other things.”

The counselor wanted to address that every individual has needs, even if they are different. The counselor compared cars to family systems and to individual people, trying to get the family to identify problems and to discuss how they will avoid future problems.

This counselor referred to the husband as “the president of the country” and “the governor.” These metaphors for discussing the husband as the head of the household show how gender roles are implicit in the counselor’s ideas of familial norms. Several female caregivers

expressed frustration that their husbands were not successfully fulfilling their roles because they were not making enough money to support their families.

**Simple analogies.** Many metaphors used by counselors were straightforward and to the point, allowing counselors to convey an idea quickly and effectively, but not necessarily directly aligned with Tuko Pamoja content. For example, one counselor compared the family's financial struggles to the perseverance required for running a race. When one sees that someone else has finished the race, one can feel discouraged and want to sit down and give up, but they must persevere and keep racing regardless. The counselor encouraged the family to persevere despite their financial obstacles.

Many counselors shared proverbs, stating "As the Swahili saying goes," framing the comparison within their own cultural context. A counselor stated:

"You respect neighbors so that they cannot say how bad you are as a man. It is good to have respect, a Kiswahili saying goes this way, 'Respect yourself to be respected.'"

The counselor successfully intertwined a cultural saying about respecting oneself in order to be respected by others to help the family member interact kindly and respectfully with his neighbors. Also, to help a family member interact with others, a counselor compared not having forgiveness to having a disease, as he considered forgiveness to be an essential part of life.

One counselor stated that, "Rome was never built in a day," to remind to family that improvement takes time. Similarly, a counselor compared the gratification of seeing progress to farming, asking, "When you plant maize and don't see it germinating, will you be happy?" There were multiple metaphors related to farming. A counselor explained that even when one only plants a little bit, a lot can be harvested, and the same is true of love:

"For example, when you want to plant vegetables, you can plant just a little bit of the vegetables, but you will harvest a lot from that. And so, what will you do in order to start this love, so that it can continue to flourish and grow?"

This counselor connected the metaphor of planting a little so that a lot can flourish back to what is within the family's control, asking what small things they can do to help their own growth.

Some simple metaphors were more negative and foreboding. A counselor stated that an unsuccessful person "has become rotten" to discourage a male caregiver from surrounding himself with similar people who are "spoiled."

Very few analogies outside of the tree metaphor focused on the parent-child relationship, but one counselor explained how parents' disciplinary strategies change as children age. The counselor compared the daughter to a tree, which matures and bends. The counselor thought that the mother had been too harsh on her adolescent daughter and wanted her to consider that she cannot make the child do whatever she wants. The daughter is a more mature person now, not a bendable tree, thus the mother must respect that and reduce her harsh treatment.

One counselor used multiple metaphors to encourage a husband and wife to sleep together and share a bed. The counselor said:

"We need to press the wound for the pus to come out so that it can heal. The issue of a wound being here and we just put Vaseline, no. The happiness of a mother and a father begins from the bedroom."

The counselor compared solving the couple's problems to healing a wound, and thought that they should have sex to "press the wound" for it to heal. The counselor also described the couple sleeping apart as "one in America and the other in Canada," showing that they see themselves like "hyena and sheep." The counselor used metaphors to show how damaging it was for the couple to sleep separately. In the counselor's opinion, they had to share a bed and have sex for them to fix their marital problems.

**Lengthy and didactic analogies.** A few metaphors, explained in long lectures by counselors, had unclear messages. It is possible that this is due to issues with translations and

that the families could understand and interpret them, but several times, counselors didactically told stories that were long-winded and became lectures. For example, one counselor explained a story of a tortoise and a rat. The rat aspired to live as long as the tortoise. Although the message of this metaphor was clear, the counselor delivered it within a long speech. Ultimately, the tortoise told the rat that the secret of living a long life is “living with people” and “talking with good friends.” Then the counselor told the family that the story reminded him of the female caregiver, who the counselor wanted to encourage to talk and laugh more with people to reduce her anger. Although the message was simple, the delivery was lengthy and indirect. Another counselor had the same problem of a simple message but convoluted delivery. The counselor explained about planes, having a fear of flying, and a specific woman who was afraid on a plane but was comforted by her husband, all to say that a plane is similar to a house because they both require partners to comfort each other. The counselor gave direct advice, stating, “You need to say don’t worry; let us encourage one another and we will succeed.” This was potentially useful guidance, but the airplane analogy did not seem to be an efficient way to deliver it.

## **Religion**

Incorporating religion into counseling sessions was the most commonly identified community-based practice. Counselors consistently suggested faith and prayer as important strategies for coping with the challenges that families faced. Beyond religiosity as a solution, counselors commonly alluded to God and prayer in their colloquial language. References to religion, praying, going to church or mosque, God, the Bible or Jesus were ubiquitous in every counselor’s therapy. Counselors often referenced putting hope or trust in God, frequently using the phrases, “if God wills it,” “God willing,” and “pray to God.” Counselors and families usually



prayed together before and after therapy. The prevalence of religion as a community-based practice in therapy is not surprising, since most counselors were religious leaders.

Counselors and families alike invoked faith in God as an important part of their lives. Counselors did not appear to insist on discussing religion and faith if families did not want to do so. Instead, families showed that their religiosity aligned with that of counselors. It is possible, though, that families knew that this is what counselors wanted to hear.

**Importance of attending church or mosque.** Counselors frequently emphasized the importance of the family attending church together to be united and successful as a family. They would ask the children in counseling if they attend church and occasionally would probe more and ask them what they learned at church. Counselors presented attending church as a way to promote children's wellbeing and family happiness, providing advice like "bring them up in a church setting, and they will grow up well." Attending church was presented as a solution for a mother whose daughter felt that they were not close enough. The counselor suggested that going to church together could help them to connect.

Counselors frequently connected the tree metaphor used in Tuko Pamoja to the act of attending church. The church was described as part of the roots of the tree, helping the family to be firm and solid. Thinking of the church or mosque as the foundation of the home, the "roots of the tree," was a common way to encourage families to go to church together. For example, a counselor explained:

"I did ask you to be going to the church together so that we can pray together. That will change things. You as the wife can pray, and things will change. Your children are good examples. They have held on to the faith. You see a house that prays and stays together will stand firm; even if strong winds come along, they will be able to withstand it. When shaken, it won't shake because the roots are firm."

The counselor incorporated the importance of religion into focusing on what individual family members can do and their own autonomy, which is an important tenet of Tuko Pamoja. The counselor stated that the mother can pray; it is within her control and it is an action she can take to promote change in her family. Counselors also suggested that if families do not attend church, the “tree will fall down,” incorporating the tree metaphor of Tuko Pamoja into what the counselors see as a repercussion for not attending church. Counselors also stressed that parents should be religious role models for their children:

“You will also find that when the mother is good at religion, the child will get good education or foundation in that family because there is that relationship between the leaves, tree and the child.”

Counselors framed religion as an important part of family dynamics, bringing the family together and strengthening their bonds. If someone in the family admitted that they were not attending church, the counselor took this as a bad sign that the problem in their lives was worsening. To counselors, church was central to family wellbeing. Counselors used examples of other families that regularly attended church as successful families if the family they were counseling had not been going as frequently as the counselor wanted. One counselor summarized the importance of attending church best when the family’s counseling sessions were almost over, and he wanted to ensure they grasped the importance of attending religious services:

“Something else that we did not touch about it in the past is that if you get time, go to church. When you go to church you will get good things there, you will be saved and know your life with God, your life and your neighbor and so on will be good and will help you. Don’t miss the church service and when you miss, ask from a friend what they learnt. Thank you and God bless you.”

**Religion-centered solutions.** Religion and prayer were suggested as specific solutions to different problems, including fighting within the family and financial struggles. For example, one counselor told an adolescent:

“Even when you lack school fees, just trust in God that he will help you. Be prayerful.”

Both at the beginning of a difficult experience and when all other options have failed, people can look to God to have hope that their situation might improve. The counselor embraced faith and prayer as a potential solution to the fact that the adolescent’s family cannot afford for him to go to school.

Counselors also used religious references to help couples with marital problems. One counselor encouraged the mother and father to take action to improve their marriage, while at the same time recognizing the importance of looking to God to help their relationship:

“May God bless and uplift you to be able to improve your marriage. As someone who will support you in this marriage only, you are the ones to decide how your marriage would be and according to how you have talked is that you want your marriage to be firm and I thank God and we will pray God for your marriage to be firm.”

The counselor skillfully acknowledged the importance of faith and prayer while also reminding the couple that they are the ones who will shape the marriage.

Counselors invoked religion when speaking to adolescents about solutions as well. When discussing a child’s social situation and his different options, the counselor explained the predicament as having Satan on one side of the issue and God on the other side. Counselors sometimes spoke of religion as sufficient to solve their problems, stating guarantees similar to: “You will thank God and you will see that he will remove problems.” Counselors conveyed the message that when family members act in certain ways, such as attending church, thanking God and “growing together,” God may reward them and solve their problems.

Although prayer was a common solution, sometimes counselors framed it as an especially important option when all other solutions had been tried. A counselor explained that when there is no other way to get money, “that is the right time to kneel and pray to God telling him you know me, you know my mother very well, you very well know that in this house, we

have nothing. You see that is the time God can help you.” Similarly, a counselor explained to a family that “for a person who is very stubborn, the only way out is prayer.” Counselors had a pattern of implying that although faith is essential no matter what, it is especially important when all other options have been exhausted. Occasionally, counselors steered family members away from only using prayer as their solution, encouraging them to communicate with each other as opposed to praying alone. Some counselors skillfully acknowledged the balance of praying but not leaving it all up to God, stating: “You cannot let it to God; we have to look for ways to help this child.”

**Religious lessons related to family problems and engagement in therapy.** Counselors also invoked God when families seemed to be improving, stating affirmations such as “I can see God helping you in your ways” and “I thank God that you got money.” Counselors constantly referenced God and the importance of putting faith in God. Counselors continually thanked God for allowing them to be there, stating “God has enabled us to be together.” Counselors called on participants to “be someone who depends on God.” Sometimes counselors began preaching about God and the dangers of Satan, speaking for long periods of time in a sermon-like way, which was inconsistent with their training as TP counselors. Framing the therapy in religious ways seemed to be used as a strategy to assure families of God’s approval and encouragement of the intervention. Occasionally, counselors used religious appeals to encourage participants to participate in therapy

“Whenever you have any question, do not be quiet; ask so that you can know. Do not think that by asking you are a fool, no one is a fool; God never created a fool.”

Counselors sometimes used biblical examples that they deemed relevant to the family’s problems. Using an example from the Bible to lend himself authority, one counselor suggested

that to solve a families' problems of alcoholism and infidelity, they should pray, trust each other, and help each other:

“Your children will be happy to see you praying together as a family. We would wish to see you being together, walking and praying together. You can start by avoiding going to alcohol dens so that your wife can have the peace that she is crying for. She says she needs to you and you have to be honest with her. You should build love in your home so that your children will be happy. You have to trust one another. You should stop adultery. That is why Apostle Paul said that people should get married each one should have a wife or a husband. You the wife should try and help him out.”

The counselor boldly stated what the father and mother must do to improve their family's wellbeing, pointing to a biblical passage to validate his commands.

In linking the tree metaphor to the Bible, one counselor described how Jesus praised someone for building on rock instead of sandy ground because the former's work would be more solid in the ground:

“The tree can't control the storms in the same way a family can't control the troubles in their lives. That means that if the family can't control the troubles, then we can strengthen our family to withstand the storm. If it can't withstand the storm, then there will be trouble. In the bible, an example of two builders was given for the one that built on the rock and another who built on the sandy ground. Then Jesus asked his disciples, 'Between these two, which one can withstand the storm? The one on the sandy ground or the one on the rocky ground?' So, families are required to be built on the rock, on firm ground.”

The counselor used religious appeals to explain intervention content, connecting the importance of strengthening the tree to events in the Bible.

Another counselor used an example from the Bible when one mother in counseling did not want to share a bed or have sex with her husband because of his alcohol use. The counselor alluded to biblical expectations about how the wife should act:

“Why did God want a wife and a husband to live together? He wanted to live together to be happy together and the happiness of the married is sex. Paul said do not deny your wife his right and the wife do not deny the husband his right, and the style that you are talking I have discovered that you may not be... do you have the marriage relationship?”

The counselor implied that to fulfill what God wants, the wife should be willing to have sex with the husband. This religious framing of the marital relationship illustrates the counselor's notion of gender roles, which also were evident when he stated that the wife has a duty to clean the house: "It should be clean because God made it special for a family, not a place to play with," he said. Although it was not common for counselors to frame gender expectations in religious ways, it occurred more than once. Counselors also incorporated religion into their discussion of marriage in ways that promoted equality between partners, explaining that God put two people in a home because one would be lonely and that each partner needs the other one for different reasons. Counselors emphasized the partners' unity: "You had mentioned about trust and love. When we talk about this, even the Bible tells us you are no longer two but one body."

One specific strategy in Tuko Pamoja is asking the family what their lives would be like if a miracle occurred and the problems they faced disappeared over night. A few counselors interwove God into this question, asking families to consider what would be different about their lives if God created a miracle, going beyond solely asking what would be different if a miracle occurred.

### **Self-Disclosure**

Self-disclosure refers to counselors sharing about their own lives and experiences. Counselors often employed self-disclosure, explaining strategies they have used in their own lives or sharing their own struggles and how they worked through them. Counselors disclosed examples of positive successes in their lives and negative examples as well. Counselors disclosed about their drinking, their marriages, their relationships with their children, their relationships with their own parents and how they dealt with daily stressors. Counselors sometimes used hypothetical examples involving themselves to show how they would handle a situation similar

to what the family had been experiencing. They often invoked faith in God as a way to overcome their obstacles. They also tied their self-disclosure examples to skills related to Tuko Pamoja, like the importance of listening and contributing to the discussion.

**Self-disclosure about overcoming and dealing with problems.** Counselors often disclosed about their own problems, like financial stressors and alcoholism, and how they overcame them through prayer. When counselors disclosed about these issues, it was always because members of the family receiving treatment were dealing with similar problems. For example, one counselor explained how he turned to God to stop drinking, a problem faced by the father he was counseling:

“I was a drunkard. I could take alcohol throughout the day and by around 2 - 3:00pm, the drunkardness in me could be over and I would usually start thinking of whom I may have done something wrong to, I would ask God to just help me stop taking alcohol; look here, I didn’t take any drugs to stop drinking alcohol, God helped me. Don’t you think he can help you too?”

This specific counselor repeatedly disclosed about his own drinking, including its effects on his marriage. Since the couple he was speaking to also faced marital issues due to the father’s drinking, this example was very pertinent to the family’s most troubling problems.

“I first prayed for my wife when they had denied me saying that the moment I stopped drinking alcohol is when they will give me back my wife. I prayed for her to accept me the way I was, why did God give me the wife the way I was yet the family had refused? Secondly God never forsake anyone, I was living in a leaking house and I prayed and he gave me a house, are you listening?”

When this counselor disclosed, he points to his belief in God and looking to God to guide him as his solution. All of his examples point to prayer as the solution, especially to deal with the problem of alcoholism. Other counselors also disclosed about their struggles overcoming alcoholism. In addition to faith to overcome alcoholism, one counselor described how his faith in God helped him to grow and progress in life.

Counselors enjoyed using self-disclosure to present themselves as examples of success. A husband and wife who worked as counselors together often disclosed examples from their own family, showing how they communicate when they face financial problems. The wife explained:

“Sometimes as the mother we might have fetched more than we have in the house and therefore it is over. This is where we are forced to dig deep into our pockets and this is where we involve the father. I involve my husband. I probably tell him that maize/ flour is over in the house so I ask him to buy some more because you know we love ugali, I don’t know if you also love ugali.”

One counselor even shared his own past experience with the problem of homicidal thoughts. Again, he spoke of God as the solution.

“I want you to tell me honestly. I for example one time felt that my parents do not like me and loves my other siblings and it reached a time I thought of the best thing to do is to buy rat drug and since this people drink milk I will poison the drug inside the milk so that they can die. The devil showed me that the whole farm will belong to me and even now when I think of it I say God is important... Now can you tell me one of such negative thoughts?”

Counselors self-disclosed about problems related to alcoholism, financial struggles, and HIV testing, which the families receiving therapy could relate to. Faith in God and prayer were common solutions used by counselors in their self-disclosure, in addition to open communication and honesty with their family members.

**Self-disclosure to relate to specific family dynamics.** Counselors recognized the importance of family functioning in their own lives, independent of solving specific problems. Counselors embraced the fact that family functioning is valuable in and of itself, and not just a means to deal with issues like alcoholism and financial stress. Counselors used self-disclosure to connect and relate to parents and children and their relationships with each other. Very commonly, counselors used self-disclosure to show that they understood what participants dealt with in their lives and relationships. For example, one counselor said to a father:



“It is normal to feel bad when the child does something wrong to us. I think that time when you saw my adolescent doing that [quarrel with siblings in front of visitors] I was also feeling bad.”

The counselor validated how the father is feeling badly about his son fighting with his sisters in front of family guests and friends.

Counselors also showed how they try to be successful parents, aware that their children might become afraid of them if they are too harsh:

“We also talked about being harsh, like for me, I am the harsh one, but I should not forget and be too harsh forgetting that I have my children also there and they can get too scared of me. They can even be too scared to tell me that they do not have any pens to use for writing. Have you seen that?”

The counselor validates the caregiver’s inclination to employ harsh parenting, but presents a repercussion that they have experienced because of their harsh treatment of their children. The counselor’s children became occasionally afraid of sharing their problems. The counselor uses this personal example to steer the caregiver away from being too harsh towards their children. They used self-disclosure to guide children as well, explaining their respect towards their own parents:

“Now have respect to one another. I personally respect my father because he is a parent; to be where I am now is because of him and I must respect my parents. I will not refuse to respect them because they took care of me, they are your Gods.”

The counselor directly models how he thinks the children should treat their parents with how he treats his own. He presents himself as a role model to the children because of his respect and appreciation for the care his parents provided him.

The married counselors used a hypothetical example from their own lives to address an issue facing the family they were counseling. The mother cooked meals but the father would not eat them. The counselors explained how they would feel in that situation:

Counselor 1: "It is painful, my wife cannot be cooking food in the house which I don't eat; will you be happy?"

Counselor 2: "I will feel that he hates me with the food or there is a place that he normally eats."

Counselor 1: "For my wife if I will be going out without eating her food, I will cause her problems. First she will feel that I hate her, secondly she will think there is a place I eat and thirdly the children will ask her why their father don't eat food at home."

The counselors present themselves as a relatable example to the couple they are counseling, showing how the situation would make them feel and why the mother feels upset when the father does not eat at home. The counselors subtly took the side of the mother, stating that if they hypothetically were in the same situation, it would be unfair to her.

The male counselor, who counseled with his wife, spoke to the couple about sex. The male counselor encouraged them to have sex, discussing his own expectations about sex in his marriage. He explained that "the happiness of a mother and a father begins from the bedroom," demonstrating how important he considers sex to be to marriage. He alludes to the fact that if he and his wife were not having sex, they would wonder if each other were having affairs. The female counselor in the counseling couple connected to the mother in the family about the universal experiences of all women, stating:

"The important thing [mother] is that for sure us women have a small heart but let us remember our grandmothers and mothers persevered that is why they are still living."

A strong example of self-disclosure occurred when a counselor shared their own story of misbehaving as a child and then encouraged the mother and the father to share their own stories of misbehaving to help them reflect on their own childhoods and relate to their child. Counselors also used self-disclosure to help spouses relate to each other, explaining that everyone is different, thus different behaviors mean different feelings and moods for different people:

"I do also keep quiet sometimes, not that I am thinking about anything bad but maybe I have my thoughts somewhere else but whenever someone talks to me, I will also talk. So it is important that you understand him because we are created differently."

Self-disclosure about the counselors' own familial relationships and how they communicate within them and think about them were very common. In one instance, a counselor used self-disclosure explicitly to promote Tuko Pamoja specific practices within the family, which are important to successful therapy. A counselor described that family therapy had helped him, too, building on components of therapy relevant of Tuko Pamoja:

“I also love this program because it has helped me. When I pass through such challenges I know that I need to do this and this. I need to stand firm like this tree so that for all things when the wind blows, you know sickness which is an example of a wind, isn't it?”

In this example of self-disclosure, the counselor incorporated the tree metaphor, showing their own effort to practice what they had been teaching to the family.

**The effects of self-disclosure.** All examples of self-disclosure show a pattern of using the practice as a way to relate and connect to family members' thoughts, feelings and experiences. This attempt at relating and connecting helped to elicit participants' contributions to discussions in counseling. One counselor tried to help participants work through their anger by explaining how he works through his own so that they could have meaningful therapy sessions:

“Try to control yourself not to be angry so that you can talk. I also try to control myself like there were sugarcanes and oranges that I planted and were not yet ripe and when I came back home I found the children picking... I asked my wife since I am not always at home should be responsible in all the roles, I asked her to be at home and do the house chores, now look at the farm, the fruits are destroyed, where were you? I now learnt that my wife was not at home and if I came and realized that the fruits were destroyed and took a stick to beat her, I would have hurt someone who was not present.”

Self-disclosure was a way for counselors to connect to the family members receiving therapy and make them feel more comfortable. Counselors' self-disclosure helped family members understand that they were not alone in their problems, worries and relationship struggles.

## **Examples and Role Models**

Counselors frequently gave examples of people outside of the families who had gone through similar situations. Counselors gave examples of other people more frequently than they self-disclosed about their own experiences. Examples were positive, negative, and strategy-focused, providing individuals with examples of specific ways to navigate situations. Examples included actual, known people who the counselor interacted with in real life, and also hypothetical people described as similar to those in their community. Counselors shared many stories about people they had known and experiences those people had that were relevant to family members. Counselors often incorporated religion into their examples, stating that a certain successful person went to church or had faith and then improved their situation or overcame their obstacle. Many examples related to alcohol consumption, either to warn caregivers of the risks of drinking or to motivate them to decrease their drinking.

**Positive examples.** Counselors gave positive examples mainly to motivate families and show them that improvement was possible. Counselors mostly gave examples of other people in the local community, with either specific names or broad terms, such as “a lady I once knew.” Some counselors gave examples to establish their counseling expertise. One counselor even disclosed the story of the adolescent who had been sexually assaulted to another family, explaining that he went with her to be tested for HIV and that she was negative.

Counselors also used examples to validate and contextualize families’ experiences as ordinary, reminding them that, “It is normal for anyone going through what you are going through to do that.” Almost all counselors, at least once, explained that they knew someone in the same situation as the family member or entire family, and through prayer, communication or counseling, their situation improved. For example:

“There is also a neighbor of mine who was in the same situation as your husband. He is known as Yusuf; I thank God today. He used to fight with his wife, hurting each other and the children suffering because he used to take alcohol. Today, he works together with his wife doing some business... They are now doing well. That is after they were counseled and he changed. I am also praying that you will change like Yusuf’s family.”

Counselors used examples to motivate family members, reassuring them that improvement was possible. Counselors gave examples of how they were able to help people before, establishing their credibility as a way to encourage families to put effort into and participate in counseling:

“I had a friend of mine who was my neighbor and had the same problem as yours they were quarreling and fighting all the time and I had to sit down with them and we talked and they both listened to me and we managed to solve their problem the husband managed to open a charcoal business and they are doing well now, so misunderstanding in a family is normal but you have to look beyond that and see the future of your children because if you separate, the children will suffer.”

With this example, the counselor encouraged the caregivers to listen to each other, reminded them that misunderstandings within families are normal and warned them that separating would damage their children.

One counselor struggled to help an adolescent boy imagine his family improving. The metaphor of a miracle made the boy skeptical, as it seemed impossible to him that his family could improve in such drastic ways:

Counselor: “If you slept one night and you have a miracle happen, and when you wake up in the morning all the problems are gone, what will happen?”

Child: “How will that even happen surely!”

Counselor: “I am just asking what if it happens. Look at someone like Asbel Kiprop. Do you know that he used to carry water for someone who had a hotel while doing his training? At one point, her mother was even locked out because she didn’t have money to pay rent. His father was a drunkard; I am just giving you his example. Kiprop ran, he won his first race and that family changed. So don’t say that your family cannot change. God does his miracles; you know.”

Asbel Kiprop is an Olympic runner from Kenya. The counselor alluded to Kiprop as a way to show the adolescent that change for his family was possible. However, it is possible that Kiprop

was not a relatable example for the boy. It is possible that Kiprop's success felt too far removed for the adolescent boy to be inspired or convinced that change was possible.

Sometimes counselors' stories of successful people were long and confusing. One counselor tried to explain how he successfully helped someone, but the story consisted of rambling anecdotes. Other examples' relevance was unclear, such as the example that "white people are active" and train to keep their minds "busy, fresh and steady for anything." The counselor connected this example to the adolescent he was counseling, who experienced many stressors and had a "heavier load," making for a confusing comparison.

Positive examples were mostly targeted towards children, inspiring them to do well in school and treat their parents with respect. In one interesting example, a counselor used children as a model for parents.

"Take an example of small children; they play together, hurt each other but they apologize to one another and they move on; your being used to one another should be that of friendship. You can see when children are playing and one falls down, the other will help him/her up; dust him/her and say sorry; those kids are so friendly; isn't it?"

The counselor invoked the forgiveness and friendliness of young children to help the couple overcome their fighting. This example is also noteworthy because it challenges notions of seniority based on age, which are prevalent in the community. It is rare to think that children have interpersonal skills that a couple is lacking.

One counselor gave a non-specific example of men who are able to drink alcohol while still providing for their family:

"There are people... you see... drunk but when you reach their homes, he provides for the children. He ensures that the farm is done and the children are taken care of."

The counselor gave this example to a female caregiver trying to cope with her husband's drinking. The example potentially gave her hope that even if her husband does not stop drinking, the family's financial situation could still improve.

**Negative examples.** Counselors often gave negative examples to show parents and children what would happen if they did not improve. Negative examples had a threatening, foreboding tone, such as, "A time will come when you will testify what I am telling you. You have heard of people dying because of stress, others getting paralyzed," and, "There are other people who told me that they laugh only once a year during Christmas... do these people have love?" Counselors wanted family members to take counseling seriously. To influence parenting, counselors gave negative examples to encourage parents not to discipline too aggressively:

"You will find that many parents have failed in disciplining the children. Whenever the child wrongs, he/she is beaten and the parent may even injure the child by doing that... The life of the child in future will be affected because you find that he/she has not good relationship with the child."

The counselor's example served as a warning to parents that if they were too harsh or beat their child too much, they would negatively affect their child's future. The recognition that many parents fail in this regard helps the parents to not feel isolated in their use of corporal punishment, but the stern warning of a damaged future steers the parents away from the aggressive behavior. Counselors even told stories of other children's suicide attempts to show parents the repercussions of ignoring or discounting their children's stress.

One counselor used an example of a corrupt politician to show that even those with wealth can have problems. Felix Koskei is a Kenyan politician who was investigated for corruption, ending his tenure as Agriculture Cabinet Secretary in the Kenyan government. The counselor explains:

“Mr. Koskei should kneel down and pray to a living God and repent to God that for him to fall... Mr. Koskei fell because of his deeds, God sees the heart, not the physical body, and he sees the thoughts and your heart and gives you accordingly. Mr. Koskei should be told to get saved, he has wealth but he is stressed.”

The counselor tried to show the family that they should aspire to be good people through their thoughts and prayers, as opposed to aiming solely for wealth.

Another negative example was a warning to a teenage girl about being drugged. The counselor told a story of when he had to intervene at a bar because a girl was too intoxicated, helping to ensure that she was taken home “because of the issues with boys.” He made the connection to the adolescent clear: “She is a good girl and I thought people like [adolescent] should see that as an example. The parent is unaware, thinking the child is safe but she was given soda and some mixture [was] added to it.” The counselors drew connections between people inside and outside of counseling to warn family members. Similarly, a counselor warned an adolescent girl of a student who had studied hard and received a job but died of HIV: “I am giving this example because of your education. You saw that girl studied and when people were coming for her celebration of graduation, they celebrated a painful burial.” Negative examples served as warnings to adolescents about what unfortunate fates might await them if they failed to act accordingly.

Most other negative examples revolved around alcoholism. Examples of alcoholism were related to embarrassment and judgement from others in the community. One counselor explained how a child drunkenly stumbled around town and fell on someone’s groceries. Everyone saw him and asked “isn’t that the child of [family name]?” The behavior was not only embarrassing for the family of the drunk adolescent, but also ruined the groceries of a community member. This shameful example was meant to serve as a warning to the father in the family, who had been drinking, that he should do all he can to avoid such embarrassment for himself and for his



family. Negative examples of drunken behavior also included counselors' stories of finding people passed out on the road from drinking, where they could have been robbed or injured, and of people who had to be hospitalized and required other people to care for them because of their drinking. Negative examples of drinking alcohol were usually targeted towards male caregivers and occasionally towards adolescents.

**Examples of strategies for improvement.** Counselors gave examples of how people, hypothetical and real, navigated problems that family members were facing. They frequently gave examples of people utilizing prayer and counseling to achieve improvement. Counselors qualified improvement by stating that these other people gained material items or attained wellbeing. Although many of these examples were positive in nature, they went an additional step in providing an action-oriented strategy that family members could model. A counselor explained that a well-known child in the community was successful in school "because he loved the church, he loved the parents and was obedient." His success relieved his parents of paying school fees because he received a scholarship, an effect that the counselor emphasized. Another counselor gave an example related to academic success to an adolescent. The counselor presented two types of students to the adolescent, one who thinks they will fail and another who thinks they can persevere:

"First there is this student at school who always think that he/she will fail the exams, I cannot do my exam well, I will fail. There is the other saying even though it is difficult I can read and pass. Can you give me the difference?... Tell me using the example, which one do you have is difficult and what can you do to solve it? You have heard that here of two students whom one said I cannot pass the exam and the other said though it is difficult I will pass. According to you both are in your mind, tell me what was difficult and what can you do to achieve your goal in life?"

The counselor wanted the adolescent to have a positive and ambitious mindset, believe in himself and work hard. After presenting the examples, he directly asked the adolescent which mindset he had to motivate him to try in school.

To help a distressed adolescent cope with his mother's anger, a counselor told him to "force yourself to be happy, not sad." The counselor gave him an example of a hypothetical child who is beaten by his mother, stating, "You talk to him well and warmly, show him love, try to love all the time." It appears that the counselor encouraged the adolescent to treat himself with the same kindness he would give to others. A different counselor told an adolescent in counseling that "most people who are respectful and successful in life are people who respected their parents." These clear, direct examples are easy for children to understand, and the messages are clear. However, the examples could also be perceived by children as unsupportive and didactic, leading them to feel disengaged from counseling. Several other counselors gave examples related to respect, encouraging all family members to practice respect towards each other. Examples were of other people who practice respect in their families. Examples were also of specific ways that family members can demonstrate respect, such as listening to and understanding each other.

Several examples were related to strategies for dealing with financial stressors. One counselor used a non-specific example to show parents that they did not need formal employment for their children to go to school. Instead, they could do casual jobs in order to have sufficient school fees.

"I will show you right here of people talking about that and it's not even people with a formal kind of employment. Many people think that you need a formal kind of employment to take your children to school and pay for their school fees. There are things you can do at home that can help you pay for school fees."

This counselor's example is solution-oriented. According to the counselor, others have shown that it is possible to provide for their children and send them to school, even without formal jobs.

One counselor presented prayer as a strategy to a female caregiver coping with her husband's alcoholism.

“There is a woman around this place whose husband was an alcoholic... Nobody pushed them to go to church but he went to church out of [his] wife's prayers. Nobody forced him to go to church. In the same way, you can also pray for your husband and he will change too.”

The counselor's example seems to steer the female caregiver away from “pushing” her husband to stop drinking and go to church, and instead towards praying for him to change. Other counselors' examples also encouraged female caregivers to take a passive approach. A counselor told a story about a mother reporting her husband for issues related to his alcoholic behavior and he was taken to jail, but she then became afraid for his safety and regretted it. The counselor then told the female caregiver that she should not want her husband to be in jail and absent from their children's lives, using the example to discourage her from reporting her husband. In another interesting example targeted towards a female caregiver, a counselor explained that another woman he counseled wore revealing clothing, “next to walking naked.” However, he praised her effort, as her outfit was part of doing “everything to make her husband see her.” He also recognized her husband's efforts to show his wife that he was trying in their relationship, praising the couple on their efforts despite the wife's revealing clothing.

### **Interpersonal Relationships Outside of the Family**

All counselors advised family members about their interpersonal relationships outside of family relationships at some point throughout their counseling, including extended family members, neighbors, religious leaders and the counselor. This included counselors discussing concepts of what is appropriate or inappropriate and good or bad in these relationships, how

family members should go about navigating these relationships, who they should discuss problems with and how family members should handle interpersonal conflicts.

As part of therapy, counselors ask family members who they usually go to when they have problems. Some family members' existing sources of support were more useful than others, and the same source of support was beneficial for some and problematic for others. For example, family members expressed that going to village elders made things worse, that going to a grandfather had no impact and that going to friends was both very helpful and the cause of their problems.

In response to family members describing tense or difficult interpersonal dynamics and situations, counselors responded with either clarifying questions or advice. Counselors often focused on making sure that family members were listening to each other.

**Relationships with counselors.** After counselors asked family members who they went to for support or who they could confide in, family members occasionally stated that they would now choose to go to their counselor for help. Counselors expressed their appreciation in response to this answer. They did not seem to assume or dictate that they should be a supportive resource for families, but let family members come to this realization on their own.

Both as part of benefitting from relationships with counselors, and as a way to seek support outside of therapy, counselors encouraged family members to be comfortable asking questions. To elicit question asking, a counselor reminded family members that they are often not the only one with questions:

“Have you ever gone for a meeting where they request people to ask a question? When you ask a question you will have saved like twenty people in the meeting. They had a similar question as yours but because of fear that they might ask a question and he/she is laughed at he/she goes home without getting knowledge.”

The counselor tapped into a common fear that one's question will be thought of as silly, and reminded them that people often have the same question. The counselor's message is that asking questions is brave, and useful to others and themselves.

**Relationships with friends.** Counselors discussed relationships with friends to either help participants identify sources of support, or discuss how their friends were contributing to problematic behaviors. The most common discussion related to alcoholism and how "bad friends" enable male caregivers to continue drinking. For example,

"Your friends that you just mentioned that you take alcohol together, you have to know how you will deal with them otherwise even if you try stopping taking alcohol; they will still push you to it and it will make it difficult for you."

Linking male caregivers' drinking to their friends and suggesting that they stop spending time with their friends was very common. The notion that drinking had become problematic "because of friends of bad company" was echoed by female caregivers as well:

Mother: "His problem is his friends... When he leaves home he does not come back early. He can leave home and goes to sleep out..."

Counselor: "You think the friends are leading him in a way that is not good?"

Mother: "That is it. It is bad because you have gone to someone's home to sleep, you don't eat and so on. That is not good. I don't like that and it is something that upsets me."

Both the counselor and the female caregiver were on the same page that the father's friends contributed to his drinking. This frustration was compounded by economic circumstances for multiple female caregivers because husbands spent money on alcohol with their friends, as opposed to spending money on family needs, although a few husbands claimed that their friends bought alcohol for them. The main solution for fathers with alcoholism was for them to stop associating with the people who they drank with. Counselors told them to "avoid those people who have no good intentions." When a father confirmed that he still had some "bad friends," the counselor asked questions about the friendship, and the father reassured him that it was

“shallow.” Counselors asked many clarifying questions, such as, “[Did you] depend on your friends for that week?” and “What do you feel when they tell you so?” in response to a father explaining that neighbors tell him about his wife’s drunk behavior, one of the only discussions about a female caregiver’s drinking. In response to the father’s idea to call a relative on his wife’s side of the family, the counselor asked the father if he thought it would help, if he had done it before and what the impact of the previous attempt was. Fathers recognized their friends’ roles in contributing to their drinking and were agreeable to plans to avoid these friends to reduce their alcohol intake, citing the stress on their children and marital fighting as motivating reasons. Counselors expressed a negative view of friends’ true intentions. A counselor told a father:

“Many friends are not good... Most of them want to pull you down. It is hard to find friends who wish that you prosper... You have seen from the example of ladies that you sent to go for your wife.”

The counselor identified the wife’s friends as positive and supportive but rare, reminding the father that he should be cautious of his friends and their intentions for him.

Alcohol was not the only problem described as caused by friends. A counselor also explained that some of the problems in a couple’s marriage were caused “as a result of your friends,” remarking that “through communication between yourselves, you will be able to improve your marriage.” The counselor encouraged the couple to talk to each other as opposed to their friends about their marital troubles. When a female caregiver expressed frustration about neighbors gossiping about her husband, the counselor asked the father what he would do “to avoid other people’s stories.” The counselor challenged the husband to not act in ways that would give the neighbors news to gossip about so that the wife did not have to deal with neighborly gossip about his behavior. Moreover, counselors described how families’

improvement and progress could make others jealous, especially regarding improvements in marriage. “Many of them won’t like seeing you progress,” one counselor warned.

Discussions about interpersonal dynamics related to friendships were also relevant to adolescents. Multiple female caregivers described feeling angry, frustrated, hurt, or worried when their husbands or children slept outside of the home, sentiments that counselors validated. A counselor discussed this issue with a family’s teenage son. The counselor tried to help the adolescent realize on his own why his behavior was upsetting his mother. The counselor also wondered if the son was questioning his sexual orientation, and indirectly asked him by probing about what activities he did with his friends. In one counseling session, a father encouraged a child to have “good friends” who would help him focus on schoolwork, and the counselor echoed the father’s concerns. Counselors asked adolescents who their favorite friend was and why, which warmed them up to talking about themselves. One counselor probed deeply into a boy’s time with his friends, asking what motivated him to spend time with his friends and how they helped him to feel better. Counselors expressed concern about who the children’s friends were, but also presented spending time with friends as a solution to their emotional distress, stating that they should want to play with their friends.

**Relationships with house guests.** Several families discussed problems related to house guests. When a family in Eldoret has house guests, the female caregiver is expected to provide food for the guest, a task that usually brings female caregivers satisfaction. Some families experienced problems related to how each caregiver handled house guests and the food preparation prior to their arrival, including tension over food going cold, not being ready on time, or guests not being offered certain meals. Counselors responded to these issues with clarifying questions but did not share their insights or ideas about solutions. This contrasts sharply to how

counselors usually gave direct commands and advice in other circumstances. For example, a counselor told an adolescent, “Appreciate [your siblings] whenever they do something good.” The counselor then told the adolescent that whenever he behaves well, visitors will recognize his effort, making the counselor proud of him. Counselors discussed what would make them feel proud and prideful to elicit children to act in certain “respectful” ways.

**Relationships with neighbors.** In response to counselors’ questions about families’ existing sources of support, some family members described going to neighbors. Counselors asked what happened when families tried to gain this type of emotional support from neighbors, to which one father responded that “it helped to some extent though the hearts were still hard.” Counselors encouraged children to have positive, respectful interactions with neighbors:

“Actually it is not good when you live somewhere having disagreements with the neighbors, you quarrel until when they see you they say ‘look at him/her, she/he is coming.’ It is good to interact happily with the neighbors.”

The counselor tried to steer the child’s behavior towards respect and having appropriate manners towards his neighbors, illustrating how important respect is in the community. The counselor linked his advice to a warning that, if there are disagreements with neighbors, they will be upset when they see the child approaching. Framing direct advice with a warning or threat was a common counseling strategy.

In discussing his wife’s suicidal thoughts, a father explained:

“I just talked to her by myself because this has not become so serious to the stage of inviting friends or neighbors to talk to her or if she had refused and said that she must kill herself then I would have invited neighbors to come and talk to her. Because I talked to her and I have seen some small changes then I decided not to inform anyone.”

The counselor did not reprimand the father for not telling anyone else about his wife’s suicidal thoughts. Instead, the counselor acknowledged how long the father and mother have been together and how they must understand each other well. For the father, reaching out to neighbors



or friends for help with a spouse's mental health is reserved for the worst, most dire circumstances. The counselor did not express agreement or disagreement with this, and only acknowledged how well the spouses know and understand each other.

Several families had issues with neighborhood gossip and nosy neighbors. Caregivers worried about neighbors knowing that they were going hungry or arguing. For example, a mother did not want to borrow food from her neighbors, as she found it "shameful." In this instance, her counselor encouraged her to become comfortable asking the neighbors for assistance so that, when the family faced severe financial strife, she would be able to ask them for food. This family struggled to have privacy from neighbors, even for counseling, which the counselor recognized:

"Because today is Sunday and most of your neighbors are around and I know they are also listening wanting to know what is wrong with your marriage, I would rather stop there for today."

Counselors were receptive to the discomfort that families felt because of the proximity of neighbors. The counselor quoted above considered when the neighbors would be around while scheduling sessions with the family, knowing that caregivers would be more comfortable speaking with the neighbors gone.

Another female caregiver experienced immense distress because of gossip from neighbors in her community about her husband's infidelity, and the counselor's response reflects gender expectations:

Counselor: "So everyone in the village believes that that child belongs to your husband?"

Wife: "Yeah; everyone! The aunties, her sisters and brothers, everyone!"

Counselor: "You have heard your wife say that all the problems are caused by you taking alcohol and lack of trust. [FCG name], when you started suspecting him, did each one started sleeping on his/her own?... Didn't you think that that would make him go out often?"

Wife: "If he had decided to do so then it is upon him!"

Counselor: "But you know when he gets drunk he will only think of going there because he does not get his conjugal rights from his wife. Don't you think it causes problems?"

Wife: "When you look at that woman; she is old. I think I am older than her first born by two years."

In response to the wife's stress about her husband's infidelity and gossip that he is the father of another woman's child, the caregiver blames her for not having sex with him. The expectation of "conjugal rights" as an excuse or explanation for the husband's infidelity and alcoholism reflects counselors' discourse in relation to religious justifications for a wife's role and puts pressure on the wife to have sex with her husband. The counselor's response to her frustration illustrates the pervasiveness of gender roles and expectations, as they manifest in the counselor's approach to helping the couple solve their marital problems.

**Relationships with extended family.** Relationships with extended family were also discussed in the context of existing sources of emotional support. To help a child when his mother treats him badly for unfair reasons, such as yelling at him for not doing his chores even though he had completed them, a counselor discussed how the boy could go to the counselor himself or his uncle or grandmother for support.

"Sometimes you may have feelings that sometimes you cry, your mind is hard and the heart is beating is the time you need surrender your problems. You can say '[Counselor, I have a certain problem,] I will then encourage you. Be honest with your problems and identify the right person who can help you. At home you can trust an uncle...Or a grandmother or anyone [who] you trust in the family such that whenever you have certain problem you go to [them] and [they] will help encourage you."

The counselor helped the child identify sources of support and people with whom he can discuss his emotions and problems. As opposed to evaluating or judging to whom he had been going for help before counseling, the counselor explored whom he could go to for support in the future.

In the tree metaphor, the roots of the tree – the family's foundation – include extended family. When teaching the tree metaphor, sometimes discussions of the roots lead to discussions about specific family members, such as "the uncle...you can talk to them for advice." When a counselor asked an adolescent, "Who can help you build a healthy tree?" the adolescent

answered “my uncle or aunt,” to which the counselor responded, “It is good to have someone else in mind, apart from the counselor.” The counselor did not directly state that extended family members should be used as a source of support but asked the child who he would feel comfortable going to because the counselor should not be the only one, as that would not be sustainable after the intervention ends.

Counselors also took a more specific approach to discussing extended family members. One counselor facilitated a meeting between a male caregiver and his brother-in-law to help the male caregiver attain school fees for his child. In reflecting on his efforts, the caregiver said, “We must see how we can help each other.”

**Relationships with religious leaders.** There was limited discussion of relationships with religious leaders. Almost all discussions were about their role as an option for emotional support or help dealing with problems. One counselor described how church leaders can mediate when sons “turn on” parents:

“When a child overwhelms you because... you are a mother, the boys can turn on you and beat you. You need now to be going to church and doing all those things, isn’t it?”

The counselor identified church and church leaders as a supportive community when children beat their mothers. Suggesting that the mother goes to church when this happens, instead of the children, shows a gendered approach to problem solving that does not address the root cause of the problem: the children’s behavior and anger.

**Interpersonal trauma.** Extended family and community were not only discussed as forms of support but also of harm. Several counselors had to navigate discussions related to sexual violence in therapy. In one family, a mother was concerned that her son had been abused and asked the counselor to explore this possibility with her child. The mother was concerned because “his stomach keeps disturbing him... but there is nothing that is detected” by health care

providers. The counselor asked the child about his friends and experiences and eventually asked him directly, to which the child responded that he had never been molested.

Discussions related to sexual abuse and rape were mostly related to children, but in one incident, a mother disclosed that she had been attacked and raped, from which she became pregnant and had her first child. This came up when the counselor asked the caregivers about their own childhoods to help them relate to their adolescent. The mother described that she was beaten very badly and afterwards slept for a month without eating. The counselor responded, “You see that everyone is passing through issues... You slept out and got pregnant because of disobeying your parents.” The counselor had immense candor in discussing the mother’s traumatic experience and its repercussions. He goes on:

“You can see everything that you pass through when you were young so it is normal for an adolescent to do what they are doing, do you see it? If you knew it, you could not go. Maybe you could be a nurse now after completing your education.”

Because the mother had gone out drinking when she was young and was attacked, beaten and became pregnant, she was not able to finish school or realize her professional goals. The counselor’s frank statement of these facts as a way to help her relate to her child is gendered, as he blames the mother for what happened to her because she “disobeyed” her parents.

One adolescent disclosed her rape and suicide attempt to her counselor, who incorporated many culturally-informed supports and approaches to helping the adolescent in ways that the counselor thought would be best. He asked the adolescent many questions about the specifics of what happened to her, as opposed to focusing on her emotions. He was interested in solving problems related to the trauma, such as HIV status, pregnancy status and who committed the crime, as opposed to focusing on and validating her emotions. The child explained that her fear of others began when a man scratched her hand while greeting her. She said that she was once

told that if someone scratched one's hand the way that man did, "then that person isn't a good person." The counselor eventually asked if she had been raped directly, stating, "I did ask you before if someone ever slept with you; maybe he forced you or you may have accepted it willingly; is there any such incident?...Don't fear anything, just tell me. I am your counselor and I am doing this so that I can help you on what is good and bad." Once the child began sharing the story in detail, the counselor continued to ask specific questions about who was there and if the adolescent physically struggled or sustained physical injuries. When the adolescent continued to cry, the counselor encouraged her to continue, saying, "Persevere so that you can explain to me." She also shared that she had a friend who was raped and did not tell anyone, including her parents, adding to the counselor's concerns about her lack of disclosure. The counselor ended this therapy session with solutions and advice, telling her not to go anywhere alone and to keep herself busy.

As the counselor continued to support the adolescent, he focused on her HIV status and disclosing what happened to her mother. He asked her to identify reasons that she should tell her mom what happened to her, saying, "Do you fear her or hate her or you think she can punish you?" and "How do you feel by not giving your mother a chance to know what you are passing through?" He then took it upon himself to disclose the rape and suicide to her mother. Regardless of the counselor's disclosure of the child's private information, she continued to feel comfortable with him and shared some of the story with her mother.

The counselor's approach to the adolescent's trauma focused on problem solving to avoid future incidences. He gave her specific action steps to deal with problems, as opposed to emotional support. The counselor summarized his recommendations for the adolescent and emphasized what was at stake with her future. If she chose not to follow these steps, he said, her

future career aspirations would be jeopardized. Looking forward, he also told her that she could be “an ambassador” to her other friends, sharing the techniques he taught her. He reminded her that sex is not necessary for love, and pushed her to continue talking and sharing. Overall, the counselor’s handling of the child’s trauma was warm and supportive, but overly focused on safety and problem solving strategies. The counselor showed a lack of emotional validation, and seemed to think that informing the mother about the daughter’s trauma was vital to moving forward. The counselor taught a few emotional coping skills, connected the daughter to HIV testing services and warned the daughter about the risks of promiscuous behavior and the danger of boys. Despite his extensive advice giving to the daughter, the counselor gave little to no directive guidance to the mother about how to support her child.

### **Community Dynamics and Resources**

Counselors and families often discussed resources in the community and broader community dynamics as they related to the families’ problems and circumstances. We have distinguished these from participants’ interpersonal interactions with other community members, summarized in the previous section (Interpersonal Relationships). Resources include institutions and individuals such as hospitals, churches, women’s groups, chiefs, and elders. These organizations and individuals within the community were discussed in terms of the ways they might help or harm people. For example, counselors discussed community gossip about a male caregiver having a child out of wedlock but also gave advice about resources for HIV testing. Although this section is broadly defined, discussions of community dynamics and resources were limited.

**Poverty and economic circumstances.** As discussed in the previous section on neighbors (Interpersonal Relationships), one counselor encouraged a family to ask neighbors for

financial support when they were struggling financially, despite the mother's hesitation. There were several other discussions of financial strife related to community dynamics and resources. Some counselors gave families direct financial advice, asking, "Do you think you can reduce it [alcohol expenditures] to twenty shillings a day?" Others focused more on skills related to dealing with financial issues, such as honest communication between family members and tips for saving.

**Socio-cultural supports.** Counselors also referenced broader socio-cultural supports. This often arose in relation to the metaphor of the tree as a family system, which is part of *Tuko Pamoja* (see Metaphors/Proverbs). In this metaphor, the roots of the tree represent traditions, religious beliefs, extended family, religious congregations, and other elements of a community that create the foundation for a healthy family. In explaining the tree metaphor to an adolescent, one counselor gave examples of what "cultures, rules, norms" are to help the adolescent understand the roots of the tree:

"The roots are the cultures/rules/norms of the family, for instance, our Nandi culture where we circumcise the boys. Which other culture do you know? The other culture is the marrying off the ladies; a man comes from their home to the girl's home for a ceremony before he goes with her. The other culture is what the family believes for instance the denomination. For instance, you do go to church; that is a culture; you do go to worship with others. The other norm that is in the roots is the foundation of the family; who is the eldest, who is the youngest; who will do what about work at home. You have known where the parents are represented on this tree, where the culture is. Now, what will happen if this tree does not stand strong?"

The counselor worked to establish an understanding of what culture means by giving examples of culture in the adolescent's life. Circumcision, marriage practices, church and responsibilities of the eldest child are all examples that the counselor used to help the adolescent conceptualize what culture is, demonstrating what culture means to the counselor as well.

When explaining the positive communication skills that are part of the Tuko Pamoja intervention, which follow the acronym CLEAR for conversation, listening, encouragement, appreciation and respect, the counselor connected respect to the Nandi people:

“The fifth is respect for the child. We say respect is powerful in Nandi; our people were not fools because you can see all these things that we use are the things that our people used to do. The whites copied our things and used it, but when you follow the Nandi culture keenly, we were good to the end. It is just the other day that it becomes bad. We need to consider it and put together our culture and what we have now.”

The counselor established respect as something that has always been a part of the family's culture. Respect is not to be viewed as a Western idea being imposed on the child but something that has always been important to the Nandi people. The counselor states that white people copied the Nandi culture, affirming respect as a norm within their culture.

**Discussion of institutions: health care, schools, and churches.** Community institutions were discussed as general resources for support and as a way for the counselor to connect with and better understand family members. For example, counselors occasionally asked how church was going for family members. Counselors were not probing about specific relationships related to attending church, but instead more broadly inquiring about the experience of attending church. Additionally, when asking parents to reflect on their childhoods to help them relate to their children, counselors would probe about their experiences attending school as children.

Discussions related to health and medical services came up several times. On one occasion, a counselor said that he could take the female caregiver to Moi Teaching and Referral Hospital for counselling services because she had expressed suicidal thoughts. The counselor informed the woman of available resources. In another family, a counselor gave in-depth thoughts, options, and advice related to HIV testing in response to the adolescent who disclosed her rape. He shared resources regarding HIV testing and the prevalence of the disease to



encourage her to get tested, reminding her that only the doctor and her would know her results and “all the doubt will end.” He also mentioned that he had noticed the high prevalence of experiences of sexual trauma among her age group, shared his medical knowledge about HIV/AIDS, warned her about pregnancy, and gave examples of the bodily changes that come with puberty. The counselor wanted the adolescent to feel comfortable sharing about herself with her mother, especially regarding sex and puberty.

“With all the changes that come to your body... talk to [your] parent so that she/he can support you since he/she is grown up and knows all the problem, like when you have sex before time can affect you in your life.”

To encourage the adolescent to be tested for HIV, he explained that getting tested is the “first step,” since it is impossible to know one’s HIV status without being tested.

“For your case when the act happened to you, no step was taken, the boy is free to do his things and free but for your health, you do not know your status. It might be fighting but it will reach a time when you take the test and [you could] be surprised you were infected. It starts affecting you. First ensure that you take the first step to solve the issue.”

The adolescent did eventually get tested for HIV when the counselor went with her. She did not have HIV, but the counselor wanted to make sure that this realization would not lead her to engage in sexually risky behavior and reminded her of the risks of “the bad ones who will mislead you,” referring to those who can lie about their HIV status. He warned the adolescent about peer pressure and the importance of surrounding herself with good people. The counselor tied his messages to the adolescent’s mother, encouraging them to communicate about these sensitive topics.

“You have seen your mother have said there that she is ready to support you to make sure that your education [reaches] the level that she wants and [is] ready to protect you and be with you, so what can you tell your mother?”

The counselor’s discussion of health care resources related to HIV and the risk of sexually transmitted infections, all very sensitive topics, was comprehensive and focused on promoting

dialogue between the adolescent and the mother so that these difficult conversations related to sexual health could continue after counseling ended.

## **Discussion**

This study sought to identify and describe the community-based practices used by lay counselors delivering Tuko Pamoja, a family therapy intervention piloted in Eldoret, Kenya. Although the content of Tuko Pamoja had been culturally informed through qualitative work in the community, counselors also were encouraged to draw upon their own community-sourced understandings in different ways as they delivered the intervention. Counselors' community-based practices fell into six broad themes: providing metaphors and proverbs, incorporating religion, self-disclosure, using examples and role models, discussing interpersonal relationships outside of the family, and referring to community dynamics and resources. Counselors incorporated these practices to explain core tenets of the Tuko Pamoja intervention. For example, the tree metaphor, a core tenet of the intervention, was explained through religious appeals and Biblical references. Counselors also used community-based practices to share lessons outside of or only briefly mentioned in the manualized intervention. For example, counselors emphasized the importance of respect and the impact of prayer as part of their counseling, drawing upon their own cultural values as they worked to help family members interact with each other.

The community-based practices were forms of content changes that counselors intertwined with the content and aims of Tuko Pamoja. In Chowdhary et al.'s 2014 systematic review of cultural adaptations of psychological treatments for depressive disorders, they found that adaptations predominantly reflect efforts to enhance the acceptability of the treatment, as opposed to adaptations of core content, maintaining fidelity to the original treatment. Counselors were found to have generally high fidelity to the intervention (Puffer et al., 2018), thus the

counselors' community-based practices align with what Chowdhary et al. identified as most common in cultural adaptations: an approach focused on improving the acceptability of intervention content, as opposed to incorporating different lessons or takeaways. Besides Swahili proverbs, the practices were rarely unique to the culture of the counselors, but they were contextually grounded to their own experiences, values and priorities.

Many of the counselors' community-based practices seemed to have the goal of eliciting family member engagement, particularly from children. Community-based practices were often employed as a way for counselors to connect to family members and make them feel at ease, focusing on relatability and validation. Discussing religion seemed to be a culturally-grounded protective factor. Prayer can help to improve a difficult situation, and recognizing God's power also gives people a feeling of peace in that whatever happens is outside of their control.

Counselors invoked religion at both ends of this spectrum, with some assuring families that faith in God would solve their problems, and others explicitly reminding them that they should take action beyond prayer.

Gender roles were incorporated throughout several community-based practices, manifesting in discussions of religion, counselors' self-disclosure, examples of successes and struggles in other families, and novel metaphors provided by the counselors, such as the family as a car with the mother in the passenger seat and the father behind the wheel. Notions of gender roles did not seem to differ dramatically between counselors and family members, but counselors should be made aware, by supervisors and in their initial training sessions, of potential discrepancies between their own expectations of gender roles and those of family members, since counselors commonly incorporated gendered expectations into other community-sourced discussions.

Some practices were more easily and effectively incorporated into therapy, such as self-disclosure and the use of role models and examples. Other practices were used in potentially problematic ways by some counselors and skillfully by others, such as discussions of religion and interpersonal relationships outside of the family. All types of practices were implemented in skillful ways by some counselors and unskillful, awkward ways by other counselors. This illustrates the importance of individualized approaches to supervision with different counselors. When local supervisors oversee counselors in their delivery of psychological treatments, supervisors should try to understand the ways that counselors incorporate their own community-sourced attitudes, beliefs and ways of explaining content, as counselors in Tuko Pamoja have shown that these practices manifest in a diverse spectrum of ways. It seems that a one-size-fits-all approach to specific community-based practices would not be appropriate, and instead an individualized approach that addresses counselors' own unique approaches should be used. However, the practice of presenting role models and examples, both negative and positive, appeared to be a very helpful practice as a way to validate participants' experiences, motivate participants and steer them towards or away from certain behaviors. Discussions of interpersonal relationships outside the family seemed to be one of the least helpful strategies, as counselors often tried to give direct advice that did not facilitate the process of families generating their own solutions (Carr et al., 2016). The breadth of ways that each community-based practice was used demonstrates how manualized, culturally adapted interventions require an iterative process of evaluation to ensure that counselors receive appropriate, individualized supervision.

The thorough description and understanding of the community-based practices used by counselors in Tuko Pamoja can be used to develop specific community-sourced implementation strategies. Community-based practices have not been sufficiently studied in LMIC settings to

inform implementation strategies. Integrating these practices into existing interventions could improve their acceptability, feasibility and effectiveness, strengthening the ways that the informal practices outlined in this study can be used in conjunction with evidence-based approaches. Jordans et al. (2013) described how research-practice mismatches contribute to the limited impact of child mental health interventions, since there is limited research on how to translate knowledge into effective real-life practice. My thesis provides some interpretation of how certain practices seemed to be helpful or harmful, but this needs to be systematically assessed in relation to effectiveness and implementation outcomes. The practices should then be codified in an implementation strategy, which could be used in the scaling up and adaptation of Tuko Pamoja to other settings in the East African region. Community-based practices can be incorporated into therapy in both helpful and harmful ways. Using this study to inform a context-specific, multifaceted implementation plan with guidance on how counselors should incorporate the identified community-based practices could improve the intervention's effectiveness.

There are notable limitations to this study. First, this study has limited generalizability to communities and individuals outside of the context in which the study was conducted. Although it is likely that others from the community would have similar community-based practices, the diversity of strategies as part of each practice among the counselors analyzed in this paper illustrates the importance of evaluating the community-based approaches used by counselors in individual task sharing interventions so that implementation plans can be adjusted accordingly.

A second limitation is the issue of translating. Since the therapy sessions were translated from Kiswahili to English, this thesis relies on the assumption that the translations of the transcripts are accurate and that the words did not lose or significantly change meaning when translated. There is a risk that the explicit meanings of the words in English were different in

Kiswahili, which could potentially change how some community-based practices were defined and understood.

Lastly, my own lens on the world and on what constitutes culture and community inevitably influenced the data analysis. Since I was not present for the data collection and the counselors did not know that their therapy sessions would be analyzed for cultural and community content, the existence of this study did not affect the data gathering. However, my own idiosyncrasies have some role in the interpretations of the counseling sessions. Although I tried to be as grounded to the data as possible, the subjective dimension to qualitative analysis should be recognized.

## **Conclusion**

The study's identification and description of community-sourced practices used by lay counselors in delivering a family therapy intervention in Eldoret, Kenya shows the diversity of approaches that counselors use when implementing mental health interventions. Counselors naturally use cultural supports and explanatory models that align with their own local understandings and norms as part of their therapeutic and pedagogical strategies. The implementation of task sharing interventions necessitates descriptive research to understand the community-sourced practices that counselors in different settings use to identify which practices promote acceptability, fidelity, and effectiveness and to make recommendations for context-specific implementation plans. Improved understandings of community-sourced practices are essential to translating and adapting mental health interventions across cultures, bridging the gap between science and practice.

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