



# Therapist competence in global mental health: Development of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale



Brandon A. Kohrt<sup>a, b, c, d, \*</sup>, Mark J.D. Jordans<sup>a, e, f</sup>, Sauharda Rai<sup>a, d</sup>, Pragya Shrestha<sup>a</sup>,  
Nagendra P. Luitel<sup>a</sup>, Megan K. Ramaiya<sup>d</sup>, Daisy R. Singla<sup>g</sup>, Vikram Patel<sup>h, i, j</sup>

<sup>a</sup> Transcultural Psychosocial Organization (TPO) Nepal, Kathmandu, Nepal

<sup>b</sup> Department of Psychiatry and Behavioral Sciences, The George Washington University School of Medicine, Washington, DC, United States

<sup>c</sup> Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, United States

<sup>d</sup> Duke Global Health Institute, Duke University, Durham, United States

<sup>e</sup> Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London, United Kingdom

<sup>f</sup> Research and Development, HealthNet TPO, Amsterdam, The Netherlands

<sup>g</sup> Department of Psychology, McGill University, Montreal Quebec, Canada

<sup>h</sup> Centre for Global Mental Health, London School of Hygiene & Tropical Medicine, Keppel Street, London, United Kingdom

<sup>i</sup> Public Health Foundation of India, New Delhi, India

<sup>j</sup> Sangath Center, Alto Porvorim Goa, India

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## ABSTRACT

Lack of reliable and valid measures of therapist competence is a barrier to dissemination and implementation of psychological treatments in global mental health. We developed the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale for training and supervision across settings varied by culture and access to mental health resources. We employed a four-step process in Nepal: (1) *Item generation*: We extracted 1081 items (grouped into 104 domains) from 56 existing tools; role-plays with Nepali therapists generated 11 additional domains. (2) *Item relevance*: From the 115 domains, Nepali therapists selected 49 domains of therapeutic importance and high comprehensibility. (3) *Item utility*: We piloted the ENACT scale through rating role-play videotapes, patient session transcripts, and live observations of primary care workers in trainings for psychological treatments and the *Mental Health Gap Action Programme (mhGAP)*. (4) *Inter-rater reliability* was acceptable for experts (intraclass correlation coefficient, ICC(2,7) = 0.88 (95% confidence interval (CI) 0.81–0.93), N = 7) and non-specialists (ICC(1,3) = 0.67 (95% CI 0.60–0.73), N = 34). In sum, the ENACT scale is an 18-item assessment for common factors in psychological treatments, including task-sharing initiatives with non-specialists across cultural settings. Further research is needed to evaluate applications for therapy quality and association with patient outcomes.

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## 1. Introduction

Availability of evidence-based psychological treatment (PT) in low-resource settings is crucial to reduce the global burden of disease attributable to mental disorders (Fairburn & Patel, 2014). This requires task-sharing (WHO, 2008) which involves training non-specialists, such as individuals without professional mental

health clinical degrees, to be competent in PT delivery.<sup>1</sup> In both high and low resource settings, non-specialists can effectively deliver a

<sup>1</sup> Task-sharing, also known as task-shifting, refers the involvement of non-specialist service providers to collaborate in delivery of health care services traditionally relegated to experts with professional degrees or certification (WHO, 2008). In the context of global mental health, 'non-specialist' refers to a person who lacks specialized professional training in fields such as psychology, psychiatry, or clinical social work. Non-specialists in both low- and high-resource settings may include community health volunteers, peer helpers, social workers, midwives, auxiliary health staff, teachers, primary care workers, and persons without a professional service role.

\* Corresponding author. Duke Global Health Institute, 213 Trent Hall, 310 Trent Drive, Durham, NC 27708, USA.

E-mail address: [brandon.kohrt@duke.edu](mailto:brandon.kohrt@duke.edu) (B.A. Kohrt).

range of PT (Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010; van Ginneken et al., 2013). However, a lack of reliable and valid measures of therapist competence impedes the dissemination of evidence-based PT (Fairburn & Cooper, 2011; Muse & McManus, 2013; Rakovshik & McManus, 2010). Such measures are crucial to (1) interpret outcomes of effectiveness studies, (2) evaluate and refine training and supervision models, and (3) scale-up and disseminate PT in real-life context. Our goal was to develop a tool to evaluate competence in PT delivery across settings varied by culture and availability of professional resources.

Therapist competence is “the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects,” (Fairburn & Cooper, 2011, p. 373). Therapist competence also should be reflected in therapy quality, which is “the extent to which a psychological treatment was delivered well enough for it to achieve its expected effects,” (p. 373), and, ultimately, in patient outcomes. Variability in therapists’ training and competency may explain the lack of significant differences in some comparative treatment studies (Brown et al., 2013; Ehlers et al., 2010; Ginzburg et al., 2012). Because training and background of specialists and non-specialists may vary considerably, reliable and valid competence and quality assessment tools are crucial for global mental health research.

Miller’s (1990) hierarchy of clinical skills includes 4 levels (Muse & McManus, 2013): Level 1 “knows” refers to conceptual knowledge of a PT and typically is assessed through multiple-choice questions. Level 2 “knows how” refers to knowledge of how to apply theory, which can be assessed through decision-making questions following clinical vignettes. Level 3 “shows” refers to competence in demonstrating the ability to apply skills, which can be assessed through role-plays with standardized patients. Level 4 “does” refers to how therapists apply skills in practice, which reflects therapist quality and is typically assessed through rating treatment sessions. Measurement of competence (Level 3, “shows”) is one of the least examined skill domains (Muse & McManus, 2013) and is especially lacking in training and research conducted in low- and middle-income countries (LMIC).

A major question in assessment of competence is *what skills should be measured*. Competence typically entails “limited domain intervention competence” (Barber, Sharpless, Klostermann, & McCarthy, 2007), which refers to specific practices for particular interventions, such as facilitating activation in cognitive behavior therapy. However, research has demonstrated that *common factors* in psychotherapy are vital for successful outcomes. Common factors have been categorized differently by scholars (Frank & Frank, 1991; Lambert & Bergin, 1994; Rosenzweig, 1936; Wampold, 2011): the main domains relate to therapist qualities and therapeutic alliance, mobilization of client and extra-contextual factors, promoting hope and expectancy of change, collaborative goal setting, ritualized procedures to work toward that goal, eliciting feedback, explanation for treatment grounded in a patient’s belief system, and a healing setting.

In practice and research, it is difficult to disentangle common factors as distinct processes (Wampold, 2011). Common factors are interrelated, and they overlap with specific practice elements. A key distinction is that practice elements have a demonstrated evidence base for a specific patient population and typically are administered from selected manualized modules whereas common factors refer to those practices assumed to be universal for delivery of any effective PT (Barth et al., 2012). Therefore, if one is starting with non-specialists, they need to be competent in these common factors first before teaching them the required treatment-specific skills. Competency in common factors contributes to phenomena such as the “primary care paradox”, the observation that some conditions can be well treated by generalists despite delivery of

manualized care that is of lesser technical proficiency (Stange & Ferrer, 2009). Unfortunately, common factors have received limited attention in LMICs (Jordans, Komproe, Tol, Nsereko, & de Jong, 2013; Kabura, Fleming, & Tobin, 2005) despite importance for care delivered by non-specialists.

Although tools to assess common factors are available in high-income countries (HICs), application of these tools are limited across settings varied by culture and professional resources. Barriers to applying these tools include experts required for scoring, narrow focus on content, reliance on patient feedback, length of tools, and high costs to administer some copyrighted tools. Moreover, although common factors are important across cultures (Frank & Frank, 1991; Othieno et al., 2013), instruments developed for use by educated professionals in HICs might overly represent values and treatment philosophies that are not associated with outcomes across cultures, such as an emphasis on biomedical models (Kleinman, 1988).

This study is part of a larger endeavor to improve mental health care in low resource settings (Lund et al., 2012) and to strengthen measurement of competence and quality for and by non-specialists in global mental health (c.f., Singla et al., 2014). The focus of the current study is to develop a tool to assess competence in a manner that is not restrictive to HIC specialists and is relevant across cultural settings. We employ a four-part process to (1) collect a range of items related to common factors, (2) determine their face validity in a South Asian cultural context, (3) pilot the tool for feasibility and acceptability, and (4) establish psychometric properties. This is a systematic description of a procedure that can be replicated for developing common factors assessments across a range of interventions, provider disciplines, and cultural context.

## 2. Methods

We developed this tool within a task-sharing initiative in a low-income, non-Western cultural setting. Nepal, a post-conflict country in South Asia with high prevalence of depression (Kohrt, Hruschka, et al., 2012) and suicide (Jordans et al., 2014), is participating in the Programme to Improve Mental Health Care (PRIME), an initiative in LMICs to develop mental health care in primary and community health settings (Jordans, Luitel, Tomlinson, & Komproe, 2013; Lund et al., 2012). In Nepal’s Chitwan District, primary care and community health workers are being trained with a locally developed Mental Health Care Package (Jordans, Luitel, Pokharel, & Patel, *in press*), which includes the *mental health Gap Action Programme—Intervention Guide (mhGAP-IG)* (WHO, 2010), psychosocial skills modules, and brief modified versions of behavior activation (the Healthy Activity Program, HAP) and motivational interviewing (Counseling for Alcohol Program, CAP) from the Programme for Effective Mental Health Interventions in Under-resourced Health Systems (PREMIUM) (Patel et al., 2014; Singla et al., 2014). The Nepal Health Research Council approved the protocol.

In the context of our study, ‘non-specialist’ refers to the primary care workers being trained in PT through PRIME. ‘Expert therapist’ refers to individuals who have completed a six-month training and have been practicing therapy for more than five years. Their six-month training course includes 400 h of classroom learning, 150 h of clinical supervision, 350 h of practice, and 10 h of personal therapy (Jordans, Tol, Sharma, & van Ommeren, 2003). All role-plays in the study were 15–20 min and covered a range of common patient presentations including depression, harmful drinking, sexual violence, other traumatic experiences, academic stressors, and self-harm. We generated role-plays based on actual patient interactions. Role-plays used with the common factors tool were designed for all items to be applicable. Expert therapists were trained to perform as standardized patients for all role-plays.

### 2.1. Step 1. Item generation

To generate a pool of common factors items from which to develop a global mental health competence tool, we began by identifying patient–therapist interaction instruments used in HIC from a systematic review (Cahill et al., 2008). Instruments were included in our item generation procedure if they addressed at least two common factor domains from the established literature (Wampold, 2011). Instruments were excluded if they were limited to knowledge-only ratings; they were exclusive to rating couples, family, or children; items were limited to inner experiences of therapists or patients; or only psychodynamic concepts were included. Additional instruments were reviewed when identified through references of included publications. The goal was to generate a breadth of items rather than produce a list of representative frequency, which has been done previously for common factors (Grencavage & Norcross, 1990). A diversity of tools was coded including those related to cultural competence and manualized treatment assessment scales when they included common factors. We extracted and coded items from tools using QSR International's (2012) NVIVO 10. We grouped items into domains based on conceptual similarity.

In the second component of Step 1, 13 Nepali expert therapists participated in four role-play sessions with standardized patients to generate items. Each session consisted of two role-plays. After each role-play, we conducted semi-structured discussions about techniques and general practice. Prompts included, “What techniques did you recognize during the role-play?”, “What techniques have you used with similar patients?”, “When did you notice positive or negative reactions from the patient, and what was the therapist doing at that time?”, “In the role-play and your work, which therapist actions, behaviors, and techniques are most helpful to patients?” We generated additional common factor-related items from these sessions.

### 2.2. Step 2. Item relevance

After items were generated, the next step was to score each item for *comprehensibility*, i.e., was a concept understandable for basic PT training, and *importance*, i.e., how important was the item in affecting therapeutic change. Ten Nepali expert therapists rated comprehension on a 1-to-3 scale: ‘1’ Concept is not clearly comprehensible in my experience and training. ‘2’ Concept is generally clear and comprehensible. ‘3’ Concept is very clear and I could explain it to my patients or therapy trainees. They rated importance for therapeutic change similarly: ‘1’ Concept is not usually essential for effective therapy in my experience. ‘2’ Concept is important sometimes in my therapy. ‘3’ Concept is important for all of patients. We selected items with high comprehension and therapeutic importance for piloting in the next step.

### 2.3. Step 3. Item utility

The goal of the utility phase was to pilot the tool and evaluate the items and overall instrument for face validity (Did the items reflect practices assumed to be important for therapeutic change? Were important items missing?), feasibility (Was the behavior observable and was the format for scoring user-friendly?), and reliability (Did raters share a mutual understanding of ratings?). We evaluated these criteria qualitatively through pilot-testing and discussions with raters. Discussion prompts included “Which items were difficult to rate or unclear for scoring?”, “Which items were duplicates?”, “How did you distinguish among scores?”, “How user-

friendly was the format?” In addition, we asked expert raters which common factors were the most in need of remediation among trainees performing role-plays.

In the first phase of piloting, two Nepali expert therapists used the tool to rate non-specialists conducting 15-minute role-plays after PRIME trainings. Each therapist rated eight non-specialist role-plays. After the role-plays, a focus group discussion (FGD) was conducted to qualitatively explore validity, feasibility, and reliability. Then five Nepali expert therapists rated two videotaped role-plays of Nepali expert therapists with standardized patients and participated in FGDs. Seven American psychiatrists with experience in psychotherapy training and research in global mental health viewed the Nepali videos (with English subtitles) and participated in a FGD.

Next, English language translations of Nepali audio recordings were qualitatively coded. The audio recordings included 27 non-specialist role-plays with standardized patients after PRIME trainings and four sessions of expert Nepali therapists with actual patients. Actual patient sessions were included to identify potential items not captured in role-plays. Transcripts were coded by three raters (one American graduate student, one Nepali psychosocial researcher, and one American psychiatrist with extensive experience working with Nepali patients) using the tool as the initial guide. We used NVIVO after establishing adequate coder inter-rater reliability (>80% agreement). The goal of coding was to assess the same components as above: validity, feasibility (specifically regarding what could and could not be rated with transcripts), and reliability. We used the qualitative findings from Step 3 to revise, remove, add, and collapse items, and to reformat the tool.

### 2.4. Step 4. Psychometric properties

After developing an 18-item version of the tool, we assessed inter-rater reliability for expert therapists and non-specialists. Expert inter-rater reliability was assessed with Nepali therapists (N = 7) who had not participated in prior phases of the research. They rated two 15-minute videotaped standardized patient sessions from which we calculated a one-way random effects model, average measures intraclass correlation coefficient (ICC). Non-specialists inter-rater reliability was calculated with 34 primary care health worker trainees completing the PRIME training. At the end of the training, each of the 34 trainees completed one 15-minute role-play with a standardized patient with depression. Each trainee took a turn performing the role-play in a group with 2–4 other non-specialist trainees observing and scoring the interaction. Each of the 34 role-plays was rated by 2–4 peers (mean = 3.32 peers) totaling 113 peer ratings. We calculated a two-way random effects model, average measures ICC utilizing all peer ratings.

These trainee role-play peer ratings (N = 113) also were used to calculate internal consistency (Cronbach's alpha) of the scale among non-specialists. In addition, we calculated Cronbach's alpha for experts using Nepali therapists who provided one rating for each of the trainee role-plays (N = 34).

## 3. Results

### 3.1. Step 1. Item generation

For selection of tools from which to extract items, we began with a systematic review of therapist–patient interaction assessments that included 56 tools (Cahill et al., 2008). Thirty-three of these tools qualified for item-specific extraction based on our inclusion/exclusion criteria. We identified an additional 65 tools from

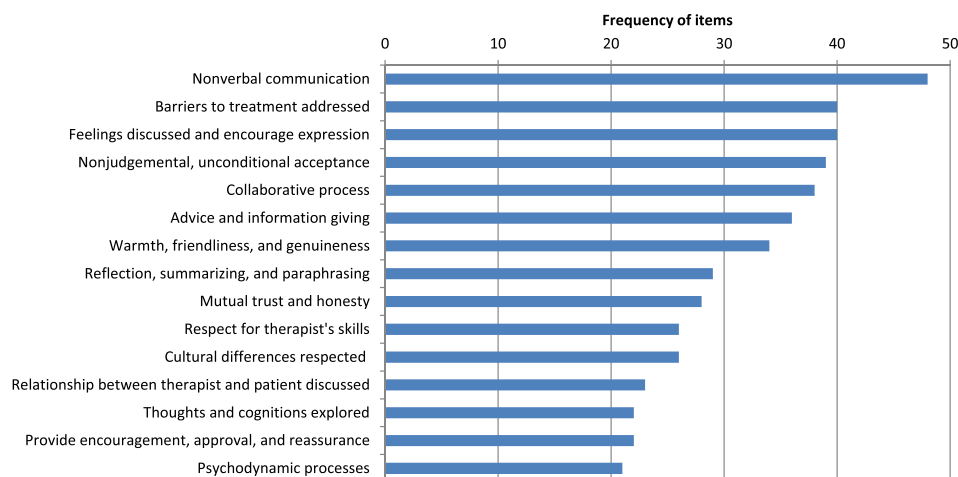


Fig. 1. Frequency of items in top 15 domains among 1081 items extracted from 56 common factors-related assessment tools.

references for each of the 33 included tools; 21 of these 65 additional tools met inclusion criteria. One additional tool was included because it previously had been used to rate competence of common factors in a LMIC (Kabura et al., 2005). In addition, the mhGAP-IG was coded to identify common factors-related skills needed to implement task-sharing programs. In total, we reviewed 123 articles and included 56 tools (33 tools from the prior systematic review, 21 from references for these tools, and two from global mental health literature, see Supplemental File). We extracted 1081 items from the 56 tools and grouped them into 104 domains based on conceptual similarity following approaches consistent with prior common factors reviews (Grencavage & Norcross, 1990). The top 15 domains accounted for 44% of the 1081 items (Fig. 1).

We identified additional themes from semi-structured role-plays and discussion sessions with Nepali therapists. Therapists prioritized assessment and management of patient safety. They discussed adapting confidentiality practices to the physical location of health encounters. They explained that primary care visits rarely are conducted in a confidential space. Another communication issue was the role of ethnicity, caste, gender, and age, which influenced the relationship between health workers and patients.

Therapists reported the importance of explaining therapy in culturally-appropriate idioms and concepts. Direct translations of psychological terminology related to cognitions and behavior was inadequate. Therapists employed Nepali concepts of *man* (heart-mind), *dimaag* (brain-mind), and their interconnection.<sup>2</sup> In addition, therapists emphasized avoiding local stigmatizing idioms and biomedical jargon.

Eleven items were added based on these Nepali therapist role-plays and discussions (Fig. 2). At the conclusion of Step 1, there were 104 literature search-generated items and 11 Nepali therapist-generated items, totaling 115 items.

### 3.2. Step 2. Item relevance

Nepali therapists who had not participated in the previous step rated the 115 items for comprehensibility and therapeutic

importance. Comprehension and therapeutic importance were correlated ( $r = 0.50$ ,  $p < .001$ ). Mean comprehension ranking was 2.51, and mean therapeutic importance was 2.48. Top rated items were *collaboration*, *assessing social support*, and *warmth, friendliness, and respect*. Among the lowest-rated items were *use of persuasion and biomedical explanations of mental health involving neuroscience and genetics*. In total, 49 items (43% of all items) had a therapeutic importance score greater than 2.50 and were selected for piloting. All items selected for piloting had a comprehension mean of 2.25 or greater (Table 1).

### 3.3. Step 3. Item utility and scoring

We piloted the 49-item version of the tool with expert therapists rating non-specialist role-plays, experts rating videotaped role-plays, and researchers coding transcripts. Therapist feedback highlighted concerns about the length of the tool: 49-items could not feasibly be rated in brief sessions during live observation. In addition, discussions and transcription coding revealed a lack of clarity about scoring (e.g., item redundancy, items representing different skill levels of a single process). Therefore, we reduced the number of items from 49 to 18 through three main processes: elimination of items, grouping items into a single category, and using items to indicate different skill levels within the same domain.

The final version of the tool included nine items that were common in HIC instruments: *non-verbal and verbal communication* (Items 1 and 2), *collaborative processes* (Item 12), *rappport and self-disclosure* (Item 3), *interpretation of feelings* (Item 4), *empathy* (Item 5), *encouragement and praise* (Item 8), *exploring the relationship between life events and mental health* (Item 9), and *problem solving* (Item 15).

Nine items on the final tool required significant adaptation to address task-sharing and cultural context: *Explanatory models* (Items 7 and 14) were deemed crucial for success of PT in this South Asian cultural setting and could be scored easily through observations and transcript ratings. Eliciting explanatory models was important given the low relevance of biomedical models in therapist ratings. *Assessing functional impairment* (6) was prioritized to raise awareness among patients about the relationship between mental health and daily activities, which was important to mobilize participation in care for patients and families.

*Promoting realistic hope and expectancy of change* (Item 13) was

<sup>2</sup> The concept of *man* (heart-mind) refers to the organ of emotion and memory, whereas *dimaag* (brain-mind) refers to cognition and social regulation of behavior (Kohrt & Harper, 2008). These concepts have been used in cultural adaptation of cognitive behavior therapy and other psychological treatments in Nepal and for ethnic Nepali Bhutanese refugees (Kohrt, Maharjan, et al., 2012).



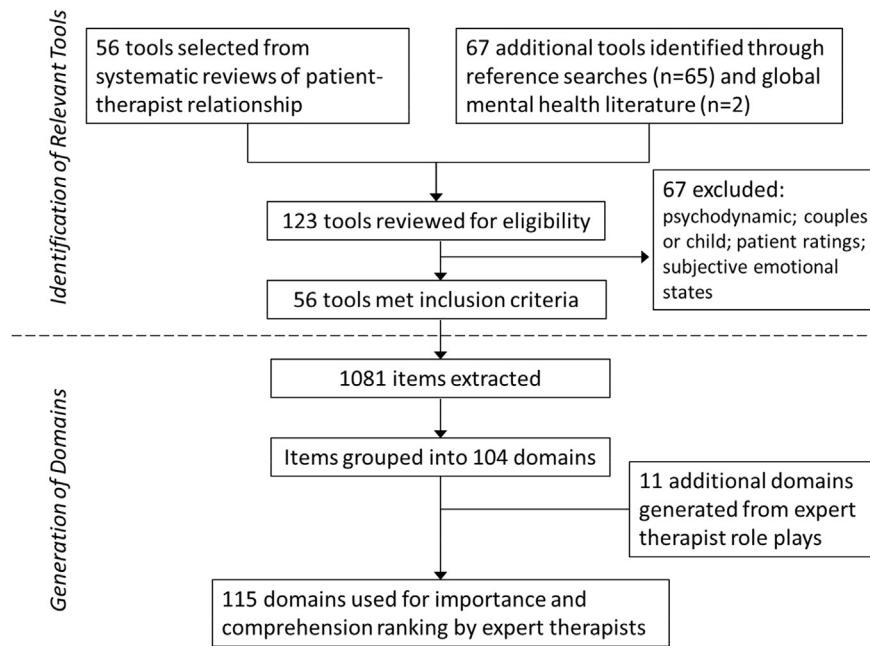


Fig. 2. Identification of relevant tools and generation of domains for Step 1 of tool development process.

included because many non-specialists trainees created unrealistic expectations of what PT could accomplish. Nepali therapists reported difficulty when teaching non-specialists to explain PT and foster feasible expectations. American psychiatrists underscored the need for realistic expectations when working with populations unfamiliar with psychotherapy. Non-specialists typically lectured patients without assessing their understanding of diagnoses and treatment. Therefore, we combined *eliciting feedback* with *providing advice* (Item 16).

In Nepali and American focus groups, therapists prioritized *working with families* (Item 11) as a crucial skill in cross-cultural context. An area for improvement was over emphasis on speaking with family members to the neglect of patient concerns. Involvement of families also influenced *confidentiality practices* (Item 17).

The need to do *holistic health assessments* (Item 10) including *suicide screening* (Item 18) was important for low resource settings where non-specialists may make diagnoses, manage mental and physical health issues, and be the only health workers available to address psychiatric emergencies (c.f., WHO, 2010).

Based on piloting, we changed scoring options. Initially, the three scoring levels were 0 'not at all', 1 'minimal use', and 2 'effective use'. After working with non-specialist and expert raters, we changed the scoring options to 1–2–3, with 1 'needs improvement', 2 'done partially', and 3 'done well'. We chose these responses because scores of '0' and terms such as 'not done' or 'inappropriate' were socially awkward for non-specialists to endorse when rating peers in Nepali culture. By eliminating '0' respondents said they felt more comfortable endorsing the lowest value on the tool. This facilitated an environment for peers to engage in quality improvement and led to a greater range on item responses.

#### 3.4. Step 4. Psychometric properties

Expert ICC (2,7) based on therapists rating videotapes was 0.88 (95% CI, 0.81–0.93). Non-specialist peer ICC (1,3) based on post-training role-plays was 0.67 (95% CI 0.60–0.73). Cronbach's alpha

based on 34 expert ratings of non-specialist roles plays was 0.89. Cronbach's alpha for non-specialist peer-ratings was 0.80 (N = 113).

#### 4. Discussion

The ENhancing Assessment of Common Therapeutic factors (ENACT)<sup>3</sup> rating scale was developed to facilitate rating therapist competence. We employed a systematic process to generate items, evaluate relevance and utility, and calculate basic psychometric properties (Fig. 3). The tool demonstrated good psychometric properties. Nine of the items in the final tool were commonly included in HIC tools: *non-verbal and verbal communication* (Items 1 and 2), *collaborative processes* (Item 12), *rapport and self-disclosure* (Item 3), *interpretation of feelings* (Item 4), *empathy* (Item 5), *encouragement and praise* (Item 8), *exploring the relationship between life events and mental health* (Item 9), and *problem solving* (Item 15) (Table 2).

The other half of the items captured features relevant for cross-cultural task-sharing initiatives. Culturally-specific additions included *assessment of the patient's and family's explanatory models* (Item 7) and *explaining psychological therapies and mental health treatment* (Item 14). Explanatory models include perceptions of symptoms, etiology, and treatment seeking behaviors. Use of explanatory models and ethnopsychology (local psychological concepts) is a crucial aspect of adapting PT across cultural settings (Hinton, Hofmann, Pollack, & Otto, 2009; Kohrt, Maharjan, Timsina, & Griffith, 2012). A recent meta-analysis of cultural adaptation of PT found that use of explanatory models, also known as "illness myths", was the sole moderator of superior outcomes for culturally-adapted therapies (Benish, Quintana, & Wampold, 2011).

*Promoting hope and expectancy of change* (Item 13) is a common factor for effective treatment (Snyder & Taylor, 2000). Cross-cultural family therapy research and medical anthropology studies have highlighted the crucial need for hope to be *reasonable*

<sup>3</sup> This tool has been previously presented as the Training and Supervision Common Therapeutic Factors Rating (TASC-R) Scale (Kohrt, 2014).

**Table 1**  
Comprehensibility and therapeutic importance for 49 highest ranked items.

Item	Comprehension <sup>a</sup>		Therapeutic importance <sup>b</sup>	
	Mean	Std. Err.	Mean	Std. Err.
1. Collaboration between therapist and patient	3.00	0.00	3.00	0.00
2. Assessing patient's social support network	3.00	0.00	3.00	0.00
3. Warmth, friendliness, and respect toward patient	3.00	0.00	3.00	0.00
4. Empathic understanding of patient	3.00	0.00	3.00	0.00
5. Reflective listening	3.00	0.00	3.00	0.00
6. Rapport building with patient	3.00	0.00	3.00	0.00
7. Problem assessment and prioritization	3.00	0.00	3.00	0.00
8. Goal setting	3.00	0.00	3.00	0.00
9. Explaining confidentiality	3.00	0.00	3.00	0.00
10. Assessing patient's insight for key problem	2.88	0.13	3.00	0.00
11. Use of problem solving strategies	2.88	0.13	3.00	0.00
12. Identification of patient coping strategies	2.88	0.13	3.00	0.00
13. Making a plan of action for each session	2.88	0.13	3.00	0.00
14. Identification of patient's resources	2.88	0.13	3.00	0.00
15. Providing emotional support toward patient	2.88	0.13	3.00	0.00
16. Nonverbal communication	2.75	0.16	3.00	0.00
17. Praising patient's efforts	2.75	0.16	3.00	0.00
18. Develop therapy agenda for course of treatment	3.00	0.00	2.88	0.13
19. Therapist's belief that treatment approach will help patient	3.00	0.00	2.88	0.13
20. Assessing patient's strengths	2.88	0.13	2.88	0.13
21. Explaining how therapy works	2.88	0.13	2.88	0.13
22. Assessing patient's active help seeking	2.75	0.16	2.88	0.13
23. Discussing patient's explanation for difficulties (explanatory model)	2.75	0.16	2.88	0.13
24. Assessing patient's ability to develop multiple solutions to problems (pathways thinking)	2.75	0.16	2.88	0.13
25. Therapist's ability to flexibly employ different therapy techniques	2.63	0.18	2.88	0.13
26. Assessing patient's recent life events	2.75	0.16	2.75	0.16
27. Identification of appropriate location for confidentiality	2.75	0.16	2.75	0.16
28. Providing general psychoeducation	2.75	0.16	2.75	0.16
29. Operate within time-limited treatment frame and prepare for termination	2.63	0.26	2.75	0.16
30. Therapist adjusts content of session to limitations of settings	2.63	0.26	2.75	0.25
31. Patient's belief that therapy will address problem	2.63	0.26	2.75	0.25
32. Patient leads in ranking goals	2.63	0.18	2.75	0.16
33. Pacing and efficient use of time	2.50	0.19	2.75	0.16
34. Eliciting patient's feedback	2.38	0.26	2.75	0.16
35. Develop trust and respect for therapist	2.25	0.31	2.75	0.16
36. Use of specific family psychoeducation	2.88	0.13	2.63	0.18
37. Assessing and managing harm and safety	2.88	0.13	2.63	0.18
38. Assess patient's experience of empathy and feeling understood	2.88	0.13	2.63	0.18
39. Therapist exploration of patient's experiences and feelings	2.75	0.16	2.63	0.26
40. Avoiding negative therapist attitude	2.75	0.16	2.63	0.26
41. Therapist exploring level of patient's family support	2.75	0.16	2.63	0.18
42. Giving feedback	2.63	0.18	2.63	0.18
43. Assessing patient's level of functioning before treatment	2.63	0.18	2.63	0.18
44. Assessing patient's belief in self to solve problems (agency thinking)	2.63	0.18	2.63	0.26
45. Discussing patient's secure attachment relationships	2.63	0.18	2.63	0.18
46. Assessing patient's personal motivation	2.50	0.19	2.63	0.18
47. Building patient's hope	2.50	0.19	2.63	0.18
48. Assessing patient's amount of hope	2.50	0.19	2.63	0.18
49. Family's belief that therapy will help patient	2.25	0.25	2.63	0.26

<sup>a</sup> **Comprehension of Items** was rated on 1 to 3 scale: '1' Concept/process is not clearly comprehensible in my experience and training (for example, I have rarely heard this term or process discussed). '2' Concept is generally clear and comprehensible in my experience and training (for example, I have heard of this term or process, but I still have some questions about the term or process). '3' Concept is very clear and I could explain it to any of my patients/clients or to therapy trainees.

<sup>b</sup> **Importance for Therapeutic Change** was rated on a 1 to 3 scale: '1' Concept/process is not usually essential for effective therapy in my experience. '2' Concept/process is important sometimes in my therapy and with some patients/clients. '3' Concept/process is important for all of my patients/clients.

and *realistic*, especially in context of endemic poverty and political violence (Eggerman & Panter-Brick, 2010; Weingarten, 2010), otherwise providers risk raising expectations leading to demoralization among patients and therapists when rapid gains are not achieved (Griffith & Dsouza, 2012).

An area not commonly evaluated in HIC instruments was *assessment of daily functioning and its association with mental health* (Item 6). In cross-cultural mental health, assessment of functioning is important to avoid the "category fallacy" in which psychiatric symptoms are assumed to have the same meaning and life impact regardless of cultural context (Kleinman, 1988).

We included Item 11 to support skill development toward *appropriate family involvement* because therapists reported the importance of family for successful treatment, and it was a skill

poorly executed by most non-specialists. We included *confidentiality* (Item 17) because of the settings for PT in LMIC (e.g., lack of individual consultation rooms, conducting therapy in outdoor settings). We included *providing advice with eliciting feedback* (Item 16) because of the tendency to lecture patients and family members without eliciting their understanding of problems and treatment.

*Holistic health assessment* (Item 10) and *assessment of suicidal behavior and safety* (Item 18) were included because these responsibilities fall on non-specialists as incorporated in the *mhGAP-IG*. Safety assessment was of particular importance given the evidence for suicidality screening as an effective prevention strategy (Mann et al., 2005) and high prevalence of suicide in South Asia (Jordans et al., 2014).

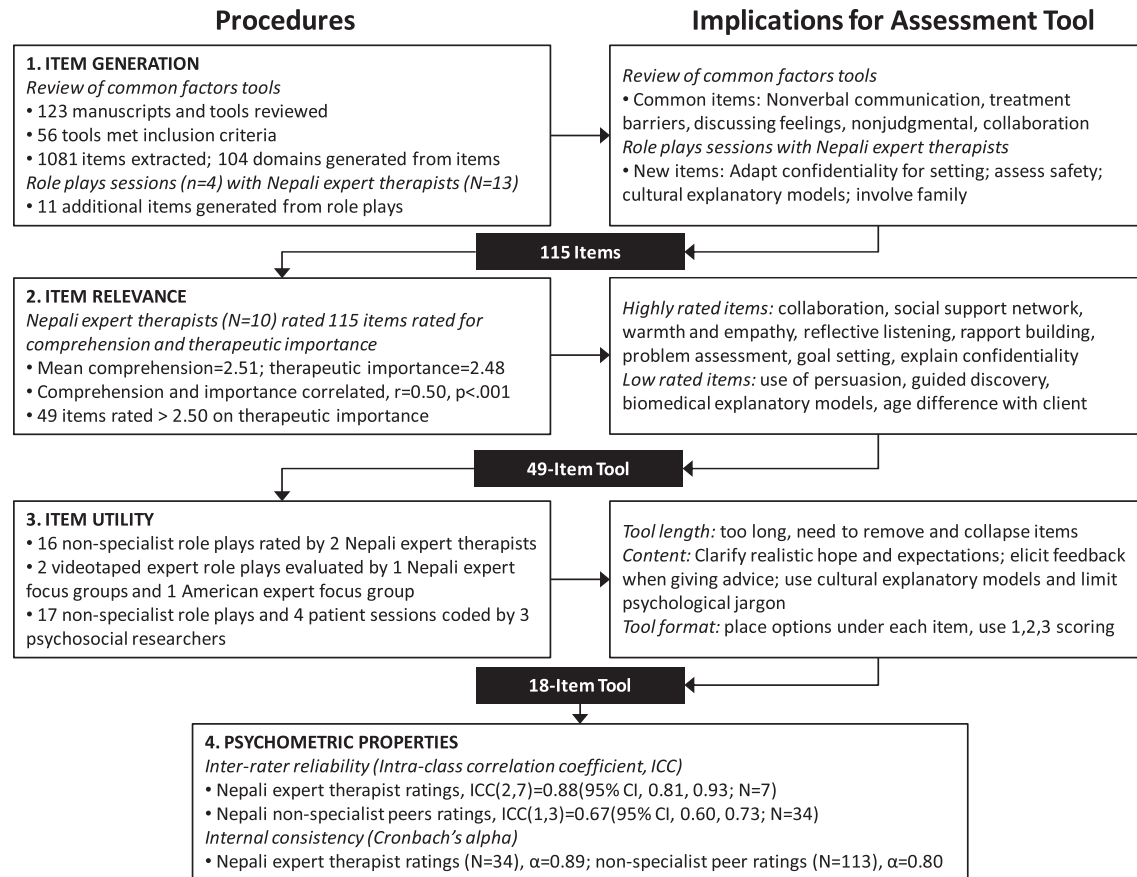


Fig. 3. Four-step systematic process of development for the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale.

#### 4.1. Limitations

Assessment of therapist competence has a range of challenges (Muse & McManus, 2013), especially in LMIC task-sharing initiatives which have a small, but growing, research foundation (van Ginneken et al., 2013). Our approach has limitations to consider when applying the tool across settings. First, we chose to employ an item generation process that focused on a breadth of potential common factors rather than a systematic review to assess frequency among all extant tools, which has been done previously for common factors (Grencavage & Norcross, 1990) and CBT tools (Muse & McManus, 2013). The overlap of our domains with these reviews suggests that we captured the majority of key domains. Another challenge was the coding process which suffers from the same limitations as pointed out in prior reviews (Grencavage & Norcross, 1990): specifically, how items are grouped varies based on one's discipline and training.

Given the lack of studies on relative contribution of different common factors and treatment specific factors on patient outcomes in LMIC task-sharing studies, there were not databases available with information on patient outcomes to compare with common factor competency of non-specialists. Therefore, reliance on expert Nepali therapists' subjective appraisal of what they perceive is effective in psychological treatments was a pragmatic first step. There is potential inconsistency between what therapists perceive to be effective and what actually benefits patients. A convergent finding of our process was Nepali therapists' inclusion of common factors domains that have shown effectiveness in prior studies and meta-analyses (Wampold, 2011). Future studies in PRIME will compare common factors items with patient outcomes to further

refine the skills to be evaluated and promoted in task-sharing interventions.

Compared to knowledge-based measures of competence such as multiple-choice questionnaires, a limitation inherent in our approach is the requirement for subjective observer ratings. Usefulness of the tool is dependent upon the ability of non-specialists to make ratings. A hopeful development is that ratings of therapy quality by non-specialists approached those of experts over successive applications in PREMIUM (Singla et al., 2014). In addition, non-specialist peer ratings collected in groups allow for averaging among non-specialist raters, thus reducing the impact of single raters poorly applying the tool. Group peer ratings also increase the potential for the tool to foster feedback and learning.

Regarding psychometric properties established during tool development, the ICC for non-specialist peer-raters was 0.67. This was comparable to the ICC achieved for non-specialist peer-raters scoring general skills in PREMIUM,  $ICC = 0.62$  (Singla et al., 2014). Supervision provides an important opportunity to improve understanding of common factors, and ICC for non-specialist peer-raters may improve during the supervision process.

This common factors tool does not supplant the need for evaluation of treatment-specific and phase-specific components of evidence-based interventions. Our goal was to address the gap in instrumentation for common factors across types of interventions in global mental health research. Practitioners will gain a greater understanding of mechanisms in PT and skill levels needed for dissemination through a combination of treatment-specific tools and culturally-appropriate, systematically-developed common factors tools. Ultimately, assessing patient outcomes against both treatment specific and common factors competencies can help

**Table 2**

ENhancing Assessment of Common Therapeutic factors (ENACT) 18-item rating scale.

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<p><b>ITEM 1. NON-VERBAL COMMUNICATION &amp; ACTIVE LISTENING: EYE CONTACT, FACIAL EXPRESSION, BODY LANGUAGE &amp; GESTURES</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = does not make any eye contact or stares at patient; shows anger; laughs at patient; mocks patient; turns away from patient; repeatedly interrupts patient; ignores patient; answers mobile phone without permission</p> <p><input type="radio"/> 2 DONE PARTIALLY = does not consistently use body language to express interest; rarely makes eye contact; shows limited emotion; appears artificial</p> <p><input type="radio"/> 3 DONE WELL = makes appropriate eye contact throughout interaction; smiles when appropriate; sits at appropriate angle from patient and leans in to show interest; use of ‘uh-huh’, ‘hmm’ or other culturally appropriate non-lexical utterances to signal interest</p>
<p><b>ITEM 2. VERBAL COMMUNICATION SKILLS: OPEN-ENDED QUESTIONS, SUMMARIZING &amp; CLARIFYING STATEMENTS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = uses mostly ‘yes/no’ questions, e.g., “Will you? Can you?”</p> <p><input type="radio"/> 2 DONE PARTIALLY = uses open-ended questions but does not explore topics further or offer summaries for patient reflection</p> <p><input type="radio"/> 3 DONE WELL = uses open-ended questions, summarizing and clarifies statements, e.g., “What happened? Tell me more.”</p>
<p><b>ITEM 3. RAPPORT BUILDING &amp; SELF-DISCLOSURE</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not introduce him/herself or attempt to make the patient feel comfortable or clinician dominates the session talking about his/her own experiences</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician introduces him/herself but does not help the patient feel comfortable through small talk and informal conversation or clinician disclosure but it is not related to patient experience or needs</p> <p><input type="radio"/> 3 DONE WELL = clinician introduces him/herself, tries to make the patient feel comfortable and disclosure focuses on patient needs</p>
<p><b>ITEM 4. EXPLORATION, INTERPRETATION &amp; NORMALIZATION OF FEELINGS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask about patient’s feelings or clinician is judgmental/critical about patient’s emotions and feelings (e.g., “You shouldn’t feel that way”, “You should stop thinking or feeling that.”)</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks about feelings but does not normalize/validate or does not explore feelings in detail with patient</p> <p><input type="radio"/> 3 DONE WELL = clinician explains that the patient’s feelings in context and if appropriate, feelings are expected for a person in his/her situation</p>
<p><b>ITEM 5. DEMONSTRATION OF EMPATHY, WARMTH &amp; GENUINENESS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician is critical, hostile, or dismissive of patient’s concerns or complaints</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician is generally warm and friendly to patient, but does not demonstrate the ability to put him/herself in the experience of the patient</p> <p><input type="radio"/> 3 DONE WELL = clinician demonstrates that he/she understands the experience of patient in a genuine and sincere manner</p>
<p><b>ITEM 6. ASSESSMENT OF FUNCTIONING &amp; IMPACT ON LIFE</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask the patient about the impact on functioning and daily life from feelings, thoughts, psychosocial problems, etc.</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks about functioning and daily life activities but does not connect it to psychosocial/mental health concerns</p> <p><input type="radio"/> 3 DONE WELL = clinician explores the relationship between psychosocial problem and functioning</p>
<p><b>ITEM 7. EXPLORATION OF PATIENT’S &amp; SOCIAL SUPPORT NETWORK’S EXPLANATION FOR PROBLEM (CASUAL &amp; EXPLANATORY MODELS)</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask the patient about his/her own view of the cause or is judgmental/critical about patient’s explanation (e.g. “Witchcraft doesn’t cause these problems, that is an ignorant/backwards idea!”)</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks patient about his/her own view of cause but does not explore if this the same as the family’s view</p> <p><input type="radio"/> 3 DONE WELL = clinician asks the patient about cause and asks if family/support network have similar or different explanations</p>
<p><b>ITEM 8. INCORPORATION OF COPING MECHANISMS &amp; PRIOR SOLUTIONS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask the patient about how he/she has coped or clinician is judgmental about how patient has coped (e.g., “Why did you think that work?” or “That isn’t helpful.”)</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks about coping and prior solutions, but does not provide positive feedback</p> <p><input type="radio"/> 3 DONE WELL = clinician asks about coping and provides positive feedback in regard to agency or pathways thinking</p>
<p><b>ITEM 9. ASSESSMENT OF PATIENT’S RECENT LIFE EVENTS &amp; ACKNOWLEDGEMENT OF IMPACT ON PSYCHOSOCIAL WELLBEING</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask about triggering life events</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks about life events but does not connect with current mental health issues</p> <p><input type="radio"/> 3 DONE WELL = clinician asks about life events and discusses connection with current mental health</p>
<p><b>ITEM 10. ASSESSMENT OF OTHER MENTAL HEALTH PROBLEMS, ALCOHOL/DRUG USE &amp; PHYSICAL HEALTH PROBLEMS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask about any related conditions, e.g., alcohol or drug use, physical health problems, injuries, head trauma, medications, etc.</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician takes partial history but does not explore positive responses in relation to mental health, e.g., clinician does not connect other health problems or substance use to current mental health</p> <p><input type="radio"/> 3 DONE WELL = clinician assesses related health issues and explains relationship to patient’s condition when appropriate</p>

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inform evidence-based trainings and dissemination efforts.

#### 4.2. Applications

We designed the tool for multiple applications: training evaluations and supervision; selecting trainers, supervisors, and research supervisors; and monitoring common factors in interventions to

compare with patient outcomes (Table 3). Innovative protocols can be used to explore novel supervision and training approaches. For example, video and audio recordings of role-plays with standardized patients can be shared over the internet to conduct ratings in a crowdsourcing platform (Fairburn & Patel, 2014). More research is required in other cultural context. In other settings, an abbreviated adaptation process could begin by producing videos of role-plays



Table 2 (continued)

<p><b>ITEM 11. APPROPRIATE INVOLVEMENT OF FAMILY MEMBERS &amp; OTHER CAREGIVERS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = <i>When family member is present</i>: clinician ignores family during session or clinician only talks to family members and ignores patient; <i>When family member is not present</i>: clinician does not ask about family at all</p> <p><input type="radio"/> 2 DONE PARTIALLY = <i>When family member is present</i>: clinician interviews both patient and family but does not facilitate interaction between family and patient during session; <i>When family member is not present</i>: clinician asks about family involvement but does not explore patient's reasons or preferences for involvement or non-involvement</p> <p><input type="radio"/> 3 DONE WELL = <i>When family member is present</i>: clinician helps both patient and family participate and encourages interaction between them; <i>When family member is not present</i>: clinician explores preferred family engagement with the patient and does role-plays or coaching</p>
<p><b>ITEM 12. COLLABORATIVE GOAL SETTING &amp; ADDRESSING PATIENT'S EXPECTATIONS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask patient about his/her goals and expectations for treatment, or clinician just tells patient what to do without asking his/her expectations</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks patient about goals but does not discuss if these are realistic or can be accomplished</p> <p><input type="radio"/> 3 DONE WELL = clinician asks about goals and discusses with patient what is and is not achievable through treatment, and clinician and patient collaboratively establish treatment plan</p>
<p><b>ITEM 13. PROMOTION OF REALISTIC HOPE FOR CHANGE</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician either gives no hope (e.g., you will never get better) or gives unrealistic expectations (e.g., you will be cured in a few weeks and never have problems again) for what to expect in treatment and recovery</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician vaguely tells patient what will happen during treatment</p> <p><input type="radio"/> 3 DONE WELL = clinician helps patient feel positive about the future and creates realistic expectations about what can and cannot be achieved through treatment, and clinician checks patient's understanding of realistic change</p>
<p><b>ITEM 14. PSYCHOEDUCATION INCORPORATING LOCAL (ETHNOPSYCHOLOGICAL) CONCEPTS &amp; TERMS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician uses technical jargon to explain mental health or uses stigmatizing terms or does not explain how treatment works</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician uses a limited amount of technical jargon and no stigmatizing terms, but clinician does not incorporate patient's explanatory model or other local psychological concepts into psychoeducation</p> <p><input type="radio"/> 3 DONE WELL = clinician conducts psychoeducation using local psychological concepts including patient's explanatory model (see Item 7), local terminology, and idioms of distress to explain mental health and treatment in non-stigmatizing language, and checks to see if patient understands</p>
<p><b>ITEM 15. USE OF PROBLEM SOLVING STEPS: PROBLEM FORMULATION, PRIORITIZATION, SOLUTION GENERATION &amp; ACTION PLANNING</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does work with patient to formulate key problem requiring help, support, or treatment</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician helps patient formulate and prioritize key problem, but does not complete steps #2-4 (see below)</p> <p><input type="radio"/> 3 DONE WELL = clinician helps patient (1) formulate and prioritize primary problem, (2) brainstorm solutions, (3) explores advantages and disadvantages, and (4) formulate action plan</p>
<p><b>ITEM 16. ELICITATION OF FEEDBACK WHEN PROVIDING ADVICE, SUGGESTIONS &amp; RECOMMENDATIONS</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician lectures patient about what to do without asking if this is acceptable and comfortable for the patient, or clinician does not give any suggestions at all</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician gives focused advice but does not ask for feedback from patient to see if the advice is helpful</p> <p><input type="radio"/> 3 DONE WELL = clinician gives a few suggestions when asked by patient and asks for patient feedback about suggestions</p>
<p><b>ITEM 17. EXPLANATION AND PROMOTION OF CONFIDENTIALITY</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not address confidentiality or does not adjust topics of discussion based on setting</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician tells patient that everything is confidential without explaining exceptions such as harm to self or others, or clinician states everything is confidential while conducting session in non-private setting</p> <p><input type="radio"/> 3 DONE WELL = clinician explains that all clinician-patient discussions are confidential with the exception of harm to self and others, and clinician adjusts conversation topics based on private or non-private setting</p>
<p><b>ITEM 18. ASSESSMENT OF HARM TO SELF, HARM TO OTHERS, HARM FROM OTHERS &amp; DEVELOPING COLLABORATIVE RESPONSE PLAN</b></p> <p><input type="radio"/> 1 NEEDS IMPROVEMENT = clinician does not ask about harm to self or others</p> <p><input type="radio"/> 2 DONE PARTIALLY = clinician asks about harm to self or others, but does not help patient develop a plan for safety</p> <p><input type="radio"/> 3 DONE WELL = clinician asks about harm to self or others and facilitates appropriate planning and actions to assure safety</p>

for specific interventions and conducting workshops with intervention experts to view and rate the videos with the ENACT scale translated into the local language. Then the tool could be piloted with the target providers, further modified, and applied to determine psychometric properties. Because the collaborative therapeutic alliance is the most frequent commonality in therapeutic engagement (Grencavage & Norcross, 1990), this tool also has potential for health applications beyond PT. Patients in primary care would benefit from provider competency in common factors even if treatment were not a manualized PT.

## 5. Conclusion

Competent specialist and non-specialist therapists are needed

to increase availability of effective psychological treatment. Current training programs and research trials are limited by the lack of competence assessment tools that can be easily administered across a range of cultural settings and intervention programs. We developed the ENhancing ASessment of COmmon THerapeutic factors (ENACT) scale to meet these needs. Continued development and application is required to determine the cross-cultural and cross-intervention utility, association with therapy quality, and validity for predicting patient outcomes. Only through development of such tools will we be able to measure accurately what works and how best to disseminate and implement psychological treatment to meet the needs of diverse populations throughout the world.

**Table 3**

Application of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale for global mental health research and implementation.

Competence rating periods	Objectives of competence rating	Sources for ratings	Raters
Training evaluation	<i>Trainee evaluation:</i> Post-training evaluations of trainees with standardized role plays to certify individual trainees meeting minimum competence level; <i>Training effectiveness evaluation:</i> Pre- and post-measures of trainees to assess effectiveness of training curriculum and trainer to improve trainee competence	<i>Modality:</i> Standardized patient role plays; Group training exercises (role plays) <i>Formats:</i> Live observations, video recordings, audio recordings, transcripts	Trainers with some mental health expertise; Peer trainees without mental health expertise; External raters with mental health expertise
Clinical supervision	<i>Health worker skill improvement:</i> Standardized role plays could be used periodically in supervision and rated to assess maintenance and improvement of competence over time.	<i>Modality:</i> Standardized patient role plays; <i>Formats:</i> Live observations, video recordings, audio recordings, transcripts	Non-specialist peers after completion of task-sharing training; Supervisors including peers or mental health experts; External raters with mental health expertise
Selection for training or intervention	<i>Primary selection:</i> Selection of non-specialist health workers to participate in training to deliver mental health services; <i>Secondary selection:</i> Selection of non-specialist health workers with prior experience to become trainers, supervisors, or to participate in intervention trials	<i>Modality:</i> Standardized patient role plays <i>Formats:</i> Live observations in clinical settings, video recordings, audio recordings, transcripts	<i>Primary selection:</i> Trainers with mental health expertise <i>Secondary selection:</i> Trainers or clinical managers with mental health expertise
Intervention trials	<i>Competence throughout trial period:</i> As a complement to traditional measures of fidelity, competence can be assessed at intervals during trials to measure maintenance or drift in skills	<i>Modality:</i> Periodic role plays <i>Formats:</i> Video recordings, audio recordings, transcripts	External raters with mental health expertise

## Conflicts of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

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## Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.brat.2015.03.009>.

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