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Article

Perceptions of HIV-related trauma in people living with HIV in Zimbabwe's Friendship Bench Program: A qualitative analysis of counselors' and clients' experiences

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Abstract

This study investigated the experience of lay health workers (LHWs) delivering problem-solving therapy (PST) for common mental disorders (CMD) as well as clients' views of the PST program referred to as the Friendship Bench (FB). Semi-structured interviews were conducted with LHWs (n = 5) and clients living with HIV (PLWH) (n = 10). Data were analyzed using thematic content analysis. LHWs described a severe form of CMD amongst PLWH with a history of trauma, naming it *kufungisisa kwe njodzi* (excessive thinking due to trauma), a local cultural equivalent of PTSD. The term *kufungisisa* (thinking too much) has been used as the local equivalent for CMD. Trauma or *njodzi* was seen both as a circumscribed event and as linked to ongoing

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pervasive experiences such as living with HIV, stigma, and poverty. Although LHWs recognized symptoms of PTSD such as intrusion, avoidance, and hyper-arousal, they did not know how to address these specifically and chose to address them as a severe form of *kufungisisa*. There is a need to integrate aspects of PTSD management within care packages for CMD delivered by LHWs.

Keywords
HIV/AIDS, lay health workers, people living with HIV, PTSD, qualitative methods

Introduction

People living with HIV (PLWH) in sub-Saharan Africa have a high occurrence of post-traumatic stress disorder (PTSD) (Adewuya et al., 2009; Breuer, Myer, Struthers, & Joska, 2011; Seedat, 2012). In a recent Zimbabwean cross-sectional study of PLWH utilizing primary care services, a PTSD prevalence of 45% (Verhey, Chibanda, Gibson, Brakarsh, & Seedat, 2018) was found using the Posttraumatic Stress Disorder Checklist PCL-5 (Blevins, Weathers, Davis, Witte, & Domino, 2015). PTSD is often associated with other common mental disorders (CMD) such as depression and anxiety disorders (Patel, Todd et al., 1997; Todd et al., 1999). In Zimbabwe, a study using the locally validated screening tool, the Shona Symptom Questionnaire (SSQ) (Patel, Simunyu, Gwanzura, Lewis, & Mann, 1997), found that 68% of the urban population had a CMD.

The majority of PLWH live in low- and middle-income countries (LMIC) with fewer than 50% accessing anti-retroviral therapy (ART) (UNAIDS fact sheet, 2016). The burden of HIV disease affects both emotional and physical well-being, which are not adequately addressed due to the large treatment gap in LMIC (Dua et al., 2011).

High prevalence of CMD is often associated with poverty characterized by low levels of education, food, and housing insecurity (Lund et al., 2010). There is growing focus on the role of such daily stressors in PTSD development and other mental health issues. Several studies in conflict, post-conflict, and non-conflict settings have found that continuous low-level stressors are cumulatively more predictive of psychological distress than single event exposure (Al-Krenawi, Lev-Wiesel, & Mahmud, 2007; Miller & Rasmussen, 2010; Suliman et al., 2009). Traumatic exposure to armed conflict and organized violence is often experienced as distal and found to be less salient over time (Miller & Rasmussen, 2010), in comparison to daily stressors such as poverty, overcrowded housing, chronic illness, and failure to meet daily basic and medical needs (lack of access to clean water, education, medication, or sufficient food, to name a few). These daily stressors are particularly prominent in LMIC, where they erode psychological resilience and the effectiveness of coping mechanisms, thus impeding individuals' overall mental health (Kubiak, 2005). Prolonged psychophysiological response to chronic

stress is associated with the development of physical and psychological disorders (Christopher, 2004).

There is a need for comprehensive care for those affected by HIV, PTSD, and CMD at the primary health care level (PHC) (Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). Such a care package must incorporate clients' social and cultural frameworks (Petersen, Hancock, Bhana, & Govender, 2013) and consider a sociocultural model of illness rather than a purely biomedical approach, as is currently being discussed in South Africa (Burgess, 2014).

The task-sharing approach of letting trained and supervised lay health workers (LHWs) deliver interventions is considered a potentially effective way of offering health care services, especially with respect to mental, neurological, and substance use disorders (MNS) (Joshi et al., 2014; Petersen et al., 2012; van Ginneken et al., 2013). Several studies have demonstrated the feasibility, acceptability, efficacy, and cost-effectiveness of such an approach (Araya et al., 2003; Nakimuli-Mpungu et al., 2014a, 2014b).

The Zimbabwean Friendship Bench (FB) Program (Chibanda et al., 2011) is an example of using LHWs to reduce the treatment gap for MNS. It is currently the most established initiative of this type in the country (Chibanda et al., 2011). The FB program started in 2006 in one of Harare's high-density suburbs, Mbare. Embedded within the City Health Department of Harare, it was scaled up to all the city's primary health care clinics ($n = 36$) after it was shown to be effective in a randomized controlled trial (Chibanda et al., 2015). The FB program offers cognitive behavioral therapy (CBT) based problem solving therapy (PST) with a behavioral activation component aimed at reducing symptoms of CMD as measured by a locally validated screening tool (Chibanda et al., 2015, bib182011). A detailed description of the FB intervention is found in Chibanda and colleagues (Chibanda, Cowan, Verhey et al., 2016). All visitors attending primary care clinics are screened for CMD using the Shona Symptoms Questionnaire (SSQ-14) tool, which has good internal consistency and a Cronbach's alpha of 0.85 (Patel, Simunyu et al., 1997). Those scoring nine and above (cut-off) are referred to the FB counselors who reside in the same communities as their clients and are employed by the city health services of Harare. The sessions are held on a bench, the Friendship Bench, which is placed in a discrete area on the clinic premises (Chibanda et al., 2011) and allows for an acceptable level of confidentiality. The FB intervention has been shown to be culturally acceptable and easily accessible for PHC users (Chibanda, Weiss et al., 2016).

Approximately 80% of the FB clients are PLWH, and of these 30% present with symptoms of both CMD and PTSD (Abas, Ali, Nakimuli-Mpungu, & Chibanda, 2014; Chibanda et al., 2011, 2015; Patel, Simunyu et al., 1997). In the Zimbabwean context, HIV infection is seen as society's symbolic punishment for those who have been "immoral" (Campbell et al., 2011). Such perceptions contribute to stigma which can lead people to delay or avoid testing and increase the incidence of CMD in this population (Brown, Macintyre, & Trujillo, 2003).

This study focuses on the experience of LHWs delivering PST to clients with a history of trauma as well as the clients' experience of receiving the intervention. It aimed to ascertain what additional intervention aspects are needed to expand the FB program to address trauma symptomatology as part of the scale-up described in the scale-up strategy (Chibanda, Verhey, Munetsi, Rusakaniko et al., 2016), as the program's promising results have led to policy makers showing interest in a national scale-up effort. A further aim was to define the local indigenous terms used in relation to PTSS/PTSD through these qualitative interviews.

Methods

Setting

The study was conducted at Edith Opperman Clinic, the largest of three primary care clinics in Harare's suburb Mbare. The FB program has been running at this clinic since 2006 (Chibanda et al., 2011). It is led by 14 female LHWs who have had extensive training in PST and other CBT related techniques, including provision of peer supervision to other LHWs involved in the scale-up of the FB. LHWs in Harare are traditionally well-respected female community members. The LHWs from Mbare have a mean age of 54 (Chibanda et al., 2015). They are employed by the Harare City Health Authorities. This study was carried out between April and June 2016.

Study design and sampling

We carried out 15 in-depth semi-structured interviews with key informants including both LHWs (n = 5) and clients living with HIV (n = 10) whom the counseling supervisor (EM) identified as having experienced one or more traumatic events based on the FB clinical database, and who met PTSD criteria according to *the Diagnostic and Statistical Manual of Mental Disorders DSM-5* (American Psychiatric Association, 2013). The LHWs were selected on the basis of years of experience, as described in a previous qualitative study (Chibanda, Cowan, Verhey et al., 2016). We included both of these groups of key informants in order to obtain necessary information about how the Friendship Bench intervention in its current form is seen by both delivering agents and beneficiaries in terms of its helpfulness and appropriateness for PTSD-related issues and to enable us to triangulate the data.

Data collection

Data collection comprised semi-structured interviews carried out by a Zimbabwean member of the FB research team (AV). The field research team consisted of four members, with three of them being native Shona speakers. LHWs were not part of the study team. The interview guide was developed by RV and reviewed by the

study team, who provided further input before the guide was translated into the local language, Shona, by a mental health professional who was not part of the study team. The guide was back-translated by a language expert who was unrelated to the study team to see whether the translation process had changed the meaning of the guide, which was not the case. All interviews were conducted in Shona and audio-recorded after obtaining consent from participants. AV used a constant comparative approach to data collection, discussing emerging themes throughout the data collection process with both RV and DC as a way of determining when saturation was reached. The data was then back-translated into English. Translation of all interviews was carried out by research assistants working for the Friendship Bench who have Bachelors degrees in psychology or sociology and were supervised by the Shona speaking study team.

Data analysis

Data were analyzed by RV and DC, who had participated in earlier qualitative research under the guidance of an experienced qualitative researcher leading to a number of qualitative publications (Abas et al., 2016; Bere et al., 2016; Kidia et al., 2015). The analysis was informed by an earlier study about the Friendship Bench (Chibanda et al., 2017). RV and DC initially reviewed all transcripts independently, developed themes, and attached codes related to each theme. They then shared themes with the research team ($n = 6$) and discussed commonalities and sub-themes until consensus was reached. Once final themes were agreed upon, each reviewer proceeded to complete a line-by-line analysis. Emerging new themes and sub-themes were discussed until consensus was reached. Codes were sorted into categories; the team determined category relations, and then placed them into selective coding which resulted in a descriptive model (Ruppel & Mey, 2015). This model was applied to all transcripts, with selected quotes used to illustrate the specific themes derived from the exercise. LHWs' and clients' transcripts were analyzed separately as interviews had taken place at different time points, as was done in an earlier study by Chibanda and colleagues (Chibanda, Cowan, Verhey et al., 2016). Results are therefore presented separately in the results section below, with a diagram illustrating the themes common across the two groups for better understanding of their interface.

Ethical considerations

Written informed consent was obtained from all participants and participants were reimbursed for their participation in accordance with local regulatory research and ethics bodies. Ethical approval to carry out the study was obtained from the Medical Research Council of Zimbabwe (MRCZ/A/1732) as part of the formative phase of a cluster randomized trial of the Friendship Bench (Chibanda et al., 2015) and the Health Research Ethics Committee 1, Faculty of Health Sciences, University of Stellenbosch (S14/05/102).

Results

Four broad cross-cutting themes related to traumatic experiences were identified. These themes reflected both the LHWs' and clients' experiences as illustrated in Figure 1.

Trauma, either physical or psychological, was not a primary reason for visiting the FB. LHWs did not recognize trauma-related symptoms as a medical condition; however, they identified certain symptoms as being trauma-related, such as depressed mood, suicidal thoughts, denial, addiction, substance abuse, tearfulness, and avoidance, and as representing a severe form of *kufungisisa*, the local term for CMD (Chibanda, Cowan, Verhey et al., 2016).

LHWs and clients used the term *njodzi* (trauma) to describe traumatic events that they recognized as contributing to *kufungisisa* (translated from the local language Shona as thinking too much) related to trauma. *Njodzi* was defined as being associated with both past events and ongoing circumstantial factors, such as poverty and chronic illness (Figure 1). In relation to symptoms associated with the Western defined concept of PTSD, LHWs and clients described these as part of *kufungisisa kwe njodzi*. Literally translated into English this refers to "thinking too much due to traumatic experience." In the absence of a Shona equivalent for PTSD, this term was found by LHWs, clients, and Shona speaking psychologists

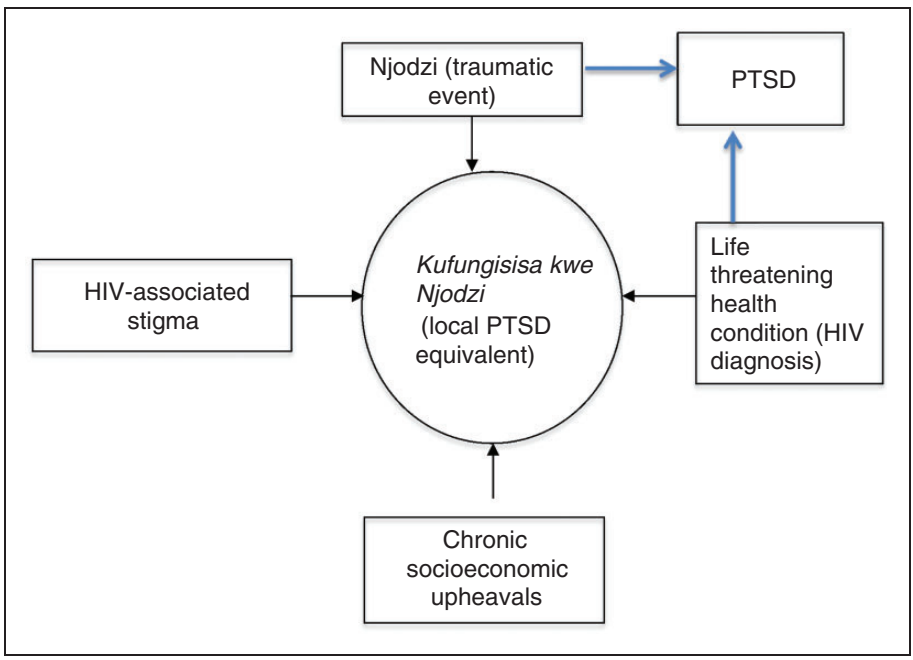

Figure 1. Themes reflecting trauma in PLWH in Zimbabwe compared to DMS-5 defined PTSD.

and social workers consulted during the study to be the Shona expression closest to the term PTSD. The term *kufungisisa kwe njodzi* seeks to describe the interaction of the consequences of traumatic life event(s) with ongoing circumstances such as poverty, unemployment, chronic illness, an inability to afford appropriate treatment, and being stigmatized (see Figure 1). In its presentation, there are more similarities than differences between DSM-5-defined PTSD and this Shona equivalent; all four symptom clusters (intrusion, avoidance, negative cognitive changes, and hyper-arousal) are clearly present. An obvious difference is found in the quality and prevalence of the events that are described as being traumatic to the participants of this study. The results are presented in two subsections, one for the LHWs and one for the clients, as it is believed this will be helpful in understanding the study's results.

LHWs

LHWs' experience with the FB. LHWs approached clients and offered help in the clinics as well as in the community, that is, when doing home visits. Clients in need of support were recognized either because they presented with physical symptoms (e.g., pulmonary TB, substance use disorder (SUD), sudden weight loss, being physically unkempt) or because of psychological presentations of CMD (Chibanda, Cowan, Gibson, Weiss, & Lund, 2016).

LHWs indicated that PLWH with underlying *njodzi* presented often as quiet and reserved, with visible *kufungisisa* marked by tearfulness, anxiety, and sleep problems, and showed subsequent relief about being able to share their stories related to living with HIV. LHWs conceptualized their work with PLWH with a history of *njodzi* as offering an ongoing support structure. This was facilitated by their geographical proximity to clients and an understanding of their role as *Ambuya Utano* (''grandmother health provider'') (Chibanda, Cowan, Verhey et al., 2016; Chibanda et al., 2011). The *Ambuya Utano* role included visiting people's homes to educate about hygiene, vaccination drives, and health campaigns, and using soft skills such as empathy and loyalty. ''I have now built a very strong relationship with most of the patients and we now know each other a lot,'' commented one of the LHWs. Another stated: ''I have such empathy for these clients, I always want to help them. At times I go on the side and cry but I stand with them. I push for them to get help because they really touch my heart. . ..''

The LHWs described their primary intervention tool as *kuvhurapfungwa* (opening up the mind) and *kusimudzira* (uplifting) of PLWH with a history of *njodzi* (Chibanda, Cowan, Verhey et al., 2016). These terms are local generic terms for the first part of the PST intervention used on the FB (Chibanda, Cowan, Verhey et al., 2016). The initial psycho-education in the FB program focuses on normalization and helping clients open up about their traumatic events. One of the LHWs described what they did as follows: ''We talk with them, explaining that HIV is like any other disease, e.g., BP''; she also described reassuring the clients that *kufungisisa* is experienced by many people. The LHWs

indicated that their behavioral advice extended to living positively and practicing safe sex as well as safe handling of an ill partner or family member: ''We explain the importance of using condoms when clients are sexually active as this has a positive impact on their health.''

***Njodzi** (trauma).* LHWs indicated a difference in presentation of clients with underlying *kufungisisa kwe njodzi*. One of the elderly LHWs said:

> Yes, there is a difference [when there is *kufungisisa kwe njodzi*], the problems that they share show a difference . . . in terms of how they share their story and who they choose to share their troubles with . . . the clients living with HIV tend to be more reserved and are not usually open to share what they are going through with their loved ones.

LHWs mostly described *njodzi* in their clients as ongoing situations, such as noticing one's health deteriorate without knowing why or being stigmatized or abused when a partner or family member discovers physical symptoms related to HIV or learns about one's HIV status, and saw this as leading to *kufungisisa*, for instance with suicidal ideation. With regards to this, one said, ''These clients are sometimes tense and agitated [hypervigilant] when they have a history of *njodzi*, so they must be empowered to be able to deal with their problems through *kuvhurapfungwa* [opening the mind], this normally helps.''

Addressing suicidal ideation was described as an important aspect of the work of the Friendship Bench and the LHWs appreciated the use of the SSQ-14 (Patel, Simunyu et al., 1997) to identify those who are suicidal: ''We use the SSQ14 at all times. A client might say she has no problems but we can assess if the client has *kufungisisa kwe njodzi* because they have answered yes to question 11.'' LHWs tended to refer clients with a ''yes'' response to question 11 (indicating suicidal ideation) to either the nurse in charge or the LHWs' supervisor, with the client thus progressing up one level of care, consistent with the design of the task-shifting approach (Chibanda et al., 2015). One LHW stated, ''If I see that a client seems to have these suicidal thoughts and they have a history of *njodzi*, I refer them quickly.''

In case of rape, LHWs also immediately referred, being cognizant of the severity of the *njodzi*, as emphasized by one participant: ''l usually refer to the rape clinic.'' Clients presenting with a history of current abuse were referred to other authorities such as the police, as explained by one of the LHWs: ''When it's a client who is a victim of violence at home, we normally start our initial PST and refer them to the police.''

HIV diagnosis. Living with HIV and having symptoms suggestive of AIDS was a major contributor to the decline in clients' mental health, as highlighted by the LHWs: ''Due to illness associated with HIV these clients tend to be overwhelmed and deeply affected by stigma, which they describe as a terrible *njodzi*.''

Sometimes PLWH end up using substances as a way of dealing with life. Another LHW mentioned the challenges associated with substances:

> [Clients] use Broncho [cough syrup containing codeine], some of them resort to taking rat poison because they have lost hope for the future [affected by stigma], you hear some of the clients saying: "It's better to die because nobody is going to want to marry me."

Stigma and disclosure. Stigma appeared to be a key socio-cultural factor contributing to *kufungisisa kwe njodzi*, as described by one of the LHWs:

> This woman was always sick but did not know why, she was losing weight and her health was deteriorating but she could not understand why. She was even afraid to tell her husband and had no one to turn to but suffer in silence. She suffered immensely due to this *njodzi*.

Furthermore, according to LHWs, trauma related to stigma and being looked down upon was evident among clients:

> The client was not allowed to use anything that belongs to the family [utensils]. Such talk can make the clients have suicidal thoughts, as they feel left out and see this as a terrible *njodzi*. The clients themselves can think it is better to die because the disease will kill them eventually.

LHWs saw their clients exposed to the pervasive experience of abuse. Culturally accepted in Zimbabwe, stigmatization creates a dynamic where the seropositive person is often being blamed and punished in the form of IPV (Shamu, Zarowsky, Shefer, Temmerman, & Abrahams, 2014). "Abuse is really a problem," one LHW commented, "some are being abused by step-parents and these [suicidal] thoughts come to them."

The pervasive stigma around HIV often made disclosure a difficult and complicated process. Lay health workers portrayed traumatic living situations as a result of failure to disclose. One of the younger LHWs stated:

> The wife started explaining her ordeal, highlighting that the husband had taken pills (ARV medication) for two years [without disclosing his status] and in those two years they had had unprotected sex. She felt her life was over, that's why she wanted to commit suicide.

Socioeconomic upheavals. According to one of the LHWs, "People should be educated on common mental disorders so that when they face problems [i.e., lack of finances to pay rent and therefore being threatened to lose their home] they know where to

turn to and get assistance [i.e., to learn to solve their problems].'' LHWs showed a strong understanding of the need to empower their clients to be able to independently find solutions, which is the focus of the Friendship Bench intervention. Giving structural support such as food aid, loans, and housing, to name a few, to alleviate the clients' stress is not an option within the Friendship Bench Program.

Counselors can become overwhelmed by the needs of their clients, especially as they live under the same conditions as their clients. At times they will go beyond their work duties to assist. One of the counselors shared:

> Most of the young people who are living with HIV often come to my house to ask for food. Sometimes I can help, but sometimes I cannot help since I don't have anything to give them at that time. They always come and I end up wondering how else could I help.

Another LHW added, ''Most of them spend time asleep because they have nothing to eat. I sometimes end up having to look for food for them, though help is not always available.''

LHWs recognized the impact of their work and wished to be empowered and encouraged to continue. As one LHW participant explained, ''It goes hand in hand. The bench work has given us skills that we did not have before. The Friendship Bench work has improved our impact in the community.''

Clients

Clients' experiences with the FB. In interviews with clients, special interest was directed to what life events or circumstances were seen to be traumatic. Furthermore, importance was placed on how the FB clients perceived the quality of the services they used. Clients know that LHWs move around in the community helping people and providing health education. A common statement from the clients was, ''I first met the LHW in the community.'' Most of the clients reported that their first contact with a LHW was initiated due to visible symptomatology, such as weight loss, related to their often still unknown HIV positive status (Figure 1): ''The LHW first talked about my illness after noticing how me and my baby had lost weight. The LHW helped me to open my mind.'' Another client stated, ''When *ambuya* [grandmother] listened to me I felt so much better [*kusimudzira*] because this was the first time I managed to open up [*kuvhurapfungwa*] about my traumatic experience with HIV.''

In some cases, the trauma was associated with other medical conditions related to HIV, as described by one client—''she (LHW) approached me when I was diagnosed with TB''—or with symptoms related to a sexually transmitted infection. Another client explained, ''I had a long standing *njodzi* due to problems with my womb and I met the LHW who talked to me and encouraged me to visit the Clinic.''

LHWs were described as showing empathy when addressing sensitive issues. LHWs were very open and frank with their clients and brought up the topic of

getting tested, which was appreciated by their clients. One client explained, ''I fell sick and was encouraged by the LHW to go and get tested.''

Njodzi. Clients described various examples of *njodzi* that stemmed partly from their childhood and partly from current socio-economic and structural circumstances. Often clients reported both kinds of *njodzi* in their lives. Common *njodzi* from childhood could be found in clients' statements describing poverty, loss of caretakers/family members, abuse, (chronic) illness, deprivation, and a struggle for survival. One female client narrated, ''I lived with my mother in a squatter camp, my mother couldn't afford school fees, [I had] my first child when I was just 15,'' while another one explained how her illness affected her as a child: ''I fell sick when I was growing up. When this happened I did not know what the cause of the illness was. I had stomach cramps and diarrhea.'' In another case, a client stated, ''My mother passed on when I was 10 and my father when I was 12. I failed to continue with school. I ran away from the rural areas and I went to South Africa and lived as a street kid there. That is where I got seriously sick.''

PLWH described HIV-related difficulties such as fear for their lives/fear of imminent death after being diagnosed. One client participant highlighted the trauma of a positive test: ''... HIV testing which came out positive. It was traumatic for me to accept and my health was deteriorating.''

Suicidal ideation. LHWs addressed suicidal ideation and found it common in PLWH with a history of *njodzi*. This was affirmed by the interviews with clients. One client participant shared: ''I was in denial and at one point I was arguing with myself whether I should accept [my status] or just die.''

HIV stigma. Clients described the effects of stigma by relatives as very traumatic. One client narrated her ordeal: ''Because of my condition, my brothers decided to send me to the rural areas to live with my aunt.... [My] situation was hopeless, I was dying in their eyes.'' Another said, ''There was a time when I was terminally ill and my aunt told people that I am very sick and could die anytime soon.'' Yet another client added, ''My brothers began to sell my property and took my child to her father's family and told her I was dead.''

Due to the pervasive stigma they faced, PLWH seemed to feel a sense of worthlessness and perceived themselves as a burden to their families and their community. ''I was a self-reliant person and when I fell ill, I could not do much,'' indicated one client. Failing to understand the circumstances of getting infected contributed to symptoms of CMD and revealed the level of denial and lack of open communication between sexual partners. One client stated, ''[I worried] to the extent that I wondered how I got infected.'' As discussed in the section on the experiences of LHWs, many clients were exposed due to choices made by infected spouses who did not disclose their status, with some being in denial about their status. For example, one female client explained, ''My husband had been seriously sick for a while and he would not agree to go and get tested.''

Clients' perceptions of LHWs. Clients were very forthcoming with their appreciation for the FB counselors. One client shared feelings of appreciation for the LHWs as follows: ''There is not much I can do to show my appreciation but she [LHW] is one person who stood by me when all my relatives called my child names and shunned me.'' A male client said, ''Honestly the LHW helped me, if it were not for her maybe I would not be sitting here because I was so traumatized.'' Another client added, ''One word from them can change and help one's life.''

Discussion

This qualitative study aimed to explore the perception of LHWs delivering PST for clients with a history of trauma. In addition, the experience of clients living with HIV who utilize the FB was explored. Data derived from the two groups were analyzed and triangulated so as to inform adaptation of the current FB intervention to meet the needs of both LHWs and trauma-exposed clients.

These results highlight the need to integrate trauma-specific components in the FB program. The closest indigenous term for trauma is the Shona word *njodzi*. In our setting, it appears that *njodzi* is not only perceived as temporally circumscribed events, such as those described in the Western literature on PTSD (e.g., exposure to actual or threatened death, serious injury, or sexual violence), but can also be used to describe ongoing difficulties (*kuendereramberi kwe njodzi*) such as generational poverty, chronic illness, and inadequate medical care, all of which PLWH in LMIC are frequently exposed to.

These daily stressors are recognized to be contributors to the development of PTSD and CMD (Miller & Rasmussen, 2010). Psychosocial interventions such as the Friendship Bench (Chibanda, Weiss et al., 2016) that help to reduce the perception of lack of control over these stressors may represent a promising option to help affected populations (Miller & Rasmussen, 2010). We propose a differentiation between low-intensity stressors and those that hold potential traumatic salience. Especially in LMIC, there is a dearth of data on cultural understandings and on societal as well as psychological impacts of this concept, suggesting a need for rigorous research.

Njodzi is seen to progress from a traumatic event, such as receiving an HIV diagnosis, to *kuendereramberi kwe njodzi* (ongoing difficulties), mediated by factors such as stigma (external and internalized), declining health, fear of dying and symptoms of comorbid CMD (including those captured in the local term *kufungisisa*) as well as the above-mentioned socioeconomic difficulties. Symptoms of CMD and physical decline are recognizable to LHWs and will often bring clients to the FB.

The current PST intervention aims to reduce CMD symptoms that are prevalent among those with *njodzi* but may not address symptoms related to traumatic experiences. Despite these limitations, LHWs show an understanding of the concept of traumatic experiences as an ''unknown'' illness related to being diagnosed with HIV and being stigmatized. They also see it within the context of ongoing

njodzi such as poverty, unemployment, substance use disorder, and living in an abusive environment.

We can, therefore, assume that the LHWs trained in the FB intervention (Chibanda et al., 2015) are able to associate these traumatic exposures with *kufungisisa kwe njodzi*, the local term used to describe PTSD. In their eyes, this is a more severe form of *kufungisisa* (CMD) that is described in an earlier publication (Chibanda et al., 2011), that they address with PST and activity scheduling. LHWs often try to address the ongoing *njodzi* through practical support (e.g., by providing food to clients and/or referring them to local NGOs and similar organizations who specialize in supporting disadvantaged communities).

Although LHWs do not explicitly identify symptoms of PTSD, they do seem to address and alleviate symptoms through their work, largely on account of the co-occurrence of PTSD-like symptoms with symptoms of other CMD symptoms. There is, therefore, a need to incorporate a screen for PTSD/PTSS into the existing screening procedure. Once LHWs are able to specifically diagnose avoidance, intrusive symptoms (e.g., recurrent nightmares or flashbacks), hyper-arousal and reactivity, they will be in a stronger position to address these symptoms in combination with symptoms of CMD. Such an approach is in line with the current thinking of the common elements approach as described by Murray and colleagues (Murray et al., 2014). The common elements treatment approach (CETA) assumes that co-morbidity is the norm and therefore management of conditions should be based on an internal stepped care approach where the LHW is able to shift from an emphasis on CMD to also addressing symptoms related to trauma. Treatment approaches have to take into account the socio-economic and cultural conditions clients and counselors are facing. As mental health interventions have been shown to improve economic outcomes (Lund et al., 2011), resilience toward hardship and empowerment is more likely to be increased. The Friendship Bench approach aims to address the needs of its clients within communities, thus promoting "community mental health competence" and using this same competence to offer culturally acceptable ways into the program (Campbell & Burgess, 2012; Chibanda, Weiss et al., 2016). Mental health services must be easily accessible, available mid- to long-term, and made sustainable by embedding them within the general national health care plan.

While a number of studies in sub-Saharan Africa have highlighted the presence of PTSD in local populations that are in conflict situations (Neuner et al., 2004), this study was undertaken in a non-conflict environment. Most sub-Saharan African studies of traumatic stress have not focused on HIV positive populations, whereas the FB is primarily aimed at PLWH (Chibanda, Verhey, Munetsi, Cowan, & Lund, 2016). Similar findings from a study in South Africa suggest that health workers in primary mental health care (PMHC) conceptualize distress using a social instead of a biomedical model (Burgess, 2014). Similarly, the Friendship Bench has been successful in the past 10 years because the intervention results in improved outcomes in areas such as economic (increased employment rates facilitated by an integrated income generation component) and social (attendance in peer led support groups) aspects (Chibanda, Weiss et al., 2016).

The results of our study reveal that many clients describe traumatic effects related to their HIV infection. Some of the factors described include physical illness, finding out their partner had been taking ART and placing them at risk of infection, and the reaction of the wider community/family to their displaying symptoms of ''the illness.'' Faced by numerous socio-economic challenges such as unemployment, an ailing health system, and an ongoing HIV epidemic fueled by extreme stigma, Zimbabweans living with HIV experience the condition as an ongoing pervasive threat to their survival (Lopman et al., 2007). Furthermore, LHWs usually reside in the same communities as their clients and are exposed to the same environment with a high level of chronic *njodzi*. This may explain their intrinsic understanding of PTSD-related symptoms. In a subsequent study focusing on the mental health of the LHWs, local results showed low rates of PTSD and CMD amongst them, suggesting positive benefits of the FB work (Verhey et al., under review).

Many PLWH have been affected by their diagnosis, HIV-related bereavement, and other HIV-related trauma, which is associated with high PTSD prevalence, as suggested in the systematic review conducted by Sherr and colleagues (Sherr et al., 2011). There is need for further research on manifestations of PTSD in our setting, particularly against a background of pervasive poverty and other psychosocial upheavals.

There are some limitations to our study findings. First, this was a sample of PLWH and so these findings are not generalizable to uninfected individuals. Secondly, the intervention delivered by LHWs on the Friendship Bench is not a trauma-specific intervention that can be equated with recognized PTSD treatments such as prolonged exposure therapy and EMDR (Seedat, 2012). However, PST is effective for learned helplessness, and may address some aspects of PTSD without necessitating a formal diagnosis of PTSD (Ford, Steinberg, & Zhang, 2011; Sutherland & Bryant, 2008).

Thirdly, our work focused primarily on strengthening the Friendship Bench in Zimbabwe and our findings may not be generalizable. Our work highlights the importance of further research in this field, particularly in the area of CMD, PTSD, and poverty. Future research should take into consideration earlier critical contributions about the nature of PTSD (Bracken, 2001; Spitzer, First, & Wakefield, 2007; Summerfield, 2001), current classification based on DSM-5 criteria, and emerging knowledge stemming from the Research Domain Criteria (Insel et al., 2010; Insel, 2014).

Conclusion

A trauma history among people presenting with CMD is common, and best practice management using the existing FB intervention based on PST will require some adaptation. An increased likelihood of PTSD was recently found in Zimbabwe among people who score high on the local CMD measure, the SSQ (Patel, Simunyu et al., 1997), suggesting a need to incorporate specific trauma treatment

aspects (Verhey et al., 2018). The concept of trauma needs to be broadened in this context to include the pervasiveness of both forms identified by LHWs (chronic/ongoing and event-specific), and the impact of CMD/*kufungisisa*. There is a need to explore the effects of past trauma, such as childhood trauma or war exposure, on mental health in the Zimbabwean context. The FB realizes the need to build capacity in the management of trauma-related symptoms such as intrusion, avoidance, and hyper-arousal. LHWs are very clear about their need to learn more, indicating a readiness to screen for and manage trauma-related symptoms. LHWs are driven to help their communities. This is a core strength of the community approach used in the FB program. Further, the respect that the community has for the *Ambuya Utano*, or LHW, underscores the value of this approach. Adaptation of the intervention to equip the LHWs with tools—which most likely have to be modified to address the needs in the Zimbabwean settings—to recognize and address trauma-related symptoms using an internal stepped care approach would be a step in the right direction.

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