



Stewart, C., White, R. G., Ebert, B., Mays, I., Nardozi, J., and Bockarie, H. (2016) A preliminary evaluation of Acceptance and Commitment Therapy (ACT) training in Sierra Leone. *Journal of Contextual Behavioral Science*, 5(1), pp. 16-22. (doi:[10.1016/j.jcbs.2016.01.001](https://doi.org/10.1016/j.jcbs.2016.01.001))

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A preliminary evaluation of Acceptance and Commitment Therapy (ACT) training in

Sierra Leone

Abstract

Concerted efforts are being made to scale up psychological interventions in low and middle-income countries (LMIC). Acceptance and Commitment Therapy (ACT) aims to reduce psychological inflexibility and has been shown to be effective for treating a range of mental health difficulties. ACT training workshops have been shown to reduce the psychological inflexibility of individuals receiving training. There is a dearth of research investigating the acceptability and potential efficacy of ACT in LMIC and the influence ACT training has on health care professionals who undergo this type of training.

This paper reports a preliminary evaluation of ACT training for local NGO workers and professionals who attended an introductory workshop in Sierra Leone. Specifically, the evaluation sought to address the acceptability of this type of training for participants, and whether participants demonstrated improved psychological flexibility and wellbeing following training. Participants completed measures pre-workshop, post-workshop and 3-months post-baseline.

Results indicated that participants rated the workshops positively and reported applying some of the techniques that they had learned during training to their clinical work. Participants demonstrated improvements in psychological flexibility and life satisfaction following training. The measure of psychological inflexibility demonstrated good internal consistency when used in a Sierra Leonean context. The implications of these findings for Global Mental Health discourses are discussed.

Keywords

Acceptance and Commitment Therapy; Sierra Leone; Psychological flexibility; Global Mental Health

In recent years there has been a growing awareness of the need to address inequalities and inequities in mental health provision in low and middle-income countries (LMIC). This has led to the emergence of a field of research and practice referred as Global Mental Health. A considerable “treatment gap” has been noted between the levels of mental health services required by LMIC and the actual resources available for LMIC populations (The Lancet Series in Global Mental Health, 2007; 2011). In response, the World Health Organization (WHO, 2008; 2010) has called for the “scaling up” of mental health services in LMIC to improve access to services, increase the range of services on offer, and ensure that they are evidence-based. The *Working Together for Health: World Health Report* (WHO, 2006) highlighted a global shortage of health workers. The *Mental Health Atlas* (WHO, 2014) also highlighted marked discrepancies in human resource between LMIC and HIC.

A key strategy that has been proposed to address the lack of available specialists in LMIC is ‘task-sharing’ (i.e. the delegation of tasks to existing or new cadres with either less training or narrowly tailored training; Fulton et al., 2011). By presenting a range of case studies, Kakuma and colleagues (2011) indicated that mental health services can be delivered effectively through the implementation of task-sharing approaches that utilize non-specialist health professionals, lay workers, affected individuals, and/or caregivers. There is emerging evidence to suggest that the use of non-specialist workers is associated with positive outcomes for particular types of mental health difficulties (including general and perinatal depression, PTSD, and alcohol-use disorders), although further research in this area is required (Van Ginnekin et al., 2013).

There is recognition of the need to disseminate psychological and psychosocial interventions more widely across the globe (Fairburn & Patel, 2014). The need for these interventions may be particularly acute in contexts where populations have been subject to

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humanitarian crises such as conflict or natural disasters. This has led the WHO and UNHCR to jointly publish guidelines entitled: *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings* (WHO & UNHCR, 2012). Research has indicated that psychological and psychosocial interventions can be adapted and implemented with positive outcomes across cultures, including in LMIC (Bolton et al., 2007; Rahman et al., 2008; Tol et al., 2008), although there is a need to ensure that this is done in a culturally appropriate way (de Jong & van Ommeren 2005).

Sierra Leone is a low-income country in West Africa that was devastated by civil war between 1991 and 2002. It is estimated that 40,000 to 50,000 people were killed and 500,000 civilians fled the country (Dufka, 1999). Research studies have indicated high levels of post-traumatic stress symptomatology and depression in war-affected youths and former child soldiers (Betancourt et al., 2008; 2013a; 2013b). There is a very limited infrastructure for supporting the mental health needs of the 6 million people that live in Sierra Leone. The few available services are limited in scope and trained personnel (see: Song, van der Brink & de Jong, 2013). Following a recent situational analysis, the Sierra Leonean Ministry of Health and Sanitation (2012) has recommended shifting the emphasis of treatment to community-based psychosocial programs that involve collaboration between different sectors, including beyond the health sector (e.g., traditional healers, religious leaders). As such, important opportunities exist for building capacity for mental health care in Sierra Leone by task-sharing duties to non-specialist workers. It is hoped that this will increase access to mental health care, lessen burden on individuals, families, and communities, improve social integration and recovery, and reduce stigma. An important component of this work will involve conducting ongoing research and monitoring to evaluate these task-sharing efforts across time.

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commit and act is an NGO that works in collaboration with a range of stakeholders, including local NGOs (e.g., Caritas, Don Bosco), public sector services (e.g., Family Units of the Police Service, prison services), and health care workers within Sierra Leone to provide training and continuing supervision in a form of psychosocial intervention called Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999; 2012). *commit and act* advocates a community-based approach to delivering psychosocial support by offering ACT training to non-specialist workers employed by local NGOs. It also provides ongoing supervision and support so that individuals can develop their skills across time. By working with individuals from a range of sectors, the number of access points to psychosocial support is increased, improving access to mental health care within communities.

Applying ACT in diverse cultural settings

ACT is a behaviorally-based approach that can be adapted and trained quickly (Strosahl, Hayes, Bergan, & Romano, 1998; Richards et al., 2011). ACT uses acceptance, mindfulness and behavioral change processes to improve ‘psychological flexibility’, which is typically defined as the ability to contact one’s own experiences with openness and awareness and to persist or change in behavior in the service of chosen values (Hayes, Luoma, Bond, Masuda & Lillis, 2006). As a behaviorally-based and trans-diagnostic approach, it has been suggested that ACT can be applied to a range of issues and various cultural contexts (Hayes, Muto & Masuda, 2011; Hayes, Pistorello & Levin, 2012; Hayes & Toarmino, 1995), making it a potentially very suitable approach for the purposes of *commit and act*’s work in Sierra Leone. While ACT inevitably carries some degree of cultural bias, its focus on the “idiographic, functional, and contextual nature of therapeutic work” may help to maximize its therapeutic effectiveness while minimizing the possible negative impact of cultural biases (Pasillas & Masuda, 2014, p. 110).

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There is a growing evidence-base for the efficacy of ACT (as assessed by randomized controlled trials, clinical trials, analogue studies, etc.) across a range of clinical issues (see Ruiz, 2010). Recently, ACT has been used with minority groups in Western nations and preliminary evidence suggests that is efficacious across diverse populations (Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012). Furthermore, ACT has been evaluated in a range of middle-income countries including: Iran (Hoseini, Rezaei, & Azadi, 2014; Hosseinaei, Ahadi, Fata, Heidarei, & Mazaheri, 2013; Mo'tamedi, Rezaiemaram, & Tavallaie, 2012), India (Lundgren, Dahl, Yardi, & Melin, 2008) and South Africa (Lundgren, Dahl, Melin, & Kies, 2006). To date, ACT has not yet been trialed in a West African context.

Evidence suggests that ACT training can have a positive impact both professionally (e.g., Hayes et al., 2004) and personally (Luoma & Vilardaga, 2013) on the individuals who undergo this type of training. ACT training typically consists of a combination of didactic presentations and experiential exercises where therapists engage in ACT processes in an effort to increase their own psychological flexibility. Hayes et al. (2004) found that ACT training had a positive impact on stigma and burnout for substance abuse counselors, which exceeded multicultural training alone. Richards et al (2011) found that clinicians who had received ACT training evaluated the workshops positively, demonstrated increased levels of psychological flexibility and reported that their clinical work had been positively influenced by the workshops. A recent study by Luoma and Vilardaga (2013) found improved ACT conceptual knowledge, increased psychological flexibility, and reduced burnout in therapists following a two-day ACT training workshop.

Aims

The current study represents a preliminary evaluation of ACT training for a mix of non-specialist health workers and professionals in Sierra Leone that was piloted by *commit and act* in 2012. Specifically, the paper details how the training was delivered and presents

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data relating to: (a) the acceptability of an introductory ACT training workshop for participants, and (b) whether participants demonstrated any improvements in psychological flexibility and satisfaction with life following training. The content and structure of the workshops are described, as well as culturally adaptations to tailor the workshops to the Sierra Leonean context. As there has been no research conducted to date that has investigated ACT in a West-African context, the pragmatic decision was taken to utilize existing ACT measures for the purposes of the current study. Consequently, the research represents a preliminary attempt to explore the psychometric properties of ACT-related measures including the internal consistency of the Acceptance and Action Questionnaire-II (AAQ-II; Bond, et al., 2011) and the Valuing Questionnaire (Davies et al., 2011) in a Sierra Leonean population for the first time.

Method

ACT Training Workshops

Prior to the development of *commit and act's* ACT training workshops, the NGO's founder (BE) visited Sierra Leone and met with local stakeholders (e.g., various NGOs, religious leaders, local people, etc.) to discuss their needs and concerns and how *commit and act* might best support them. A religious leader and local NGOs assisted *commit and act* with organizing the training workshops by utilizing their existing infrastructure, networks and local knowledge. As there are no existing guidelines about how to apply ACT in African contexts (or in non-Western cultures in general), the workshop format comprised of didactic instruction led by facilitators with role plays in front of the group and then dividing into small groups to practice. The two workshops took place in Freetown and in Bo, and were 3 days in duration. The same protocol was used to guide the content of the workshops. As is customary in Sierra Leone, time was set aside at the beginning and the end of each day for prayer and song to invite both Muslim and Christian blessings on the training. The key aims of the

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introductory workshops included helping attendees to: 1) Develop a systematic approach to assessing the distress experienced by their clients; 2) Explore how workable their clients' strategies for addressing this distress have been; 3) Elicit information about clients' values; 4) Integrate relevant information into a 'case-formulation'; 5) Facilitate their clients to invest less time and energy in potentially unworkable efforts to suppress or get rid of distress; and 6) Assist their clients to broaden their behavioural repertoires to incorporate a willingness to have distress and move toward valued life domains.

Instruction was provided on a range of key ACT techniques including: the 'Matrix' approach to assessment and formulation (see Polk & Schoenndorff, 2014); exercises routinely used in mindfulness practices (i.e. mindfulness of breath, and body scans); the milestone 'birthday exercise' to clarify key values (Hayes et al., 1999); the 'Life Line' exercise to help individuals reflect on how to remain true to valued-life directions even in spite of distress (see Dahl, Plumb, Stewart, & Lundgren, 2009, p. 115); using 'defusion' exercises to help people to notice the verbal content of their thoughts rather than automatically assuming that this verbal content is factual (see Harris, 2009, p. 98); and the 'passengers on the bus' metaphor as a way of highlighting how techniques such a mindful willingness to experience distress and defusion exercises can help to support individuals to move in their valued life direction (Hayes et al., 1999, p.157–158).

The workshop facilitators (BE, RW, JN) were experienced ACT trainers from Germany, UK and US respectively. The facilitators delivered instruction during the workshops in English (the official language of Sierra Leone). Due to unreliable electricity supply, electronic equipment was not used to deliver workshop material. Instead flipchart paper, markers, workbooks, pens and pencils were used. The flow and amount of information that facilitators shared with attendees was carefully paced to minimise the likelihood of attendees feeling overwhelmed. The facilitators checked with people at regular intervals to

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assess the level of understanding and answer attendees' questions. A strong emphasis was placed on allowing attendees to work in pairs and to role-play strategies and approaches.

These role plays were observed by the facilitators who provided constructive feedback as and when appropriate.

Supervision meetings were organised following the ACT training workshops in Freetown and Bo respectively. These meetings were facilitated delivered by HB, a local ACT practitioner. The supervision meetings consisted of one full day meeting and were attended by at least one staff member from each organization who contributed staff to the training workshops. This meant that participants who attended the supervision meetings could comment on the collective experiences of their colleagues' efforts to apply ACT, whilst in turn taking information and guidance garnered from the supervision meetings back to their colleagues when they returned to their place of work. The main objectives of the supervision meeting were to: share experiences of applying ACT within the Sierra Leonean cultural context; revisit and practice implementing the ACT processes and exercises from the training workshops via experiential exercises, role plays and working in pairs; discuss cases; facilitate discussion and address participants' questions; and promote peer support to adapt, develop and apply ACT in this context.

Participants

Fifty-seven participants (26 males and 31 females; mean age=34.0 years; $SD=7.96$) attended an introductory ACT workshop in either Freetown ($n=26$) or Bo ($n=31$). These participants were a mix of non-specialist workers and professionals from over 20 different NGOs, local services (e.g., schools, social work), and religious orders who *commit and act* has been networking with. All participants were reimbursed for travel costs to attend the training and meals were provided as part of the workshops. In terms of ethnic group, 52% of participants were Mende, 8.8% were Temne, 7% were Kissi, and the remaining were Limba,

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Mandingo, Kono, Loko, Fula and Sherbro. The demographic information (i.e., age, gender, profession, level of education) are reported for each location (Freetown and Bo) and overall in Table 1. The sample had high levels of literacy, with 78.95% reporting that they had completed a college or university course. Regarding profession, eighteen participants reported holding more than one job with six health workers, five teachers, six social workers and a priest also working as a counselor. Participants reported working with clients affected by trauma (77.2%), alcohol and drug abuse (24.6%), HIV/AIDS (24.6%), victims of abuse (40.4%) and clients struggling with aggression (38.6%). Sixty-five per cent of the participants ($n=37$; 16 males, 21 females; mean age=34.7 years; $SD=8.67$) completed the measures at all three time points (baseline, post-workshop, and 3-months post-baseline).

INSERT TABLE 1 HERE

Measures

English is the national language of the country and typically written materials are presented in English. All measures were delivered in English and in pen and paper format.

Acceptance & Action Questionnaire-II (AAQ-II). The 7-item AAQ-II is the most widely used measure of psychological inflexibility (e.g., “Emotions cause problems in my life”). It has proven to be broadly useful in a number of domains and demonstrates good psychometric properties (Bond et al., 2011). The AAQ-II was found to have good internal reliability ($\alpha=.78$) in the current sample.

The Valuing Questionnaire (VQ). The 8-item VQ (Davies, Smout, Burns & Christie, 2011) was selected for the purposes of this research as it is a general (rather than domain-specific) values measure that captures two facets of valued living: *Progress* (e.g., “I did things that brought me closer to what really matters to me in my life”) and *Obstruction* (e.g., “Difficult thoughts, feelings or memories got in the way of what I really wanted to do”).

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The VQ demonstrates convergent validity with ACT-related measures (e.g., Valued Living Questionnaire) and measures of mental health and life satisfaction (e.g., Satisfaction with Life Scale; SWLS). Cronbach's alpha was found to be below the acceptable cut-off point (i.e. $\alpha=.395$). Feedback from participants suggested that some of the terms used in this scale, such as "auto-pilot" (item 7), do not translate into Sierra Leonean culture.

Satisfaction with Life Scale (SWLS). The 5-item SWLS (Diener, Emmons, Larsen, & Griffin, 1985) was included in the current research as it is a measure of global life satisfaction and is brief and easy to administer. Cronbach's alpha was found to be below the recommended cut-off point of $\alpha=0.7$ ($\alpha=.602$).

Post-workshop Evaluation Form. This 10-item form was created for the purposes of the current research. Participants were asked to indicate the parts of the workshop that they found (a) helpful, (b) unhelpful, (c) could be improved, and (d) ACT exercises that they were most likely to use in future, using an open-ended response format. They also rated their satisfaction with a number of features of the training including: whether the trainers provided a safe space to explore participants' experiences, whether they would attend another ACT training workshop in future, whether there was enough time to cover important issues, if they would like to attend supervision following the workshop to explore ACT more, and how valuable they found the experiential part of the workshop on a 3-point emoticon scale ("Happy", "Neutral" or "sad"). They were also asked whether the amount of material they covered each day was (i) Little, (ii) Good, or (iii) Too much.

Follow-up Feedback Form. At a 3-month post-baseline assessment, participants were asked to record which, if any, of the ACT exercises they had used in their work with clients using an open-ended response format.

Procedure

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All procedures were approved by the University of Glasgow research ethics committee (REC ref: 2012003). After providing informed consent, participants completed the following baseline measures: demographics questionnaire, VQ, AAQ-II, and SWLS respectively. Participants then completed the ACT training workshop. Immediately following the end of the workshop, participants completed the VQ, AAQ-II, SWLS for a second time and also the Post-workshop Evaluation Form. Follow-up measures were completed between 14 and 16 weeks post-baseline including the: VQ, AAQ-II, SWLS, and Follow-up Feedback Form.

Data analysis

Where one item was missing from a measure, the median score for that item was imputed (see Acuna & Rodriguez, 2004). Where more than one item was missing, this case was eliminated by excluding cases pairwise. All participants ($N=57$) were included in the correlational analyses that were conducted, and for the calculation of the Cronbach's alpha values for each measure using baseline scores. Subsequent data analyses only included participants who had completed the measures at all three time points ($N=37$). A one-way between groups MANOVA indicated that there were no significant differences in baseline scores on the AAQ-II, SWLS or VQ between participants who completed measures at 3-months post-baseline and those who did not. Also, there were no significant differences between participants who completed the training workshops in either Bo or Freetown.

Data analysis was conducted in two parts. First, correlational analyses were conducted to investigate the relationships between the measures at baseline. To reduce the risk of a Type I error, threshold levels of significance for correlation coefficients were adjusted for multiple comparisons by Bonferroni correction (i.e. $\alpha=.017$) (see Curtin & Schulz, 1998). Three one-way repeated measures ANOVAs were conducted to assess changes on each of the measures

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across time. Kolmogorov-Smirnov tests indicated no violations of the assumptions of normality.

Results

A significant positive correlation was observed between SWLS and VQ scores ($r=.501, p<.000$). There were no significant correlations between AAQ-II and VQ scores or between AAQ-II and SWLS scores.

INSERT TABLE 2 HERE

Three one-way repeated measures ANOVAs were conducted to compare AAQ-II, SWLS and VQ scores at baseline, post-workshop and 3-months post-baseline. The means and standard deviations for the AAQ-II, VQ and SWLS scores of participants who completed the measures at all three time points are presented in Table 2. There was a significant effect for time on the AAQ-II, $F(2, 33)=9.991, p=.000, \eta^2=.227$, with significant decreases in AAQ-II scores from baseline to 3-months post-baseline ($p=.001$) and from post-workshop to 3-months post-baseline ($p=.013$). A significant effect for time was also observed on the SWLS, $F(2, 35)=6.433, p=.006, \eta^2=.152$, with significant increases in SWLS scores from baseline to 3-months post-baseline ($p=.017$) and from post-workshop to 3-months post-baseline ($p=.037$). No significant effects for time were observed for the VQ. There was no significant correlation between the change scores on the AAQ-II and the SWLS from baseline to 3-month post-baseline.

Feedback

At post workshop, all participants ($N=57$) rated the ACT training workshops favorably on the Evaluation Form. All participants reported that they felt a safe space was provided (as indicated by a “happy” or “neutral” emoticon) and 94.7% reported that they found the experiential component helpful. While most participants indicated that the amount

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of material covered each day was “good” (92.5%), there were mixed responses regarding whether there was enough time to cover important issues, with 49.1% indicating agreement, 41.8% indicating a neutral response, and 9.1% indicating disagreement. Nearly all participants indicated that they wished to attend future ACT training (96.5%), and 87.7% indicated that they would like to receive supervision in ACT. The most commonly reported issues were that more time was needed for the workshops (29.8%); that written materials, such as handouts, PowerPoint presentations, guidelines for various ACT exercises and an ACT training manual be provided (29.8%); and that additional exercises and continuous training be provided to reinforce learning and help develop skills across time (24.6%). Other suggestions included: providing more case examples within training (particularly cases relevant to the local context), and establishing ground rules together at the start of the workshop. More general suggestions for future ACT training included training local people to become ACT trainers, monitoring and evaluating ACT trainees, *commit and act* becoming more established in the province, and creating an ACT training center.

Participants reported that the most helpful components of the workshops were the Life Line exercise (85.5%), with 82.5% reporting that they would be likely to use it in future, and mindfulness (40.4%), with 29.8% reporting that they would use it in future. Other exercises that participants reported finding helpful included the Matrix (15.8%), values clarification/connecting with values (15.8%), defusion (14%), and the ‘bus driver’ metaphor (12.3%).

The most commonly reported ACT exercises and techniques that participants reported using at 3-months post-baseline are presented in Table 3. Participants rated the ACT workshops favorably and reported using techniques they had learned during training in their professional work, with the majority of participants (82.86%) stating that they used the Life Line exercise and 40% reporting use of mindfulness exercises with clients.

INSERT TABLE 3 HERE

Discussion

The current study was conducted to facilitate a preliminary evaluation of ACT training for a mix of non-specialist workers and professionals in Sierra Leone. Results indicated that the ACT introductory workshops in both Freetown and in Bo were evaluated as being acceptable to the attendees. In addition, the results indicated that participants demonstrated significant improvements in psychological flexibility and satisfaction with life following training. This is the first time that ACT training had been delivered in West Africa. The results of the evaluation of the training workshops in Sierra Leone, a low-income country, adds to a growing literature exploring the potential acceptability and efficacy of ACT in middle-income countries (Hoseini et al., 2014; Hosseinaei et al., 2013; Mo'tamedi et al., 2012; Lundgren et al., 2008; Lundgren et al., 2006). The findings of the current research seem to support the possibility that psychosocial interventions may have value across different cultural settings (Bolton et al., 2007; Rahman et al., 2008; Tol et al., 2008).

In terms of changes in scores on specific measures that were included in the current study, participants demonstrated significant decreases in psychological inflexibility, and significant increase in satisfaction with life, from baseline to 3-months post-baseline and from post-workshop to 3-months post-baseline. These findings are consistent with Luoma and Vilardaga's (2013) study, whereby participants who attended ACT training demonstrated decreases in psychological inflexibility over time. Because ACT training is experiential in nature and attendees get an opportunity to practice exercises, reductions in therapists' psychological inflexibility have been observed (see Luoma, Hayes & Walser, 2007). It is interesting to note that the first ACT training to be delivered in Sierra Leone was associated with significant changes in psychological flexibility and satisfaction with life that were

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The results of this study provide preliminary evidence to suggest that a measure of psychological inflexibility (AAQ-II) demonstrated good internal consistency, a measure of satisfaction with life (SWLS) borderline adequate internal consistency, and a measure of values-consistent behavior (VQ) demonstrated poor internal consistency. One possible reason for the lack of internal consistency of items of the VQ is that at baseline participants may not have fully understood the ACT conceptualization of “values”. It may also have been that terminology used in the questionnaire (e.g. “auto-pilot”) was biased towards Western cultural groups. The pattern of relationships between the measures indicated no significant correlations between a measure of psychological inflexibility and measures of valued living and life satisfaction. Further research is required to investigate the validity of these measures in a Sierra Leonean context.

A relative strength of the current research is that a significant proportion of participants were retained from baseline to 3-month post-baseline assessment (64.9%). This supports the feasibility of conducting longitudinal follow-up studies in LMIC such as Sierra

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Leone. Betancourt et al. (2010; 2012; 2013a; 2013b) have conducted a range of research studies related to trauma in Sierra Leone, which have also demonstrated this to be the case.

The small sample size recruited to the current study ($N= 57$) has been acknowledged as an important limitation. In addition, the absence of a control group means that causal attributions associated with the training workshops cannot be inferred and alternative reasons for the decrease in psychological inflexibility and increase in satisfaction with life cannot be ruled out. Another limitation of the current study is that it utilized assessment measures that were developed and validated in HIC. There is contention in the Global Mental Health literature about how cross-culturally valid psychiatric diagnoses (and associated assessment tools) actually are (see Summerfield, 2008). Future research could employ rapid qualitative research procedures such as the Design, Implementation, Monitoring, and Evaluation (DIME; Applied Mental Health Research Group, 2013) approach developed at John Hopkins University to develop assessment measures specifically tailored to the context in Sierra Leone. A final limitation relates to the fact that although English is the official language of Sierra Leone, attendees to the workshop tend to speak with each other using Krio – a dialect of English. The extent to which the delivery of the workshop material in English, rather than Krio may have impacted on attendees learning is unclear.

The first stage of *commit and act*'s evaluation strategy for Sierra Leone was to examine the acceptability of ACT training for participants and whether this training would be associated with improvements in psychological flexibility and satisfaction with life in workshop attendees. The observed decreases in psychological inflexibility and increases in satisfaction with life provide some suggestion that ACT might have merit for therapeutic use in this population. Future research may specifically address the question as to whether ACT training can reduce the risk of employee burnout in non-specialist workers who are engaged in task-sharing mental health related work. Recent research has highlighted the potential

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benefit that allocating duties related to mental health to non-specialist workers can bring (van Ginnekin et al., 2013), however further research into the impact that operating in these roles might have on individuals wellbeing in LMIC is required.

The findings indicate the acceptability of ACT training in Sierra Leone – participants rated the workshops positively, stated that they wished to receive further training and supervision in ACT, and reported using ACT techniques in their work. Future research will examine the impact of *commit and act*'s work directly on clients' wellbeing across a range of clinical issues. In addition, *commit and act*'s work will seek to explore how best to adapt ACT protocols for application in Sierra Leone, and how to optimize the competency and fidelity of non-specialist workers and a variety of professionals to deliver these contextually tailored interventions in the country. *commit and act* is committed to using a 'training for trainers' model that seeks to develop the capacity of local people to become experts in delivering culturally informed interventions for promoting mental health and wellbeing in Sierra Leone. This will serve to build capacity in Sierra Leone to provide psychosocial support, whilst also involving local people in shaping and delivering the training and supervision of this support.

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Table 1

Demographic information for workshop participants in Freetown (N=26), Bo (N=31) and overall (N=57)

	Freetown	Bo	Total
Gender	13 M; 13 F	13 M; 18 F	26 M; 31 F
Age	<i>M</i> =30.28 (<i>SD</i> =5.62)	<i>M</i> =37.0 (<i>SD</i> =8.37)	<i>M</i> =34.0 (<i>SD</i> =7.96)
Occupation:			
Health worker	0	8	8
Teacher	2	10	12
Social worker	21	5	26
Religious leader	0	1	1
Counselor	7	18	25
Other	6	4	10
Education:			
Completed a college course	12	18	30
Completed a university course	9	6	15

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Table 2

Means and standard deviations for AAQ-II (N=35), VQ (N=37) and SLWS (N=37) at baseline, post-workshop and 3-months post-baseline

Measure	Mean	SD
AAQ-II		
Baseline	26.54	8.15
Post-workshop	24.31	8.25
3-months post-baseline	21.05	7.13
VQ		
Baseline	27.41	6.15
Post-workshop	29.27	4.93
3-months post-baseline	28.27	7.22
SWLS		
Baseline	19.59	4.73
Post-workshop	19.43	5.02
3-months post-baseline	22.3	6.0

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Table 3

Most commonly reported ACT exercises used by participants at 3-months post-baseline

(N=37)

Exercise	Percentage (%)
Life Line exercise	82.86
Mindfulness exercises	40
Passengers on a bus metaphor	20
The Matrix	14.29
Values exercises	14.29
70 th birthday exercise	11.43