cpe.psychopen.eu | ISSN 2625-3410 | November 2021 | Volume 3 | Special Issue |

The Official Academic Journal of the
European Association of Clinical Psychology
and Psychological Treatment

CLINICAL PSYCHOLOGY IN EUROPE

The Official Academic Journal of the
European Association of Clinical Psychology and Psychological Treatment

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Special Issue

CPE Special Issue 2021: Cultural Adaptation of Psychological Interventions

Editorial

Special Issue Editorial: Cultural Adaption of Psychological Interventions

Eva Heim & Cornelia Weise

Latest Developments

Standardised Research Methods and Documentation in Cultural Adaptation: The Need, the Potential and Future Steps

Eva Heim & Christine Knaevelsrud

It is essential to achieve a high level of quality and transparency for cultural adaptation in clinical trials with culturally diverse groups and ethnic minorities.

Description of a Culture-Sensitive, Low-Threshold Psychoeducation Intervention for Asylum Seekers (Tea Garden)

Ricarda Mewes, Julia Giesebrecht, Cornelia Weise, Freyja Grupp

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The framework allows for a reproducible and systematic cultural adaptation and demonstrates that the flexible and simple format of CETA requires only marginal adaptations.

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Annett Lotzin, Jutta Lindert, Theresa Koch, Alexandra Liedl, Ingo Schäfer

We report on the adaptation process of a transdiagnostic intervention for refugees with substance use based on focus groups with Syrian refugees and interviews with therapists.

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November 2021 | Volume 3
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Latest Developments

"Same Same or Adapted?" Therapists' Feedback on the Implementation of Trauma-Focused Cognitive Behavioral Therapy With Unaccompanied Young Refugees

Johanna Unterhitzenberger, Sophia Haberstumpf, Rita Rosner, Elisa Pfeiffer

Little is known about the necessary adaptations of trauma-focused CBT as treatment for young refugees. This paper presents crucial adaptations undertaken in a pilot study for this target group as documented by study therapists.

Reporting Cultural Adaptation in Psychological Trials – The RECAPT criteria

Eva Heim, Ricarda Mewes, Jinane Abi Ramia, Heide Glaesmer, Brian Hall, Melissa Harper Shehadeh, Burçin Ünlü, Schahryar Kananian, Brandon A. Kohrt, Franziska Lechner-Meichsner, Annett Lotzin, Marie Rose Moro, Rahmeth Radjack, Alicia Salamanca-Sanabria, Daisy R. Singla, Annabelle Starck, Gesine Sturm, Wietse Tol, Cornelia Weise, Christine Knaevelsrud

Standardised documentation, as proposed in this paper, is key to obtain reliable information regarding the effect of cultural adaptation on treatment efficacy, feasibility, and acceptance.

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Editorial

Special Issue Editorial: Cultural Adaption of Psychological Interventions

Eva Heim[1,2], Cornelia Weise[3]

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e7627, https://doi.org/10.32872/cpe.7627

Published (VoR): 2021-11-23

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Related: This article is part of the CPE Special Issue “Cultural Adaptation of Psychological Interventions”, Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Cultural adaptation of psychological interventions has been discussed controversially in literature. On the one hand, culturally diverse groups are underrepresented in psychological trials, and evidence on acceptability and efficacy of interventions cannot necessarily be transferred from one cultural group to another (Hussain-Gambles et al., 2004; La Roche & Christopher, 2008; Wendler et al., 2006). On the other hand, some researchers are concerned about the fidelity of treatment if culturally adapted (Castro et al., 2010).

There is also considerable debate about what to adapt, and the effect of such adaptations. Empirical evidence on substantial modifications is scarce, and cultural adaptation methods are often insufficiently reported in literature (Chowdhary et al., 2014; Harper Shehadeh et al., 2016). This does not only include adaptations implemented before a trial starts, but also the so called “on-the-fly” adaptations that are done during an ongoing trial.

In this special issue, experiences and empirical evidence on the cultural adaptation of psychological interventions for refugee populations are brought together. In 2016, the German Federal Ministry of Education and Research (FMER) launched a call for research proposals covering the ‘mental health of refugee populations’. Seven research projects were funded. One exclusively focuses on diagnostics, and the other six projects test evidence-based psychological interventions. Each of those six projects consists of three or more sub-projects, which are testing diagnostic tools, the efficacy and cost-effectiveness

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of interventions, and implementation methods. A total of eleven randomised controlled trials (RCTs) are implemented to test different kinds of psychological interventions among a diversity of target groups, i.e., age groups, specific disorders, or unspecific psychological distress.

In the context of the FMER call, a "task force for cultural adaptions of mental health interventions for refugees" was launched. It pursued two major goals: First, it aimed to develop a common understanding and methodology for documenting and monitoring cultural adaptations in clinical trials. Second, it aimed to integrate the findings of the first step and compile criteria on how cultural adaptations in clinical trials could be reported. The conceptual framework for cultural adaptation by Heim and Kohrt (2019) was used as a basis for this work.

This special issue features experiences, empirical evidence and recommendations resulting from this task force, as well as the final composition of the reporting criteria. The paper by Heim and Knaevelsrud (2021, this issue) provides an introduction to the methodology developed by the task force and describes how cultural adaptations across the different projects and studies were documented and monitored. A content analysis of the documented adaptations is presented in this paper. The subsequent papers highlight five examples of studies that applied the jointly developed cultural adaptation methodology, with different thematic foci. These papers are based on empirical evidence from formative research (e.g., focus groups or key informant interviews) and pilot studies.

Mewes et al. (2021, this issue) describe the development of a culture-sensitive, transdiagnostic intervention to increase knowledge about mental health problems and available treatments. This study highlights the importance of differentiating between the culture-specific adaptation of interventions (for one particular group) and the development of culture-sensitive interventions that can be used for culturally diverse groups.

Kananian et al. (2021, this issue) used Culturally Adapted Cognitive Behavioural Therapy (CA-CBT, Hinton et al., 2012), an intervention that had already been tested among different cultural groups (i.e., Cambodian, Latino, and Arabic-speaking populations). In this study, CA-CBT was prepared to be tested in a new, culturally different group (i.e., Afghan refugees in Germany). Based on a pilot study and focus groups, the intervention was further adapted to be tested in an RCT.

Böttche et al. (2021, this issue) focus on the process from formative research to adaptation. A transdiagnostic intervention, the Common Elements Treatment Approach (CETA, Murray et al., 2014), was adapted for Arabic-speaking refugees in Germany and will be provided both face-to-face and through the internet in a non-inferiority trial. In preparation of this study, cultural concepts of distress were assessed among the target population. The main focus of the paper is on the decision-making process, and the authors provide a summary of their most salient decisions.

The process of adapting an already culturally-sensitive, transdiagnostic treatment to also include substance use disorders is described in the paper by Lotzin et al. (2021,

this issue). The authors used Skills-Training of Affect Regulation – A Culture-sensitive Approach (STARC, Koch & Liedl, 2019) in their study. Focus group discussions were conducted to examine culture-specific assumptions about substance use. This data was used to adapt the treatment manual that will be tested in an upcoming RCT.

Unterhitzenberger et al. (2021, this issue) tested Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen et al., 2017) in a pilot study with unaccompanied refugee minors (URMs). The paper highlights "on-the-fly" adaptations implemented by the therapists during the pilot study. The main adaptation concerned the so-called "crisis of the week", i.e., participants struggles and concerns in their daily lives. This shows that post-migration stressors are a very important factor when adapting psychological interventions to refugee populations – an aspect that may sometimes be even more relevant than ethnic origin.

Finally, Heim et al. (2021, this issue) present the *Reporting Cultural Adaptation in Psychological Trials* (RECAPT) criteria. The RECAPT criteria were developed jointly by the above-described task force. To achieve a broader consent on the RECAPT criteria, an online survey was conducted among eleven international experts in the field of global mental health and psychological interventions for refugee populations.

In summary, this special issue features the experience of a variety of studies in which a diversity of psychological interventions were culturally adapted and tested among refugee populations in Germany. The task force provided a unique opportunity for exchange and discussions, with the aim of advancing the emerging field of cultural adaptations in mental health interventions. The RECAPT criteria (Heim et al., 2021, this issue) will hopefully contribute to a more systematised and transparent documentation of cultural adaptation in psychological research in the future. This is an important precondition to enhance the empirical evidence concerning the effect of such adaptations on the efficacy and acceptability of psychotherapy among culturally diverse groups.

Funding: German Federal Ministry of Education and Research (Nr 01EF1806H).

Acknowledgments: The authors have no additional (i.e., non-financial) support to report.

Competing Interests: Cornelia Weise is one of the Editors-in-Chief of Clinical Psychology in Europe.

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Latest Developments

Standardised Research Methods and Documentation in Cultural Adaptation: The Need, the Potential and Future Steps

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e5513, https://doi.org/10.32872/cpe.5513

Received: 2020-12-27 • **Accepted:** 2021-06-08 • **Published (VoR):** 2021-11-23

Handling Editor: Cornelia Weise, Philipps-University of Marburg, Marburg, Germany

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Related: This article is part of the CPE Special Issue “Cultural Adaptation of Psychological Interventions”, Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: Refugees and asylum seekers in Europe are affected by high prevalence of common mental disorders. Under the call ‘mental health of refugee populations’, the German Federal Ministry of Education and Research (FMER) funded a series of research projects to test evidence-based psychological interventions among refugee populations in Germany. In addition, the “Task force for cultural adaptation of mental health interventions for refugees” was established to develop a structured procedure for harmonising and documenting cultural adaptations across the FMER-funded research projects.

Method: A template for documenting cultural adaptations in a standardised manner was developed and completed by researchers in their respective projects. Documentation contained original data from formative research, as well as references and other sources that had been used during the adaptation process. All submitted templates and additional materials were analysed using qualitative content analysis.

Results: Research projects under the FMER call include minors, adults, and families from different origins with common mental disorders. Two studies used and adapted existing manuals for the treatment of PTSD. Four studies adapted existing transdiagnostic manuals, three of which had already been developed with a culture-sensitive focus. Four other studies developed new

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intervention manuals using evidence-based treatment components. The levels of cultural adaptation varied across studies, ranging from surface adaptations of existing manuals to the development of new, culture-sensitive interventions for refugees.
Conclusions: Cultural adaptation is often an iterative process of piloting, feedback, and further adaptation. Having a documentation system in place from start helps structuring this process and increases transparency.

Keywords
cultural adaptation, refugees, randomised controlled trials, documentation, monitoring, formative research

Highlights

- A series of evidence-based psychological interventions are tested among refugees in Germany.
- A structured procedure for harmonising and documenting cultural adaptations was developed.
- Cultural adaptation is often an iterative process of piloting, feedback, and further adaptation.
- Documenting the decision-making process, based on evidence from formative research, is key.

In view of the increasing numbers of refugee populations worldwide (UNHCR, 2020) and the high prevalence of common mental disorders among them (Turrini et al., 2017), there is an urgent need for evidence-based mental health interventions to target these populations. According to the World Health Organization (WHO, 2017), common mental disorders include depression, anxiety, and posttraumatic stress disorder (PTSD).

Substantial empirical evidence reveals cultural variation in how symptoms of common mental disorders are expressed (Haroz et al., 2017; Kohrt et al., 2014). In addition, culture-specific assumptions about mental health and mental disorders (e.g., Grupp et al., 2018; Kohrt & Hruschka, 2010) and beliefs about treatment and recovery (e.g., Reich et al., 2015; Shala et al., 2020) have been documented. Based on this evidence, the term *cultural concepts of distress* (CCD) was introduced in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5, American Psychiatric Association, 2013). CCD include i) idioms of distress, ii) cultural explanations, and iii) cultural syndromes (Lewis-Fernández & Kirmayer, 2019). Evidence shows that CCD differ from diagnostic categories in the DSM (Kohrt et al., 2014).

There is an ongoing debate on the extent to which psychological interventions developed in Western, Educated, Industrialised, Rich, and Democratic (WEIRD) societies (Henrich et al., 2010) require cultural adaptation to be effective for the treatment of common mental disorders among ethnic and cultural minorities. Ethnic minorities are generally underrepresented in clinical trials in high-income countries (Hussain-Gambles

et al., 2004; La Roche & Christopher, 2008; Wendler et al., 2005), which means that the term 'evidence-based interventions' has to be used with caution in this context. For this reason, the WHO and other groups of researchers increasingly invest in cultural adaptation of psychological interventions prior to testing them in randomised controlled trials (RCTs) (e.g., Abi Ramia et al., 2018; Heim et al., 2019; Tol et al., 2018).

Resnicow et al. (1999) differentiate between surface and deep structure adaptations. Surface structure adaptations refer to matching materials (e.g., illustrations, language), as well as channels and settings for treatment delivery to observable characteristics of the target population. By contrast, deep structure adaptations convey salience of an intervention by considering how members of a particular cultural group perceive the cause, course, and treatment of a particular illness.

Several meta-analyses showed that culturally adapted psychological interventions are effective when compared to a variety of control conditions (e.g., Chowdhary et al., 2014; Griner & Smith, 2006). One meta-analysis (Hall et al., 2016) found that culturally adapted versions were more effective than the unadapted versions of the same intervention in direct comparison (g = 0.52). And one meta-analysis showed that the adaptation of the 'illness myth' (i.e., the explanatory model and the treatment rationale) was the most important factor contributing to higher efficacy of adapted interventions (Benish et al., 2011).

Although the meta-analytic evidence seems promising, it is important to mention that it is based on rather low quality of evidence, caused by the following three specific flaws in prior studies: First, there is a lack of theoretical underpinnings in cultural adaptation literature. Most of the literature is based on heuristic frameworks that were developed based on expert opinions and previous studies. A theory-based approach that takes into account literature from the field of cultural clinical psychology and transcultural psychiatry could potentially contribute to a better understanding of *what* to adapt and *why*. Second, previous frameworks for cultural adaptation have focused on clinical practice (e.g., Bernal et al., 2009; Castro et al., 2010; Chu & Leino, 2017; Hwang, 2006), but there are no frameworks or guidelines for implementing and documenting cultural adaptations in psychological trials. This is a particularly relevant gap in the literature, as it hinders the replicability and transparency of trials, both of which are increasingly demanded in the scientific realm. In most published studies, adaptation methods are not well documented (Harper Shehadeh et al., 2016), which leads to a 'black box' with regard to *how* the cultural adaptation was implemented. This lack of documentation also adds to blurring sources of bias when assessing and analysing factors of intervention efficacy. Third, and as a consequence of the first two flaws, there is a lack of empirical evidence on the kinds of adaptations that lead to higher acceptability or efficacy of treatments (Heim & Kohrt, 2019). In order to foster empirical research and replicability, transparent criteria on how to implement and document the process of cultural adaption are needed (Heim et al., 2021, this issue).

To address the first problem — the lack of theory — Heim and Kohrt (2019) developed a new conceptual framework for the cultural adaptation of psychological interventions as a basis for empirical research. The authors suggest using CCD as the pivotal element for cultural adaptation and to adapt treatment elements to CCD. Treatment elements are defined in accordance with a taxonomy developed by Singla et al. (2017). This taxonomy differentiates among specific treatment elements (i.e., interventions based on theoretical assumptions such as behavioural or cognitive treatment elements), unspecific treatment elements (i.e., common factors such as the therapeutic relationship or providing a meaningful treatment rationale), and therapeutic techniques (i.e., exercises and other interventions that are done to transmit the therapeutic components, such as role plays or homework). In accordance with Resnicow et al. (1999), adaptations of specific and unspecific treatment elements are deep structure adaptations. With regard to surface adaptations, Heim and Kohrt (2019) suggest considering different modes of treatment delivery (e.g., Internet-based, face-to-face, and group interventions). In addition, surface cultural adaptations include, for example, modifications to texts, illustrations, or case examples.

The present paper addresses the second problem, the lack of documentation. It outlines the work and outcomes achieved by the task force for cultural adaptation of mental health interventions for refugees. This task force was established by a group of researchers from Germany and Switzerland. In 2016, the German Federal Ministry of Education and Research (FMER) launched a call for research proposals covering the 'mental health of refugee populations'. Seven research projects were funded. One exclusively focuses on diagnostics, and the other six projects will test evidence-based psychological interventions. Each of those six projects consists of three or more sub-projects, in which different interventions with different target groups are tested, implementation methods are compared, and other aspects such as cost-effectiveness are addressed. A total of 11 RCTs (RCTs) will be conducted within these six larger projects. These research projects are currently ongoing. A total of 11 RCTs will be conducted within these six larger projects.

The task force for cultural adaptation of mental health interventions for refugees was launched as a cross-cutting project to harmonise and document cultural adaptation across the 11 sub-projects. The parallel implementation of 11 RCTs that include diverse target populations and a variety of interventions offered a unique opportunity to develop and test such a standardised procedure and to consolidate the experiences in a shared learning process.

Regarding the third problem — the lack of empirical evidence — more consistent documentation of cultural adaptation procedures will contribute to enhancing transparency and replicability in clinical trials. Consistent documentation will also foster meta-analytic evidence, as it will be possible to compare studies with regard to the level (and quality) of cultural adaptation applied in such trials.

Aim

The task force for cultural adaptation of mental health interventions for refugees aimed to develop a structured procedure for harmonising and documenting cultural adaptations of psychological interventions in clinical trials. The present paper describes the procedures and outcomes of this joint initiative.

Method

Procedures

The task force started its work in July 2019. It consisted of the coordinator (first author, EH) and representatives of the 11 RCTs. Representatives were principal investigators and post-doctoral researchers in charge of the cultural adaptation process in each study.

In a first step, the coordinator revised the project descriptions and gathered additional information in telephone interviews with representatives of each project. After these initial contacts, a first workshop was held in September 2019 in which the members of the task force agreed on a common procedure to guide and monitor the cultural adaptation process across the 11 projects. Thereafter, a series of webinars and conference calls was held between October and December 2019 to discuss upcoming topics in the cultural adaptation process. In a second workshop, which was held in February 2020, all members of the task force presented their results of the cultural adaptation process. Experiences were shared and consolidated in small group discussions about specific topics.

Documentation

A template for documenting cultural adaptations in a standardised manner was developed based on the theoretical framework by Heim and Kohrt (2019). It consisted of the following sections: i) target group; ii) formative research methods; iii) CCD (i.e., idioms of distress, explanatory models); iv) target intervention; v) deep structure adaptations (i.e., specific and unspecific elements, in-session techniques); and vi) surface adaptations (i.e., mode of delivery, materials). Researchers in their respective projects used the template to document the cultural adaptation process. This documentation contained original data (e.g., gathered through key informant interviews of focus group discussions), as well as references and other sources that had been used during the adaptation process (e.g., published papers on CCD in the target population, pilot studies, or formative work). A revised version of the template can be found in Heim et al. (2021), this issue.

Data Analysis

All submitted templates and additional materials were entered into an NVivo database and analysed using qualitative content analysis. Codes corresponded to the sections of the template (i.e., target group, CCD, elements of the target intervention, etc.). A few sub-codes were developed inductively from the data, where researchers had provided information that did not correspond to one of the sections of the template (e.g., cultural concepts of attachment). Data were analysed by the first author (EH). Since researchers themselves had allocated information on their projects to the corresponding sections and sub-sections of the template, no second coder was involved in the data analysis. Disagreements were clarified between the first author and researchers who had completed the template.

Results

Overview of Studies

An overview of the 11 projects is provided in Table 1 in the Appendix, Supplementary Materials). Eight of the 11 sub-projects returned the completed templates and additional material. The other three had already completed the cultural adaptation, with limited possibilities to document this process. In four studies, the process of cultural adaptation was documented retrospectively by analysing qualitative data collected during the adaptation process that had not been analysed nor published. And four studies adapted their interventions during the course of the present project and documented this process continuously.

Target Populations and Disorders

The first section of the template contained the target population and the 'Western' diagnostic categories addressed in the respective trials. Three studies focused on minors, five on adults, and two on families (i.e., parents and their children). The majority (seven studies) included refugees from different countries of origin, three studies included Afghan and Syrian refugees, and one study included Arabic-speaking refugees. Studies including refugees from different countries of origin developed a 'culture-sensitive' rather than a 'culture-specific' treatment approach (e.g., Lotzin et al., 2021, this issue). Across the 11 projects, the targeted disorders were post-traumatic symptoms (five studies), common mental disorders (three studies as primary outcome, and one study as secondary outcome), and substance use disorder (one study). In addition, one study aimed at increasing knowledge about common mental disorders, psychological resources, and services of care (Mewes et al., 2021, this issue).

Formative Research Methods

Researchers in the respective projects gathered relevant information for cultural adaptation from published literature and through qualitative research. Formative research revealed information related to CCD, as well as information regarding the target interventions themselves (e.g., acceptance, suggestions for adaptations). A literature review was conducted in all but one project. In three studies, information on CCD (i.e., idioms of distress and explanatory models) was gathered through focus group discussions or individual interviews ahead of starting the process of cultural adaptation.

Cultural Concepts of Distress

Results of literature reviews and qualitative research revealed mind–body concepts, idioms of distress, and explanatory models, which are described more in detail in the respective papers in this special issue. In addition to CCD, other related concepts were taken into account: Two studies considered assumptions about help-seeking, and one study reported on cultural concepts of attachment. In addition, four studies reported that fatalistic beliefs were relevant in their target populations. And one study also included cultural resources alongside CCD.

Target Interventions

The studies varied with regard to their therapeutic approaches. Two studies used and adapted existing manuals for the treatment of PTSD. Four studies adapted existing transdiagnostic manuals, three of which had already been developed with a culture-sensitive focus. Four other studies developed new intervention manuals using evidence-based treatment components.

Cultural Adaptations: Surface and Deep Structure

The levels of cultural adaptation varied across studies, ranging from surface adaptations of existing manuals to the development of new, culture-sensitive interventions for refugees. Other studies conducted deep structure adaptations of existing interventions, such as by adding, changing, or modifying specific treatment components. In addition, several studies considered the mode of delivery of the intervention, such as online vs. face-to-face, or group vs. individual. Most studies described surface adaptations (Resnicow et al., 1999), such as the use of a culture-specific or culture-sensitive language, the inclusion of specific idioms of distress, the use of illustrations and non-verbal material for non-German speaking participants, or the consideration of gender-related aspects and religious concerns (e.g., not offering food in a closing ritual during Ramadan).

Psychoeducation materials were culturally adapted in most studies, and psychoeducation was extensively discussed during the second workshop of the task force. Some of the considerations around psychoeducation involved metaphors and analogies to describe

the therapeutic process, such as the wound metaphor (trauma as a wound), the process of healing (e.g., of a broken leg), psychotherapy as training (e.g., muscle training), or the metaphor of the messy cupboard that must be cleaned up. Another relevant issue in psychoeducation concerned mental health-related stigma, which was addressed in some studies through normalising, the use of non-stigmatising terms, or using an encouraging rather than a problematising language.

Regarding specific therapeutic elements, all studies conducted a careful analysis of interventions to address the most common symptoms of psychological distress in their respective target populations. As an example, three studies discussed the inclusion or exclusion of problem solving in their respective interventions (Böttche et al., 2021, this issue; Kananian et al., 2021, this issue; Unterhitzenberger et al., 2021, this issue). This discussion showed that, on the one hand, problem solving seemed to be a helpful intervention to address the refugees' most pressing concerns, such as asylum status or family reunification. On the other hand, problem solving seemed to be overly cognitive for some participants, and it bears the risk that such practical problems become more important than the psychotherapeutic work in the sessions. The discussion across the three projects contributed to finding ways to use problem solving while keeping these downsides to a minimum.

Documentation Process

The level of detail of information provided in the adaptation template varied across studies. Researchers in two studies used the template to guide and document their process of cultural adaptation, whereas two other studies (and four sub-studies) used it to structure the documentation process retrospectively. This was mainly because in these projects, an iterative process of intervention development, cultural adaptation, and piloting had been implemented before acquiring the funding for the RCTs, and hence before the task force had started its work.

During the project, it became clear that the template required more detailed instructions on the information required in the sub-sections. In addition, researchers expressed difficulties in making decisions about cultural adaptations based on the evidence they had gathered on their target population. Two studies specifically focused on this decision-making process from formative research to adaptation (i.e., Böttche et al., 2021, this issue; Lotzin et al., 2021, this issue). Only one study documented the decision-making process itself, that is, the opinions expressed by the different researchers on the team.

Discussion

Despite the growing body of literature on cultural adaptation of psychological interventions, there is still a lack of evidence on adaptations that will contribute to increase

the feasibility, acceptance, and efficacy of such interventions. We have argued that this is mainly due to a lack of theory-based approaches to cultural adaptation (Heim & Kohrt, 2019), of systematic documentation (Harper Shehadeh et al., 2016), and of rigorous empirical studies.

In this project, a standardised documentation procedure was developed and applied across 11 studies that will evaluate psychological interventions in clinical trials with refugee populations in Germany. The parallel implementation of 11 RCTs with refugee populations provided a unique opportunity to develop and test such a standardised procedure and to better understand the process, challenges, and specific requirements of cultural adaptation in psychological trials. Experiences in this project revealed important lessons learned concerning the content (i.e., *what*) and the process (i.e., *how*) of cultural adaptation.

Regarding content, researchers in this task force described both surface and deep structure adaptations (Resnicow et al., 1999). Surface adaptations are increasingly described in the literature (e.g., Chowdhary et al., 2014). Deep structure adaptations, such as the selection or development of treatment elements in accordance with CCD and other relevant aspects, is less prominent in the literature (Hall et al., 2016). Based on the theoretical framework by Heim and Kohrt (2019), several studies included here used CCD (i.e., idioms of distress, explanatory models, and culturally salient symptoms) as a starting point for cultural adaptation. Aside from CCD, other aspects that are relevant for cultural adaptation were mentioned, such as cultural resources (Mewes et al., 2021, this issue), gender and religious aspects (Kananian et al., 2021, this issue), or cultural concepts other than CCD (e.g., attachment). Researchers considered the use of specific treatment elements in function of participants' needs and conditions, such as problem solving (Böttche et al., 2021, this issue; Kananian et al., 2021, this issue).

Regarding process, our experiences showed that the documentation system must be in place from the beginning of the adaptation process. In three studies, the adaptation was done in parallel with the work of the task force. In other studies, the adaptation process was documented retrospectively based on unpublished data, and some projects had already completed their adaptation process, with limited possibilities for retrospective documentation. It became clear that retrospective documentation is very difficult, even if unpublished data are available (e.g., transcripts from focus groups), particularly due to the difficulty to replicate the decision-making process. In addition, our experiences showed that the template for documentation should be simple and contain clear instructions to avoid additional workload for the research staff.

Decision making is a major challenge in cultural adaptation. Only one study documented the different views of the team members as a basis for decisions (Lotzin et al., 2021, this issue). Another study mentioned the risk of excluding other groups if adaptations are too specific for one particular group (Böttche et al., 2021, this issue). Our experiences show that the decision of *what* to adapt, and *why*, remains a subjective

process to some extent. In view of transparency, it is therefore essential to document the considerations behind this process, the different views of team members, and the strength of evidence that supported decisions.

That said, a further process-related lesson learned is that cultural adaptation takes time. Several studies went through an iterative process of piloting, feedback, and further adaptation. Some of the projects used culture-sensitive interventions and further adapted them to their target population (Böttche et al., 2021, this issue; Kananian et al., 2021, this issue; Lotzin et al., 2021, this issue). Keeping track of this process and documenting the different stages of adaptation is a labour-intensive and time-consuming process. One study concluded that the balance between investment (i.e., time and financial expenditure) and outcome was not yet determined (Böttche et al., 2021, this issue). Indeed, experimental studies are needed to determine the effects of cultural adaptation on the feasibility and effectiveness of interventions (Heim et al., 2020).

The present paper has several limitations. First, due to administrative reasons, not all project included in the task force were in the same adaptation phase when the task force started its activities. Some projects had concluded their cultural adaptation process, while other studies conducted the cultural adaptation as part of the task force activities. However, this allowed for considering challenges occurring at different moments throughout the cultural adaptation process, which enhanced the richness of our lessons learned. Second, all studies included in this task force were conducted in Germany, which limits the generalisability to other contexts. And third, this task force focused on the process of documentation only. Examining the effect of cultural adaptation on trial efficacy was beyond the scope of this task force. The main focus of this task force was on establishing a standardised documentation system, which will hopefully be an important step in guiding and improving the quality of cultural adaptation research in the future.

Based on our experiences, a sub-group of the task force elaborated a set of REporting Criteria for cultural Adaptation in Psychological Trials (RECAPT), which are presented in this special issue (Heim et al., 2021, this issue). As a next step, experimental research is needed to determine the impact of surface and deep structure adaptations on the acceptability and effectiveness of psychological interventions. Such experimental research may include RCTs comparing different levels of cultural adaptation (Heim et al., 2020) or other research designs like factorial experiments. In addition, standardised documentation of cultural adaptation can contribute to meta-analytic evidence, in which the association between levels of cultural adaptation and trial effectiveness is analysed in meta-regression (e.g., Harper Shehadeh et al., 2016).

In view of the increasing need to develop and test psychological interventions for diverse cultural and ethnic groups, cultural adaptation can no longer remain the unwanted stepchild in psychological science. Over the past decades, high-quality standards have been increasingly applied in clinical trials in general, which are defined in the CONSORT statement (Moher et al., 2001). Transparency and replicability are increasingly demanded

for clinical trials with psychological interventions, not least as a consequence of the open science movement. It is essential that we request the same level of quality, transparency, and replicability for cultural adaptation in clinical trials with culturally diverse groups and ethnic minorities. By using such high-quality standards, the interventions we develop will hopefully be used, have a positive effect, and help people manage their lives.

Funding: German Federal Ministry of Education and Research (01EF1806H).

Acknowledgments: The authors have no additional (i.e., non-financial) support to report.

Competing Interests: Eva Heim is one of the Guest Editors of this Special Issue of Clinical Psychology in Europe but played no editorial role in this particular article or intervened in any form in the peer review process.

Supplementary Materials

The Supplementary Materials contain the following items (for access see Index of Supplementary Materials below):

- **Appendix**
  Appendix A provides an overview table of the research projects described in this paper, i.e., target populations, target symptoms and disorders, interventions, and information on the cultural adaptation process.
- **RECAPT Template**
  A template for documenting the cultural adaptation process that was developed by the “Task force for cultural adaptation of mental health interventions for refugees”. A documented version for better understanding is provided, along with an empty template in Word format that can be used for future studies.

Index of Supplementary Materials

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Clinical Psychology in Europe (CPE) is the official journal of the European Association of Clinical Psychology and Psychological Treatment (EACLIPT).

PsychOpen GOLD is a publishing service by Leibniz Institute for Psychology (ZPID), Germany.

Latest Developments

Description of a Culture-Sensitive, Low-Threshold Psychoeducation Intervention for Asylum Seekers (Tea Garden)

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e4577, https://doi.org/10.32872/cpe.4577

Received: 2020-10-19 • **Accepted:** 2021-05-17 • **Published (VoR):** 2021-11-23

Handling Editor: Eva Heim, University of Lausanne, Lausanne, Switzerland

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Related: This article is part of the CPE Special Issue “Cultural Adaptation of Psychological Interventions”, Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: Asylum seekers often suffer from high levels of mental distress. However, as a result of a lack of knowledge about mental health and health care, as well as cultural and language barriers, the utilization of mental health care in Western host countries is often difficult for these individuals. Reducing these barriers may thus be a crucial first step towards appropriate mental health care. Previous research showed that psychoeducation may be helpful in this regard.
Method: The current manuscript describes a short, low-threshold and transdiagnostic intervention named ‘Tea Garden (TG)’. The TG aims to increase specific knowledge about mental health problems and available treatments, and may improve psychological resilience and self-care. In this manuscript, we specifically focus on culturally sensitive facets, following the framework proposed by Heim and colleagues (2021, https://doi.org/10.32872/cpe.6351), and lessons learned from three independent pilot evaluations (Ns = 31; 61; 20).
Results: The TG was found to be feasible and quantitative results showed that it was helpful for male and female asylum seekers from different countries of origin (e.g., Afghanistan, Syria,

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Pakistan, Iraq) and with different educational levels. Interestingly, even asylum seekers who had already been in Germany or Austria for three or more years benefited from the TG.
Conclusion: The TG specifically aims to be culture-sensitive rather than culture-specific, to be transdiagnostic rather than focused on specific mental disorders, and to be suitable for asylum seekers who are still in the insecure process of applying for asylum. It may also be helpful for distressed asylum seekers who do not fulfill the criteria for a mental disorder, and for healthy asylum seekers who could use the knowledge gained in the TG to help others.

Keywords

asylum seekers, culture-sensitive, knowledge, mental health (care), psychoeducation, transdiagnostic

Highlights

- There is a lack of short, low-threshold, and culture-sensitive interventions for asylum seekers.
- A transdiagnostic intervention, named 'Tea Garden' (TG), is described and findings of pilot evaluations are reported.
- The TG aims to increase knowledge about mental health (care), and improve resilience and self-care.
- The TG was found to be helpful for refugees from different origins and with different educational levels.

The prevalence of mental disorders in refugees and asylum seekers[1] is high, as they have frequently experienced different kinds of hardship and traumatic situations (Blackmore et al., 2020; Henkelmann et al., 2020). Even when asylum seekers have arrived in a safe host country, factors such as a lengthy asylum procedure, fear of deportation, or ethnic discrimination pose a risk for the aggravation or new manifestation of mental health problems (Gleeson et al., 2020). Despite high levels of mental distress, access to mental health treatment for asylum seekers is limited (Björkenstam et al., 2020; Führer et al., 2020). This is mainly a result of barriers such as a general lack of knowledge about mental disorders and mental health care, but is also caused by limited access to health care systems in host countries, cultural understanding and stigmatization of mental disorders and mental health care, and language barriers (Grupp et al., 2019; Mårtensson et al., 2020).

Systematic reviews have revealed that psychoeducation improves specific knowledge about mental disorders (e.g., about possible causes, typical symptoms of a disorder,

1) 'An asylum seeker' is defined as a person who is seeking international protection and whose claim for asylum has not yet been finalized. If protection is granted according to the 1951 Refugee Convention, the person is recognized as a 'refugee'. Accordingly, all refugees were initially asylum seekers. Many of the studies cited investigated both asylum seekers and refugees. Because of the current study's focus, we primarily use the term 'asylum seekers' and speak of refugees only if they are specifically addressed.

factors influencing the symptoms) and psychosocial functioning, including coping with symptoms, and reduces distress for people suffering from mental disorders (Barnicot et al., 2020; Tursi et al., 2013). Colom (2011, p. 339) defines psychoeducation "as a patient's empowering training targeted at promoting awareness and proactivity, providing tools to manage, cope and live with a chronic condition …, and changing behaviours and attitudes related to the condition." Consequently, psychoeducation may be an effective intervention to improve the mental health knowledge and to enable an initial mental health improvement of different cultural groups of asylum seekers in Western host countries. Such a psychoeducation intervention should be adapted to a degree that allows its use in different cultural groups (i.e., being culture-sensitive; e.g., see the suggestions on cultural adapted cognitive behavioral therapy by Hinton et al., 2012) rather than focused on one specific culture or group (i.e., culture-specific; e.g., see the examples and recommendations for specific cultural/ethnic groups by Smith et al., 2011). However, this type of psychoeducation for asylum seekers is lacking. Therefore, we developed a short, culture-sensitive intervention, named Tea Garden (TG). We chose this name because a tea garden is a familiar concept for many migrants from different regions of origin and is often associated with a positive situation. We wanted to avoid difficult names or labels (e.g. psychotherapy or psychological) that could discourage interested persons as a result of a lack of knowledge about psychotherapy and psychological interventions or a possible fear of stigmatization. Our focus was on reducing distress and increasing knowledge about the development of mental disorders, resources to cope with mental distress, and interventions, that were assumed to be of particular relevance for asylum seekers. In line with Betsch and colleagues, we aimed for a "deliberate and evidence-informed adaptation of health communication to the recipients' cultural background in order to increase knowledge and improve preparation for medical decision making and to enhance the persuasiveness of messages in health promotion" (Betsch et al., 2016, p. 813). We did not limit culture to the nationality or a set of habits and beliefs, but also account for the particular sociodemographic, legal, and living situation of asylum seekers (e.g., Napier et al., 2014).

Our main aim (I) in this paper is to describe the TG with a specific focus on culturally sensitive facets, following the framework proposed by Heim and colleagues (2021, this issue). Additionally, we provide summarized findings (II) from pilot evaluation studies with regard to the acceptability and feasibility of the TG, as well as lessons learned.

Description of the Tea Garden (TG)

The TG was developed as part of the project 'Psychotherapeutic first aid for asylum seekers living in Hesse' funded by the European Refugee Fund, EFF-12-775 (Mewes et al., 2015). The aim of the TG is threefold: (1) to increase knowledge about mental disorders most relevant for asylum seekers, psychological and psychiatric treatments, mental

health care in the resettlement country, and the special access conditions for asylum seekers in this regard; (2) to reduce stigmatization of mental disorders and mental health care, and thereby increase openness to psychotherapy and psychiatric treatments; and (3) to strengthen psychological resources and achieve first reduction of mental distress.

Team of Developers

The developing team comprised members from different countries of origin and different cultural backgrounds (e.g., Persian, Arabic, Kurdish, Turkish), some of them with a refugee background, psychotherapists working with asylum seekers, and researchers in the field of intercultural psychology.

Target Population

The target group for the TG consists of asylum seekers who have recently arrived in a host country (e.g., max. 18 months), are still in the process of applying for asylum, and may suddenly be transferred to other cities or Federal states during their asylum procedure. Participants may be mentally distressed or suffer from a mental disorder, but this is not mandatory for participation. The TG is transdiagnostic and may even be helpful for healthy asylum seekers who could use the knowledge gained in the TG to help others.

General Implementation of the TG

With the aid of interpreters, the TG is provided in a group format to provide help to several asylum seekers simultaneously. The TG consists of four modules (A-D): Module A) establishing trust and confidence; Module B) symptoms of mental disorders; Module C) resources and self-care, and Module D) treatment options. These modules are interactively presented in two 90-minute sessions delivered one week apart in groups of approximately six participants (detailed information can be found in the German manual, Mewes et al., 2015). This schedule is considered short enough to reach many target clients, but long enough to provide the required information in a relaxing and interactive manner.

A group setting is applied to enhance social support and mutual exchange, and to take into account the mainly collectivistic background of the main groups of asylum seekers (in Western host countries) as well as shared pre-, peri-, and postmigration experiences (Kananian et al., 2017; Kira et al., 2012). These benefits are assumed to outweigh possible disadvantages, such as reservations to participate in a group (e.g., worries about confidentiality and being stigmatized), the limited consideration of individual problems, and the therapists' necessity to closely monitor not only the content but also the group process (Kira et al., 2012).

Tea and food are offered to promote a relaxing and welcoming atmosphere. In addition, the TG uses images/ illustrations, symbols (e.g., rope, flowers, stones, spinning top) and familiar metaphors in order to facilitate communication and to adapt to different educational levels. Its material is free of written language or complicated figures, and operates best in gender- and language-homogenous groups of five to seven participants.

Components and Contents of the Intervention

Based on a literature review and our own work (Hinton et al., 2012; Reich et al., 2015) as well as advice from experienced psychotherapists in the field, we included several treatment components in order to foster confidence and therapy motivation, and thus to increase the usefulness of the TG. With regard to *specific components,* i.e. components that have specific relevance for the aims of the TG, we focused on psychoeducation (e.g., explaining that traumatic events can cause symptoms, explaining the concept of psychotherapy), strengthening resources (e.g., introducing possible resources, initiating exchange about useful strategies for coping and how to implement them in the daily life), giving hope (e.g., by explaining that symptoms can improve with the right care), and reducing stigmatization (e.g., by initiating exchange about problems and by emphasizing that persons with mental problems are not 'mad'). In addition, we included several *unspecific components* that should support the implementation of the TG (but do not specifically relate to the aims of the TG) such as guiding through the sessions (e.g., by outlining the structure of the sessions and monitoring the time), normalizing (e.g., by explaining that experiencing symptoms such as worries and flashbacks after traumatic events is normal), discussing advantages of and barriers to treatments (e.g., by asking for the participants' views on psychopharmacological treatments, by explaining how to get a psychotherapy and addressing possible barriers), monitoring the distress level of participants (e.g., by working with two therapists and a limited number of participants, one therapist can watch out for signs of distress), and interrupting participants when narratives become too personal/ distress becomes too high (this is part of a set of group rules which are introduced at the first session). Moreover, *in-session techniques* such as behavioral experiments (relaxation) and exchange between group participants were included to this end.

In order to consider relevant *target syndromes, needs, and concepts of distress* (Lewis-Fernández & Kirmayer, 2019) of our target group, the following contents were included in the TG:

i. *Explanatory models, etiological assumptions.* Based on a literature review (e.g., Liedl et al., 2010), we used a body-mind metaphor for the description of a traumatic event and the care and healing related to this event (i.e., the mind can be wounded by traumatic events; this wound is similar to a wound on the hand after a cut; wounds

in the mind may cause symptoms; and the wound must be nursed and will then heal, leaving a scar).

ii. *Symptom patterns and socially acceptable terms for expressing distress.* The higher relevance of bodily symptoms in many groups of immigrants in Western host countries and culture-specific symptoms such as 'burning liver' or 'pulling hair' was accounted for by explicitly introducing these symptoms (among others) with drawings as part of a module about symptoms (Module B). This decision was based on a literature review (e.g., Hinton et al., 2012; Rometsch et al., 2020) and experiences from the team of developers.

Culturally salient resources. As many groups of asylum seekers in Western host countries highly value religion and faith, and have strong ties within the ‘extended family’, these potential resources were introduced as part of the module on resources and self-care (Module C). This decision was based on a literature review, our own scientific work (e.g., Grupp et al., 2019), and advice from the team of developers.

Suggested Outcome Measure

In line with trials offering psychoeducation interventions for persons with serious mental illnesses (e.g., Zhao et al., 2015), the primary outcome for evaluations of the TG should be *changes in specific knowledge* with regard to mental health (please see the Appendix in the Supplementary Materials for suggestions on measures of the other aims of the TG). Moreover, the feasibility and acceptability of the TG should be assessed, e.g., the atmosphere, the comprehensibility, and the communication, as well as the personal benefit, relief, and perceptions of resources.

For the three pilot studies reported below, a questionnaire developed by our work group was used (Demir et al., 2016). This questionnaire assessed self-reported knowledge on 1) symptoms of mental disorders, 2) resilience and coping strategies, and 3) mental health care offered in the country. To facilitate assessment in illiterate and low-educated participants, we aimed for easy language and used smileys to indicate negative to positive response or low to high agreement and a right-angled triangle symbol to indicate increase in knowledge (range 1 = *not at all* to 5 = *very much*; the higher the value the more positive the assessment), respectively. Moreover, feedback on the personal benefits, and suggestions for improvement, could be given using free text.

Findings From First Evaluations of the Tea Garden and Lessons Learned

Three independent pilot evaluations were conducted with a focus on acceptance, feasibility, first hints of possible effectiveness, as well as lessons learned (mainly based on anecdotal reports of the researchers, and the therapists who conducted the TGs, and

written and verbal feedback of participants). Two pilot evaluations were conducted in Germany (Bogdanski et al., 2019; Demir et al., 2016) and one in Austria. Most participants came from Syria, Afghanistan, Pakistan, or Iraq. More detailed information is provided in the Appendix (see Supplementary Materials). By reason of the low-threshold character of the TG, participants in the pilot evaluations were not screened for mental disorders. The outcome assessments were conducted after each TG session and were supported by interpreters when necessary. After the TG, participants reported increased knowledge about mental health care, psychotherapy and self-help options, relief for general distress, improved perceptions of resources, and high overall satisfaction with the program.
Lessons learned:

i. To facilitate recruitment, potential participants needed to be educated in detail about the program, and it was necessary to establish trust, be patient, and build a network of contact persons.
ii. The outcome assessment was too complex and unfamiliar for some participants, and was simplified by only using smileys.
iii. Some participants erroneously expected to learn about asylum procedures. Therefore, flyers and invitations should be phrased very clearly and highlight the content of the TG.
iv. Even asylum seekers with longer durations of stay (e.g. three years and more) appreciated the TG.
v. The illustrations used in the TG were complemented by new illustrations in order to enhance the variety of shown human appearances and the fit for different groups of asylum seekers.
vi. The larger the size of the group the more likely conflicts between participants may emerge. We thus suggest to limit the number of participants to eight.

Discussion

In contrast to other interventions, the TG specifically aims to be culture-sensitive rather than culture-specific, to be transdiagnostic rather than focusing on specific mental disorders, and to be suitable for asylum seekers who are still in the insecure process of applying for asylum. The three independent pilot evaluations demonstrated the feasibility of the TG and its acceptance with regard to different countries of origin, spoken languages, educational levels, and durations of stay in the host countries. Moreover, they provided us with important lessons for the future recruitment of potential participants, appropriate designs for the outcome assessment, the materials used, and the recommended group size. In general, our findings suggest that the TG may be a useful first step to improve mental health care for asylum seekers. However, the generalizability and explanatory power of the presented results is limited by the single-group designs, and the lack of pre-post comparisons as well as follow-up assessments that would provide

information about the sustainability of possible benefits. These limitations will now be tackled by the multicenter randomized controlled trial 'Efficacy of Low-threshold, Culturally Sensitive Group Psychoeducation in Asylum Seekers' (LoPe; DRKS00020564), where the participants will be randomized to either the TG or a waitlist control group and changes in knowledge will be assessed pre- and postintervention as well as two and six months later.

Following the example of other projects that successfully used brief psychological interventions to reduce the treatment gap for common mental disorders in affected groups, such as the Friendship Bench project in Zimbabwe (Chibanda et al., 2016) or the Self-Help Plus project in Uganda (Tol et al., 2020), the TG might best be implemented via psychologists working in asylum facilities, trained and supervised social workers or even lay facilitators, depending on the local means and structures. By being culture-sensitive and very low-threshold, the TG considers the high diversity of asylum seekers living in Western host countries (e.g., with regard to their countries of origin, their ethnicity, religion, education level, asylum status, distress level, etc.) and avoids the discrimination of specific (often particularly marginalized) groups. The TG may, thus, be considered as a broadly applicable first-line mental health intervention.

Funding: Parts of this study were funded by the European Refugee Fund (EFF-12-775). The LoPe study is funded by the German Ministry of Education and Research (01EF1804B).

Acknowledgments: We thank Mag.[a] Vesna Maric Medjugorac (Caritas Vienna) for supporting the pilot evaluation 3.

Competing Interests: Cornelia Weise is one of the Editors-in-Chief of *Clinical Psychology in Europe* but played no editorial role in this particular article or intervened in any form in the peer review process.

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Supplementary Materials

The Supplementary Materials contain suggestions for the measures of the aims two and three of the Tea Garden and more detailed information about findings from the first evaluations of the Tea Garden and lessons learned (incl. two Tables) (for access see Index of Supplementary Materials below).

Index of Supplementary Materials

Mewes, R., Giesebrecht, J., Weise, C., & Grupp, F. (2021). *Supplementary Materials to "Description of a culture-sensitive, low-threshold psychoeducation intervention for asylum seekers (Tea Garden)"* [Additional information]. PsychOpen GOLD. https://doi.org/10.23668/psycharchives.5030

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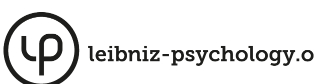

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Latest Developments

Cultural Adaptation of CBT for Afghan Refugees in Europe: A Retrospective Evaluation

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e5271, https://doi.org/10.32872/cpe.5271

Received: 2020-11-25 • **Accepted:** 2021-05-09 • **Published (VoR):** 2021-11-23

Handling Editor: Eva Heim, University of Lausanne, Lausanne, Switzerland

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Related: This article is part of the CPE Special Issue "Cultural Adaptation of Psychological Interventions", Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Abstract

Background: Culturally adapted CBT (CA CBT) is a well-evaluated, culture-sensitive intervention for refugees that utilizes psychoeducation, problem solving training, meditation, and stretching exercises. However, there is a lack of standard procedures for adapting psychotherapeutic interventions to a specific cultural context. Our working group adapted CA CBT for Afghan refugees at two different stages, which yielded promising results from a pilot trial and an RCT with a waitlist control group. This article aimed to illustrate the ongoing adaptation process of CA CBT for Afghan refugees over the course of several trials and to highlight potential limitations by evaluating how systematic adaptations were performed.

Method: The adaptation process of CA CBT was described in detail, including the methods and rationale for changes to the protocol. This process was analyzed according to a new set of proposed reporting criteria.

Results: According to the defined target population and based on multiple research strategies, culturally-specific components, such as the rationales for interventions, metaphors, and idioms of distress, were adapted. Relevant surface adaptations were implemented. However, although the steps of our adaptation process corresponded with the reporting criteria, some of the adaptation processes did not follow explicit criteria but resulted from implicit judgments.

Conclusion: In the future, compliance with and the documentation of adaptation processes following explicit guidelines are crucial for the transfer of evidence-based approaches for managing the diversity of refugee populations.

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Keywords

reporting criteria, cultural adaptation, Afghan refugees, transdiagnostic, group therapy

Highlights

- The reporting criteria (Heim et al., 2021, this issue) can be applied to analyze the documentation process of cultural adaptation in a post hoc analysis.
- The documentation process of culturally adapted CBT for Afghan refugees shows a high agreement with the reporting criteria.
- This detailed documentation of the adaptation process for Afghan refugees may facilitate the cultural adaptation for similar subgroups in future studies.

Approximately 18% of the refugees arriving in Germany in 2016 originated from Afghanistan. Epidemiological studies revealed high prevalence rates for PTSD (32.2%), affective disorders (21.9%), and anxiety disorders (33.9%) among Afghan refugees (Richter et al., 2015). In Afghanistan, war and armed conflicts have occurred since 1979, with only short periods of truce. However, after fleeing and seeking asylum in Western countries, distress can persist, due to long asylum procedures and restrictive housing regulations. This postmigration stress may contribute to the worsening or even development of psychopathological symptoms (Li et al., 2016; Miller & Rasmussen, 2017; Schock et al., 2016). A noticeable gap between the high prevalence rates of mental disorders and the low rates of seeking of treatments (German organization for psychotherapists [BPtK], 2015) may indicate a low acceptance and familiarity with CBT among Afghan refugees, which is also reflected by the higher dropout rates (de Haan et al., 2018). This may be related to the Western influence on CBT and how this may conflict with the values of ethnic minorities (Scorzelli & Reinke-Scorzelli, 1994).

As a low-threshold and easily accessible program, culturally adapted CBT (CA CBT), which was developed by Hinton et al. (2005), was chosen as the basic treatment concept (Hinton et al., 2005, 2009). Although other CBT interventions, as well as trauma-focused approaches, have been culturally adapted and evaluated with promising results (Hall et al., 2016; Shehadeh et al., 2016), CA CBT has been evaluated for several ethnicities, including Cambodian, Vietnamese, Egyptian, and Hispanic refugees (Hinton et al., 2005; Jalal et al., 2017). The treatment program focuses on the development of resilience, psychological flexibility, and emotional regulation. Furthermore, the group setting of CA CBT aims at overcoming the often experienced sense of isolation and in helping to establish new social networks. Finally, within a stepped care approach, CA CBT can be integrated into existing community settings and activities; thus offering the perspective to meet some of the principles that have been postulated for an ecological approach to mental health care for refugees (Miller & Rasco, 2004). As a theoretical framework for the adaptation process, we followed the guidelines by Barrera et al. (2013), which included five stages: information gathering, preliminary adaptation design, preliminary adaptation

tests, adaptation refinement, and cultural adaptation trials. Although the effectiveness of cultural adaptation has been shown in several meta-analyses (Hall et al., 2016; Shehadeh et al., 2016), there is currently a lack of standardized documentation criteria. In this article, we aimed to illustrate the adaptation process of CA CBT for Afghan refugees and to depict the adaptations that were administered throughout ongoing trials by applying the criteria for reports of cultural adaptation, as suggested by Heim et al. (2021, this issue).

Culturally Adapted CBT (CA CBT)

The program is conceptualized as being resilience-focused and subclinical, and it can be delivered in an individual or group setting and includes 14 sessions. Interventions, such as psychoeducation, stretching, meditation, guided imagery, and cognitive techniques (e.g., Socratic questioning), are a part of each session. It should be mentioned that due to its resilience-focused and transdiagnostic nature, CA CBT does not include prolonged exposure to trauma memories; instead, it focuses on emotional regulation and addresses different psychopathological symptoms, including depression, anxiety disorders, and somatic symptoms, as well as related disorders.

The original CA CBT group program by Hinton contained transcultural concepts and key idioms of distress, such as "thinking a lot" (Hinton et al., 2016), which are meant to be suitable for a variety of ethnic groups and were included in the protocol for Afghan refugees. Additionally, Hinton and colleagues (Jalal et al., 2017) adapted specific components, such as the rationales for meditation and guided imagery, for refugees from Middle Eastern Islamic cultures. The analysis of the modifications in the different protocols by Hinton and colleagues provided a blueprint of scalable components that we used to adapt the program to the Afghan culture.

Method

Focus Groups

Subsequently, for the pilot trial (Kananian et al., 2017), a focus group was conducted to assess the experiences of the participants. In addition, the proposed changes to the ongoing CA CBT trials were evaluated. The focus group consisted of $N = 7$ participants who had participated in the group program and whose native language was Farsi/Dari; additionally, the participants were male and over 18 years of age. The interview was conducted for approximately one hour and was audio-recorded, transcribed, and translated into German. The results were discussed by a group of experts, native speakers, and key informants. No specific qualitative analysis of the data was applied.

Experts were defined as professionals who had been working in the field of counseling psychotherapy with refugees or migrants for at least three years.

Adaptations Following the Reporting Criteria

In the following, cultural adaptions of the CA CBT are described based on the Reporting Criteria by Heim and colleagues (2021, this issue).

Definition of the Target Population

At an early stage, we defined Farsi- and Dari-speaking refugees as the target population. In addition to Afghan and Syrian refugees, Iranian refugees constituted the third largest group of refugees in Germany in 2015 (Richter et al., 2015). We discussed similarities between Afghan and Iranian cultures. Although key informants raised concerns regarding potential conflicts between these two groups, due to their major differences in history and culture, many cultural similarities were recognized. This was also reflected in several articles that included Afghan and Iranian patients in a joint sample (e.g., Shishehgar et al., 2015; Steel et al., 2011). Nevertheless, throughout the group program, we identified idioms of distress that were not understood by all of the participants.

Cultural Concepts of Distress

Literature Review — We mostly derived the cultural concept of distress (CCD) for Afghan and Iranian refugees from qualitative studies that were conducted via interviews with Afghan populations (Alemi et al., 2016; Sulaiman-Hill & Thompson, 2011; Yaser et al., 2016). After a thorough review of the existing literature following idioms of distress for Farsi/Dari-speaking refugees, we included 'asabi' (nervous agitation), 'gham' (sadness), 'jigar khun' (a general expression of intense psychological distress), 'tashwee-sh' (worry, as proposed by Miller et al., 2006), 'goshe-giri' (self-isolation), 'fekro khial' (rumination and worrying), and 'faramooshi' (forgetfulness, as proposed by Alemi et al., 2016).

Qualitative Interviews — First, we evaluated CA CBT in individual treatments of Afghan refugees. After the treatment, we interviewed the respective patients and integrated specific suggestions into the first group manual. Many patients expressed concerns that "[they] might go crazy" and that the occurrence of the symptoms was a consequence of personal sin. Although we did not systematically analyze the qualitative data, we extended the CCD by the information that was gathered through these interviews. Further idioms of distress were identified through interviews with key informants and experts.

Formative Research

Although the main aspects of the adaption process in addition to the publications of the pilot trial and the RCT (Kananian et al., 2020) were reported, no additional papers on formative research were published.

Documenting the Decision-Making Process

We documented the statements of the experts, key informants, and native speakers who were involved in the adaptation process. Nevertheless, we did not systematically document how specific decisions were derived.

Team and Roles — Professor Devon E. Hinton, Associate Professor of Psychiatry, developed the original protocol of CA CBT for several ethnic groups (Hinton et al., 2005, 2009; Jalal et al., 2017).

Professor Ulrich Stangier, Professor in Clinical Psychology and Psychotherapy, who is the head of the Center for Psychotherapy and of the counseling center for refugees, as well as a supervisor and licensed psychotherapist.

Ph.D. Sarah Ayoughi, who had many years of experience in counseling in Kabul, Afghanistan, and in speaking Farsi/Dari.

Monitoring and Documentation — The adaptation process did not follow a documentation or monitoring methodology.

Diagnostics and Outcome Assessment

Clinical Interviews — All of the diagnostic interviews were conducted by independent Farsi-speaking postgraduate psychologists. The M.I.N.I. in the original English version (Sheehan et al., 1998) was used for the assessment, whereas key symptoms of the respective disorders were translated in advance for a more fluent and standardized assessment.

Questionnaires — If they were not already available and validated in Farsi, all of the instruments were translated and back-translated, in accordance with the suggested standard procedure that were proposed by van Ommeren et al. (1999).

Deep Structure Adaptations

Specific Components — *Inner Child Metaphor.* Some trauma-focused approaches to PTSD use the inner child metaphor to explain symptoms and trauma-related catastrophic cognitions (Hestbech, 2018). We did not-presume the use of this technique because it was not accepted by refugees who were individually treated. Instead, we used the metaphor of an alarm system, which was suggested to be more neutral and accessible for our specific refugee group. Nevertheless, we used the “soothing” metaphor for emotion regulation processes that were associated with the awareness of a secure environment.

Meditation and Guided Imagery. Due to the fact that association with positive imagery is one of the key techniques for bridging cultural barriers in psychotherapy with refugees (Hinton et al., 2005), we included guided imagery of a peaceful garden (‘bagh’) for Afghan refugees.

Problem-Solving Training. Inspired by treatments that were developed in programs by Rahman et al. (2016) and Sijbrandij et al. (2017), we added problem-solving training to the treatment program, which was labeled CA CBT+. Moreover, the implementation of problem-solving targets was meant to empower patients to take independent actions within their social contexts, to further their basic needs, and to broaden their socioeconomic adversities, as suggested by Miller and Rasco (2004).

Unspecific Components — The explanation of the treatment rationale was adapted to make it plausible and meaningful for the patients. When conveying information about the treatments to the patients, the detected CCDs and adapted specific components were taken into account to provide the treatment rationale in a culturally sensitive (e.g., values) and culturally understandable (e.g., easy language) manner. Our therapists were native speakers, which included different nonspecific components, such as a sense of belonging-and familiarity.

Surface Adaptations — All of the interventions (psychoeducation, problem solving training, yoga/stretching, and meditation) were explained in short written handouts in Farsi. To improve the comprehension of this information, these handouts were also audio-recorded, and both the written handouts and audiotaped information were uploaded on a website that was accessible by the participants (Stangier et al., 2020).

Mode of Delivery — CA CBT is available as an individual and as a group treatment. We chose a group setting for the following reasons: destigmatization through exchanges about symptoms with members of the same culture or peer group, the use of group cohesion to enhance feelings of connectedness, and dialogue about one's experience regarding the asylum procedures.

Translation — Due to the fact that all of the group therapists were native speakers, no translations were required in addition to the material.

Matching Materials — All of the material was edited in a culturally sensitive manner and translated into Farsi/Dari via translation and retranslation. Cultural sensitivity, as for all of the other aspects of the adaptation procedure, implies the consideration of the cultural concepts of distress, gender, or religious aspects that may conflict with the values that are present in Afghan society (Eggerman & Panter-Brick, 2010). To ensure easier access to the content, audio material was prepared.

Documentation of Adaptations During the Trials ("on the Fly")

Some of the on-the-fly adaptions were incorporated into the group manual (Stangier et al., 2020). For example, problem-solving training has been misunderstood as a technique for simultaneously solving all problems. The rationale for the selection of problems

was explained as "picking only one stone at once from mountain". However, we did re-evaluate on-the-fly adaptation through further discussions.

Discussion

The examination of how we adapted CA CBT to Afghan refugees in Germany comprised a complex sequence of implicit and explicit developmental steps over three years. To analyze this process in a post hoc manner, we applied the criteria as suggested by Heim et al. (2021), this issue.

The process clearly showed that cultural adaptation contains multiple levels and aspects of an intervention, and the feedback of our interviews demonstrated its major contribution to the acceptance and, thereby, to the potentially increased effectiveness of an intervention. Due to the staged nature of cultural adaptation, even in our case of adapting an intervention that was already adapted to another culture, it remains a highly difficult and nearly impossible challenge to document all of the facets. This can be illustrated by the Farsi idiom for "thinking too much". After the decision for the Farsi idiom "fekro khial", we had experiences with several interpreters who suggested other translations that would be more adequate regarding the meaning of the original idiom. Throughout the varying translations of "thinking too much", we also experienced mixed reactions from patients. The specific interpretation of the idiom that was used was dependent on the region that the patient came from. This effect demonstrated how cultural adaptation can be a meandering procedure at various times. Detailed documentation may enable other mental health professionals to profit from the thoughts, ideas, and particular adaptation steps for their own adaptation process. Our documentation shows adaptation at different steps in a way that can possibly be exemplary for other professionals. When regarding adaptation to other target groups, it may be possible to transfer or adjust adaptations, due to detailed documentation.

In the clinical context, we assume that a complete traceability of adaptations will enhance the adherence of therapists for adaptations that may seem alien to them. Furthermore, knowledge of the reasons for adaptations will increase the cultural sensitivity of mental health professionals, not only for the specific intervention, but also for the entire treatment situation. This may prevent other misunderstandings.

Nevertheless, this complexity in the communication between therapists and refugees highlights how important it is to control as much of the process as possible, in order to make the process as transparent and comprehensive as possible. Only through a standardized approach for cultural adaptation can the need for culturally sensitive psychotherapy be met. The application of explicit criteria is an important tool for establishing a standard procedure for cultural adaptations.

Funding: This work was supported by the Bundesministerium für Bildung und Forschung (grant no.: 01EF1804A).

Acknowledgments: The authors have no additional (i.e., non-financial) support to report.

Competing Interests: The authors have declared that no competing interests exist.

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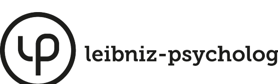

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Latest Developments

From Formative Research to Cultural Adaptation of a Face-to-Face and Internet-Based Cognitive-Behavioural Intervention for Arabic-Speaking Refugees in Germany

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e4623, https://doi.org/10.32872/cpe.4623

Received: 2020-10-30 • **Accepted:** 2021-06-17 • **Published (VoR):** 2021-11-23

Handling Editor: Cornelia Weise, Philipps-University of Marburg, Marburg, Germany

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Related: This article is part of the CPE Special Issue "Cultural Adaptation of Psychological Interventions", Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: This study aims to provide a transparent and replicable documentation approach for the cultural adaptation of a cognitive-behavioural transdiagnostic intervention (Common Elements Treatment Approach, CETA) for Arabic-speaking refugees with common mental disorders in Germany.

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Method: A mixed-methods approach was used, including literature review, interviews, expert decisions and questionnaires, in order to adapt the original CETA as well as an internet-based guided version (eCETA). The process of cultural adaptation was based on a conceptual framework and was facilitated by an adaptation monitoring form as well as guidelines which facilitate the reporting of cultural adaptation in psychological trials (RECAPT).
Results: Consistent with this form and the guidelines, the decision-making process of adaptation proved to be coherent and stringent. All specific CETA treatment components seem to be suitable for the treatment of Arabic-speaking refugees in Germany. Adaptations were made to three different elements: 1) Cultural concepts of distress: a culturally appropriate explanatory model of symptoms was added; socially accepted terms for expressing symptoms (for eCETA only) and assessing suicidal ideation were adapted; 2) Treatment components: no adaptations for theoretically/empirically based components of the intervention, two adaptations for elements used by the therapist to engage the patient or implement the intervention (nonspecific elements), seven adaptations for skills implemented during sessions (therapeutic techniques; two for eCETA only) and 3) Treatment delivery: 21 surface adaptations (10 for eCETA only), two eCETA-only adaptations regarding the format.
Conclusion: The conceptual framework and the RECAPT guidelines simplify, standardise and clarify the cultural adaptation process.

Keywords
cultural adaptation, transdiagnostic, refugees, decision-making process

Highlights

- The framework and the guidelines allow for a reproducible and systematic cultural adaptation.
- The flexible and simple format of the original CETA manual requires mainly surface adaptations.
- eCETA requires additional adaptations compared to the face-to-face version.

Arabic-speaking refugees from the MENA (Middle East and North Africa) region have constituted the largest group of refugees in Germany in recent years (Federal Office for Migration and Refugees, 2020). Epidemiological studies on the mental health of asylum seekers and refugees indicate high prevalence rates of mental disorders, especially for posttraumatic stress disorder (PTSD) and depression (Nesterko et al., 2020; Turrini et al., 2017).

Despite the need for psychological treatment among refugees, only a minority utilise specialised mental health care services. Göpffarth and Bauhoff (2017) reported that refugees in Germany have six psychotherapist contacts per 1,000 health-insured persons, compared to 20 contacts for non-refugee persons. Reasons for this treatment gap lie in structural barriers (e.g. difficult to access the health system, post-migration difficulties,

regional lack of trained therapists, long waiting lists) and cohort-specific characteristics (e.g. language, fear of stigmatisation, comorbid disorders), but are also due to a general lack of psychotherapeutic treatments for culturally diverse groups (Colucci et al., 2015; Sijbrandij, 2018).

Transdiagnostic approaches seem to be especially promising for the treatment of a wide range of psychological symptoms, as they can be effectively applied for different and comorbid disorders (Newby et al., 2015; Reinholt & Krogh, 2014). A prominent evidence-based transdiagnostic approach for war-torn populations is CETA (Common Elements Treatment Approach; Murray et al., 2014, Supplement 1: modules and content). CETA has proven to be effective in reducing common mental health problems in culturally diverse settings in low- and middle-income countries (e.g. Zambia: Kane et al., 2017; Iraq: Weiss et al., 2015). It addresses symptoms of depression, anxiety, substance use and trauma-related disorders, and follows a tailored approach, i.e. element selection, sequencing and dosage vary depending on symptom presentation. CETA might also be a promising approach to reduce the treatment gap for refugees in European countries.

Additionally, an internet-based format would enable a wider reach, since it does not depend on geography (e.g. lack of trauma therapists in the local area), and communication between client and counsellor can be asynchronous. An internet-based version could also overcome the fear of stigmatisation due to the visual anonymity of the online format. As many refugees in high-income countries use the internet (Gillespie et al., 2016), internet-based interventions are easily accessible for refugee populations.

In order to tailor mental health interventions to the context and needs of diverse cultural groups, there has been an increasing focus on culture-sensitive interventions. Meta-analyses generally indicate a superiority of culturally adapted interventions for the respective target group over non-adapted interventions (Hall et al., 2016; Harper Shehadeh et al., 2016), although it should be noted that most adaptations did not follow a systematic procedure, thus limiting the ability to compare and replicate their findings.

To overcome this weakness, a conceptual framework for cultural adaptation of interventions for common mental disorders was developed (Heim & Kohrt, 2019). This framework consists of three main elements: 1) cultural concepts of distress, including cultural explanations, cultural syndromes, idioms of distress; 2) treatment components, comprising specific and unspecific elements and therapeutic techniques; and 3) treatment delivery including delivery format, surface adaptation and setting. Specific elements refer to interventions that are based on theoretical assumptions, such as behavioural or cognitive approaches; unspecific treatment elements are the common factors such as the therapeutic relationship or providing a meaningful treatment rationale; and therapeutic techniques refer to exercises and other interventions that are undertaken to transmit the therapeutic components, such as role plays or homework (Singla et al., 2017). In addition, the framework by Heim and Kohrt (2019) includes “surface adaptations”, which refer to matching materials and illustrations to the target population (Resnicow et al.,

1999). This framework has been extended and translated into a set of reporting criteria for the cultural adaptation of psychological interventions (Heim et al., 2021, this issue; Supplement 2).

In conclusion, some of the existing barriers to psychological treatment provision for refugees in Europe might be addressed by culturally adapted and transdiagnostic interventions with different delivery formats. Thus, the aim of the present study was to conduct a culture-sensitive adaptation of a cognitive-behavioural transdiagnostic intervention (CETA) for Arabic-speaking refugees with common mental health disorders in Germany in a transparent and replicable manner, based on the framework (Heim & Kohrt, 2019) and the guidelines of reporting cultural adaptation in psychological trials (RECAPT, Heim et al., 2021, this issue). The study focuses on the decision-making process, i.e., the process from assessing cultural concepts of distress to adapting treatment components. The adaptation was conducted both for the original face-to-face context and for an internet-based context (eCETA).

Method

Procedures and Participants

The process of cultural adaptation in this study used the RECAPT guidelines (Heim et al., 2021, this issue), and consists of six steps (details on the procedures followed and the study participants are presented in Supplement 2, RECAPT guidelines; Supplement 3, adaptation monitoring form, and Supplement 4, COnsolidated criteria for REporting Qualitative research [COREQ] checklist):

First, in a workshop with the CETA developers as well as in discussions of the research team, all interventional components (e.g. treatment components, therapeutic techniques, expressions) were identified in the treatment manual and included in the free list and key informant interviews in Step 3.

Second, a literature review was conducted regarding existing cultural concepts of distress among Arabic-speaking persons in the MENA region (e.g. idioms of distress, cultural explanations).

Third, semi-structured interviews and focus groups were conducted to discuss cultural concepts of distress and treatment components with Arabic-speaking refugees/migrants and mental health experts. Participants included i) Arabic-speaking potential users without a medical and/or psychosocial background (AU, Arabic Users; n = 20); ii) Arabic-speaking mental health professionals with a migration and refugee background (AP, Arabic Professionals; n = 11); iii) mental health experts working with refugees in different institutions in Germany (HE, Health Experts; n = 6). Additionally, two focus groups of Arabic-speaking mental health professionals (male and female) discussed inconsistent results of the interviews (FG, n = 7). The structure of the interviews and focus

groups was based on Module 1 of the established Manual for Design, Implementation, Monitoring, and Evaluation of Mental Health and Psychosocial Assistance Programs for Trauma Survivors in Low Resource Countries (Applied Mental Health Research Group, 2013). The interviews were carried out on the basis of semi-structured interviews. Each type of interview contains different, non-overlapping closed and open-ended questions. In addition to the interviews, potential users (AU, n = 20) and Arabic-speaking professionals (AP, n = 11) also completed the "Barts Explanatory Model Inventory-Checklist" (BEMI-C), which assesses cultural concepts of distress (Rüdell et al., 2009).

Fourth, all adaptations and examinations were listed and summarised in a monitoring form (Supplement 3, Heim et al., 2021, this issue).

Fifth, final agreements on the adapted version were made with the help of four independent Arabic-speaking experts, who evaluated the suggested adaptations based on the aforementioned steps (Supplement 3).

Sixth, any differences between the preliminary adapted version and the experts' suggestions were discussed within the research team and a final decision was made (Supplement 3).

Data Collection

After receiving information about the study, participants signed an informed consent form prior to participating in the interviews/focus groups. All forms were provided in Arabic. The interviews (AU, AP) and the FG were conducted by Arabic-speaking trained interviewers. All interviews/FGs were audio-recorded, and the recordings were summarised and translated into German. An interview ID was assigned by the first author, who kept an encrypted digital document with the identifying keys. Basic non-identifying information about the respondents was collected (age, gender).

Interviews were conducted in Berlin and Cottbus, Germany, between December 2019 and May 2020. Final agreements (Step 6 in Procedures and Participants) were made between July and September 2020. All participants (Table 1 for more details) received an incentive for their participation (20-40 Euros). The Ethics Committee of the Freie Universität Berlin (Germany) gave approval for this study (008/2020).

Data Analysis

The data were analysed using content analysis, i.e. transcripts of the communication were evaluated and prepared for the adaptation process (Rädiker & Kuckartz, 2019) with the help of MAXQDA 2018 (VERBI Software, 2018). All responses from the AU, AP and HE interviews were listed and coded. No prior coding framework existed. A coding system was developed inductively for all three forms of interviews. Codes represented the themes provided in responses to the open-ended questions and were summarised quantitatively (e.g. 18 out of 20 AU interviewees named sport as a positive activity: sport

Table 1

Sample Description of Participants of the Formative Research (Step 3)

Interviews/Focus Group	Sample size	Age in years *M* (*SD*)	Age range	Sample size	Age in years *M* (*SD*)	Age range
Free list interview (Arabic Users)						
total	20	30.10 (8.86)	23-57			
men	15	27.40 (3.94)	23-39			
women	5	38.20 (14.46)	24-57			
Key informant interview (Arabic Professionals)				**Key informant interview (Health Experts)**		
total	11	30.78 (5.36)	23-37	6	47.83 (12.81)	32-68
men	5	31.80 (5.63)	23-37	2	45.50 (12.02)	37-54
women	6	29.50 (5.51)	24-36	4	49.00 (14.83)	32-68
Focus Group I				**Focus Group II**		
men	3	28.33 (4.73)	23-32	–	–	–
women	–	–	–	4	27.75 (3.50)	24-32

Note. SD = Standard Deviation.

n = 18/20). The frequency of the answers can be interpreted as an indicator of their importance (Applied Mental Health Research Group, 2013). Each group received different questions, so the second number always indicates the interview group (*n*/20 = AU, *n*/6 = HE, *n*/11 = AP). All data were analysed at the individual level, with the exception of data from the FGs, which were analysed at the group level. Findings of the FGs aimed to complement or contrast findings from AU, AP and HE interviews. The themes that arose from the coded framework were presented to the four Arabic-speaking experts and finalised by the research team.

Quantitative data from BEMI-C were analysed using the SPSS software, version 26 (IBM Corporation, 2018).

Results

Decision-Making and Expert Reviews

For the decision-making process, the monitoring form (Supplement 3) was used. Here, all preliminary and final adaptations in the process were written down and discussed.

First, two one-day workshops of the research group (see Supplement 2) took place in Berlin, Germany, to discuss and evaluate the results of the FL and KI interviews. These results were prepared by MB (first author) and a psychology student (RE). During the workshop, the prepared results and suggestions were read by all participants (written in the monitoring form). There was either agreement with the adaptation or further suggestions were made.

Second, based on the two workshops, the content of the FGs was elaborated and the first version of the adaptations from the workshops was adapted in writing in the document.

Third, based on the results of the FGs, the existing adaptations were modified and written down if necessary.

Fourth, the four Arabic-speaking experts were sent the form with all of the existing preliminary adaptations. The experts either agreed to the proposals in writing or noted changes in writing in the monitoring form. Explicit linguistic comments were also made here.

Finally, another two-day workshop of the research group took place. This was again prepared by MB and RE, who had written down the suggestions of the four experts so that the members of the research group could see the changes beforehand. During these two days, all changes in the document were discussed and voted on.

Cultural Concepts of Distress (CCD)

Three cultural adaptations of CETA were made with regard to the CCD. Two adaptations were made regarding idioms of distress. First, based on the BEMI-C (AU & AP), five idioms of distress were integrated into the introduction of CETA/eCETA (Table 2; in bold). Second, the AP interviews showed that the assessment of suicidal ideation in the component “Safety” should be carried out gradually, i.e. with the topic being introduced indirectly (n = 6/11, e.g. “Have you had thoughts that you would be better off dead or not waking up in the morning?”), followed by direct questions regarding suicidal thoughts and plans.

The description of Arabic-speaking refugees’ CCD (Hassan et al., 2015), as well as the data from the HE interviews, highlighted the importance of an exploratory model of psychological symptoms. Therefore, the introduction of CETA/eCETA was expanded with a section addressing fear of becoming crazy, the relationship between body and mind, and awareness of mental health problems (HE: n = 3/6, Supplement 2).

Treatment Components (Specific and Unspecific Elements, and Therapeutic Techniques)

With regard to therapeutic treatment components, HE stated that all specific CETA components were suitable for the treatment of Arabic-speaking refugees. Therefore, all components remained in the adapted manual (Supplement 1).

The HE interviews did not result in a clear conclusion regarding the fit of the component “Problem solving”, since half of the respondents assessed the content as not feasible (e.g. too cognitive, difficult to work with). Therefore, the focus groups and the research group discussed this component further during the process. Ultimately, the component

Table 2

Typical Somatic and Mental Symptoms of Arabic-Speaking Refugees (Selection From BEMI-C)

Symptoms	Free List Interview (AU)			Key Informant Interview (AP)		
	Total	Men	Women	Total	Men	Women
Somatic *n* (%)						
Sleep disturbances	15 (75)	11 (73.3)	4 (80)	9 (81.8)	4 (80)	5 (83.3)
Pain/aches	17 (85)	12 (80)	5 (100)	10 (90.9)	4 (80)	6 (100)
Fatigue/tiredness	20 (100)	15 (100)	5 (100)	11 (100)	5 (100)	6 (100)
Nerves/being agitated/restless	19 (95)	14 (93.3)	5 (100)	11 (100)	5 (100)	6 (100)
Bodily weakness	16 (80)	11 (73.3)	5 (100)	9 (81.8)	4 (80)	5 (83.3)
Nausea or feeling sick	12 (60)	7 (46.7)	5 (100)	8 (72.7)	5 (100)	3 (50)
Mental *n* (%)						
Dysphoria (feeling down)	9 (45)	4 (26.7)	5 (100)	6 (54.5)	2 (40)	4 (66.7)
Feeling irritable or fed up/bored	20 (100)	15 (100)	5 (100)	7 (63.6)	3 (60)	4 (66.7)
Feeling nervous, anxious	17 (85)	13 (86.7)	4 (80)	9 (81.8)	5 (100)	4 (66.7)
Feeling frightened or fearful	17 (85)	12 (80)	5 (100)	9 (81.8)	4 (80)	5 (83.3)
Lack of concentration/forgetfulness	18 (90)	13 (86.7)	5 (100)	10 (90.9)	5 (100)	5 (83.3)
Loss of interest/ not being able to enjoy things	18 (90)	13 (86.7)	5 (100)	7 (72.7)	5 (100)	3 (50)

Note. Bold, five most prominent symptoms included in the manual.

remained in the manual, as it was considered useful to address post-migration living difficulties.

Regarding the unspecific treatment elements, two adaptations were carried out in the introductory part of CETA. First, the component “Encouraging Participation” was extended regarding the presentation of the rules of interpretation, because interpreters are of crucial importance in the face-to-face context. Second, the literature and AP interviews (n = 11/11) emphasised the importance of understanding the treatment process in order to increase compliance (e.g., patients' active role during sessions, possible destabilisation). Therefore, the analogy of “walking on a mountain path” was explicitly added to this component in CETA/eCETA (Supplement 2).

Based on discussions and practical experiences of the research group, four therapeutic techniques were excluded due to the difficulties in implementation and delivery in an adequate online format (Supplement 1). Results from the AP interviews showed that all other therapeutic techniques were suitable (Supplement 1). Due to the asynchronous communication of lay counsellor and patient in eCETA, two role plays were adapted. This therapeutic technique, which requires simultaneous interaction, was transformed into a written "letter to a friend", in which the patient addresses an imaginary friend with the same problem. Also due to the asynchronous communication, the decision was made to fix the order of the techniques in TDW-II in CETA/eCETA.

Treatment Delivery (Format, Surface)

Regarding the delivery format, two changes were implemented. First, CETA is also offered in an internet-based context (eCETA). Second, the handling of self-endangering and third-party-endangering behaviour had to be adapted for eCETA, which is conducted by lay counsellors. As soon as such behaviour is detected, the communication immediately changes from asynchronous to synchronous (i.e., telephone).

The final category of adaptations refers to the surface, e.g. text, examples, and migration-, language-, and culture-related material. Arabic-speaking individuals (AU, AP) revealed that the expressions used in the manual are for the most part culturally appropriate. Four specific adaptations were made (i.e. translation of the phrases "a day in the life" and "here and now", expressions for "suicide" and "suicidal ideation and plans"). All other 17 adaptations are shown in Supplement 5).

Discussion

In this study, the transdiagnostic CETA was adapted for Arabic-speaking refugees in Germany. The cultural adaptation process followed an approach that enables a replicable and systematic documentation (Heim et al., 2021, this issue). The results showed that CETA in its original form seems to be largely culture-sensitive for this target group. Mainly surface adaptations were made, especially for eCETA due to its asynchronous communication.

Based on our formative research, the cultural adaptation of the manual comprised three main aspects: i) cultural concepts of distress in the target population (i.e. Arabic speakers from the MENA region), ii) treatment components to address post-migration living conditions, and iii) treatment delivery, i.e., the provision of an additional online version to address potential treatment barriers.

Concerning the cultural concepts of distress, all adaptations are in line with previous findings. The qualitative interviews showed that the introduction of CETA should be expanded to include an explanatory model to address cultural explanations. Thus, the relationship between physical and mental well-being is now more clearly demonstrated and explained, since the literature underlines that Arabic idioms of distress do not distinguish between somatic experiences and psychological problems (Hassan et al., 2015). Furthermore, the "fear of going crazy" (Shannon, 2014) was addressed by explaining the concept of mental disorders and psychological treatment. To assess suicidal ideation, different opinions were expressed, which tended either to assess suicidal ideation directly or indirectly. This difference was affected both by culture (e.g. suicide is a crime in some Arab countries, Hassan et al., 2015) and by legal aspects of the German health care system (suicidality must be clearly clarified). Accordingly, the adaptation comprises the

gradual assessment of suicidal tendencies (i.e. starting with an indirect question, followed by a direct question).

With regard to treatment components, the results indicated that the specific CETA components as well as the unspecific elements are suitable for the current context of Arabic-speaking refugees in Germany. This is in line with a review examining the effectiveness of psychological interventions in different low- and middle-income countries (Singla et al., 2017). The specific component of "Problem Solving" was considered to be important in the discussions of the research team and in the literature (Singla et al., 2017). The difficult living conditions, in which refugees have to deal with multiple social problems (e.g. asylum process, housing), have been shown to affect refugees' mental health (Schick et al., 2018). To address these difficulties, "Problem Solving" will be offered to every patient in order to provide problem-solving skills to manage some of these existential problems.

With regard to treatment delivery, an online version of CETA was developed. Since this type of asynchronous communication requires more active patient involvement, the therapeutic tasks have to be described in more detail and include more examples. Thus, some adaptations will only be applied in eCETA. Adaptations with regard to materials mostly referred to analogies, as well as examples and translations of words or phrases. A distinction was made between linguistic adaptations (e.g. translation of the phrase "a day in the life") and adaptations based on culture and migration (e.g. typical receptacles used for alcohol, everyday situations). This is in line with other studies in the field (e.g., Shala et al., 2020).

In sum, a small number of mainly surface adaptations were required. This might be a consequence of the fact that CETA was developed particularly for culturally diverse groups, already used simple language, already had an easily understandable structure, and has been used in different countries (Murray et al., 2014). This very well thought-out structure of the original CETA provided an excellent basis for the current adaptation process.

Even though the cultural adaptation was facilitated by the existing framework, some limitations remain. First, only people from two different cities in Germany were interviewed, and most of them were from Syria. However, the interviewees were of different ages and gender, and the four Arabic-speaking experts were from different countries of origin. Second, although we did not consider the entire CETA manual for adaptation, we selected an exact choice of words to explain a technique, main parts, and all interventional components that corresponded to the framework (Heim & Kohrt, 2019). Third, the decision to use the online format with an asynchronous communication was made prior to the formative research. These decisions are based on known contextual conditions (e.g. fear of stigmatisation, difficulties in accessing the health care system). All further adjustments to the format were then again part of the formative research.

The conceptual framework and the RECAPT guidelines simplify, standardise and clarify the cultural adaptation process. It can thus be summarised that adaptations do not always have to start from scratch; rather, practitioners and researchers are able to use existing material. Future research needs to compare different levels of adaptation and their impact on treatment acceptance and effectiveness. Such results might enable a balance between adaptation and the required time and financial effort.

Funding: This project has received funding from the German Federal Ministry of Education and Research (BMBF) under grant agreement No. 01EF1806A and No. 01EF1806H

Acknowledgments: We would like to thank Dr. Kristina Metz for providing us with the opportunity to gain a deep insight into CETA and to adapt the existing manual. Our sincerest thanks go to the interviewers A. Alsaod and L. Ighreiz, who did a tremendous job, as well as to the interviewees who participated and gave us constructive feedback. We would also like to thank A. Hajjir, P. Selmo, P. Nour and J. Abi Ramia for giving us their expert opinions during the final steps in the decision-making process.

Competing Interests: Eva Heim is one of the Guest Editors of this CPE Special Issue but played no editorial role in this particular article or intervened in any form in the peer review process.

Supplementary Materials

The Supplementary Materials (for access see Index of Supplementary Materials below) include detailed information about:

1. Components of CETA and decision regarding remaining, adaptation or exclusion from the adapted manual (Supplement 1)
2. Process of cultural adaptation based on the reporting criteria (RECAPT, Supplement 2)
3. Extract from the adaptation monitoring form (Supplement 3)
4. Qualitative Research Checklist (COREQ, Supplement 4)
5. Surface adaptations (Supplement 5)

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Clinical Psychology in Europe (CPE) is the official journal of the European Association of Clinical Psychology and Psychological Treatment (EACLIPT).

PsychOpen GOLD is a publishing service by Leibniz Institute for Psychology (ZPID), Germany.

Latest Developments

STARC-SUD – Adaptation of a Transdiagnostic Intervention for Refugees With Substance Use Disorders

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e5329, https://doi.org/10.32872/cpe.5329

Received: 2020-12-01 • **Accepted:** 2021-09-05 • **Published (VoR):** 2021-11-23

Handling Editor: Eva Heim, University of Lausanne, Lausanne, Switzerland

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Related: This article is part of the CPE Special Issue “Cultural Adaptation of Psychological Interventions”, Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Data [see Index of Supplementary Materials]

Abstract

Background: Refugees often suffer from multiple mental health problems, which transdiagnostic interventions can address. STARC (Skills-Training of Affect Regulation – A Culture-sensitive Approach) is a culturally sensitive transdiagnostic group intervention that has been developed for refugees to improve affect regulation. In refugees with substance use disorders (SUD), the consideration of SUD-specific elements might improve the acceptance and effectiveness of such an intervention. We aimed to adapt the STARC program for refugees with SUD in a culturally sensitive way.
Method: The conceptual framework of Heim and Kohrt (2019) was used to culturally sensitively adapt the STARC program to the needs of Syrian refugees with SUD. The results of five focus group discussions with refugees on cultural concepts of SUD and their treatment informed the adaption. An expert group suggested adaptions and decided by consensus on their implementation. Two pilot groups were conducted with the adapted STARC-SUD program. Interviews with the therapists of these pilot groups informed further adaption.
Results: The concepts related to SUD identified in focus groups and therapists’ interviews that differed from Western concepts were integrated into the STARC intervention.

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Discussion: Further studies should assess the acceptance and effectiveness of the culturally sensitive STARC-SUD program for refugees with SUD.

Keywords

emotion regulation, affect regulation, substance use disorders, addiction, refugees, group treatment, cultural adaption, formative research

Highlights

- The study offers insight into the adaptation process of a culturally sensitive group intervention.
- We report the adaptation of a group intervention for refugees with substance use.
- Cultural concepts of Syrian refugees related to substance use are considered in the adaptation.

The rising global burden of forced migration is one of the most pressing public health issues (UNHCR, 2019). Forced migration is related to many stressors that increase the risk for SUD, including loss of loved ones, different types of abuse, family separation, social and economic inequality, and discrimination in the host country (Horyniak et al., 2016). In refugees, substance use disorders (SUD) have received increasing awareness (Horyniak et al., 2016), with a prevalence rate of hazardous or harmful alcohol use ranging from 4% to 7% in community settings (Horyniak et al., 2016). The availability of substances and the often higher acceptance of substance use in the host country (e.g., drinking alcohol in public) might additionally increase the risk of SUD (Priebe et al., 2016).

While there is a need for SUD health care for refugees, this need often is not met (Welbel et al., 2013). Several barriers to access services exist. Lack of knowledge about the mental health care system in the host country prevents access (Posselt et al., 2017). In addition, refugees are often required to attend multiple psychosocial services before entering SUD treatment, risking disengagement. Interpreters are unavailable, or if available, the health insurance does not cover the costs (Jaeger et al., 2019). Additional barriers to accessing SUD health services concern different concepts of suffering and SUD-related stigma (Penka et al., 2012). The lack of knowledge and skills in cultural sensitivity in professionals further contributes to the SUD health care gap among refugees.

The culturally sensitive adaption of the existing Western evidence-based interventions seems central to reduce barriers to mental health care in refugees. The adaption of the language, culture, and context of an intervention to be compatible with the user's cultural patterns, meanings, and values (Bernal et al., 2009) may enhance its acceptability and effectiveness (Hall et al., 2016). Indeed, evidence has accumulated that cultural adaptations enhance the efficacy of treatments based on Western psychotherapeutic ap-

proaches in populations with other cultural backgrounds (Anik et al., 2021; Chowdhary et al., 2014).

As refugees often suffer from multiple mental disorders, the need for evidence-based transdiagnostic treatments has received increasing attention (Martin et al., 2018). Transdiagnostic interventions address mechanisms underlying common mental disorders. Such interventions may be preferable to disorder-specific interventions, as therapists can apply them to a group of refugees with heterogeneous symptoms. Group therapy with people who have survived the same experience seem to be more effective than individual therapeutic approaches (Kira et al., 2012).

A few transdiagnostic treatment approaches have been developed for non-Western cultures. Problem Management Plus (PM+; Dawson et al., 2015) is a five-session low-intensity intervention developed for low and middle-income countries targeting persistent distress and mild symptoms of depression and anxiety (Dawson et al., 2015). PM+ was effective in reducing psychological distress (e.g., Bryant et al., 2017), but no research examined its effects on SUD. "Common Elements Treatment Approach" (CETA) is another brief intervention for common mental health disorders developed for low-resource settings (Murray et al., 2014). CETA effectively reduced hazardous alcohol use in an at-risk sample for interpersonal violence in Zambia (Murray et al., 2020). Culturally sensitive evidence-based interventions for refugees in the middle- or high-income countries are needed to target SUD and other mental disorders in refugees.

The STARC Intervention

A culturally sensitive group intervention developed for refugees in the Western middle- or high-income countries is STARC (Skills-Training of Affect Regulation – A Culture-sensitive Approach; Koch & Liedl, 2019). STARC is a 14-session culture-sensitive transdiagnostic intervention to improve affect regulation in refugees. The intervention is based on Western skills-based elements from Skills Training in Affective and Interpersonal Regulation therapy (STAIR; Cloitre & Schmidt, 2015), the Dialectic Behavioral Therapy (DBT; Bohus et al., 2011), and the Culturally Adapted Cognitive Behavioral Therapy (CA-CBT; Hinton et al., 2011). The authors developed the STARC program according to guidelines for developing culturally sensitive interventions (Bernal & Sáez-Santiago, 2006). The manual includes culturally-sensitive metaphors and expressions and uses easy language. A pilot study in Afghan refugees indicated preliminary evidence that the intervention reduces difficulties in emotion regulation, general distress, and post-traumatic stress disorder symptoms (Koch et al., 2020).

Difficulties in regulating emotions play a key role in SUD (Aldao et al., 2010). Improving emotion regulation via culturally sensitive interventions such as STARC seems essential to reduce substance use and relapse in individuals with SUD. Such interventions need to address managing emotions effectively to regulate craving when the risk of substance abuse is high. Previous research showed that individuals with SUD benefited

from tailored emotion regulation interventions that considered their specific needs, e.g., coping with craving beliefs (Choopan et al., 2016).

While emotion regulation strategies are a centerpiece of the STARC intervention, it does not focus on the interrelations between emotion regulation and substance use. Adapting the STARC intervention for the specific needs of refugees with SUD might further enhance its acceptance and effectiveness in this vulnerable group. Therefore, the aim of this study was to adapt the STARC program for Syrian refugees with SUD.

Method

The adaption of the STARC program was conducted in preparation of a randomized controlled trial of the STARC-SUD program in refugees with substance use problems (Schäfer et al., 2020), which is part of a research network on the prevention and treatment of substance use disorders in refugees (PREPARE, Prevention, and Treatment of Substance Use Disorders in Refugees; BMBF 01EF1805A). The Ethics Committee of the Medical Council of Hamburg approved this study (PV7123).

Intervention

The STARC program (Koch & Liedl, 2019) was developed in a participatory approach with refugees. STARC is a weekly group program conducted with six to eight refugees of the same gender and an interpreter if required. It consists of fourteen 90-min sessions. The program contains four modules: 1) Introduction and training of emotional perception; 2) Training of specific emotion regulation strategies; 3) Dealing with specific emotions, and 4) Rehearsal and closure.

Module 1 aims at improving emotional awareness. Emotions and their functions are discussed, and the interrelations between feelings, thoughts, and body reactions are explained. Personal warning signals for different emotional intensities are also introduced. In Module 2, emotion regulation strategies are conveyed, including cognitive approaches, body-based strategies, and strategies to cope with intense feelings. In Module 3, coping with specific emotions, such as anger or fear, is discussed. In Module 4, the group reviews the learned skills and celebrates program completion (for a more detailed description, see Koch & Liedl, 2019).

Procedure of Adaption

In the current study, we focused on Syrian refugees as they represent one of the largest refugee groups in Germany. Due to restricted resources, we shortened the program to ten sessions. The sessions were reviewed with the authors of STARC, sessions with overlapping content were merged. The shortened STARC program was extended with SUD-specific elements while keeping the basic concept of the program. The STARC ses-

sions were adapted by referring to substance use as a dysfunctional emotion regulation strategy throughout the sessions. In addition, we integrated elements used in SUD group treatment, such as discussions about the risk and protective factors of SUD and the short- and long-term consequences of substance use (Körkel & Schindler, 2003; Lindenmeyer, 2016).

In accordance with Heim and Kohrt (2019), cultural concepts of substance abuse were collected as a first step of the cultural adaption process. Five focus groups with three to nine refugees were conducted to assess their core assumptions, beliefs, and concepts of SUD. The focus group discussions were based on a published interview guideline and followed standard procedures for reporting qualitative studies (Lindert et al., 2021). The focus groups included 19 purposively recruited male adult Syrian refugees. They were aged 20 to 50 years and lived in Germany in metropolitan, urban, or rural areas. A native-speaking professional translator and one facilitator conducted the focus groups. The facilitator was a female PhD student in Psychology with a background in Ethnology. Inductive content analysis (Mayring, 2014) was applied to analyze the transcribed data and extract common themes.

The results of the focus groups with refugees yielded culture-specific information about core assumptions, beliefs, and concepts related to SUD and its treatment with refugees. The results of the focus groups were published in a separate paper (Lindert et al., 2021). Based on the results of the focus groups, three experts proposed adaptions in a standardized adaption sheet. The first expert (second author) was a researcher in the field of migration research; the second expert (first author) was a mental health professional and expert in the field of traumatic stress and psychotherapy research; the third expert was a mental health professional from Afghanistan working with refugees with a flight history. In a consensus meeting, the three experts commented on the suggestions of each other and then discussed and decided on the adaptions. In case of disagreement, the suggestion was discussed together until an agreement between the discussants was reached.

A STARC-SUD prototype was created and then piloted in two groups with Syrian refugees with SUD. The pilot groups were conducted by trained therapists in routine SUD care facilities. The therapists had a German background. All content was translated simultaneously during the sessions. After completion of the program, the therapists were invited to an unstructured interview to provide feedback on their experience with the program. The interviews were conducted by a clinical psychologist experienced in the conduction of group therapies. The interviewer noted the key points in the adaption sheet during the interview. These interviews informed further adaption of the program that were documented and consented by the same expert group in a second consensus meeting.

All adaptations are described in Supplement 1. In accordance with the procedure of Heim et al. (2021), this issue, and Heim and Knaevelsrud (2021), this issue, a standardized

template was used to document the adaptations (see Supplement 2). This template includes the following sections: i) target group; ii) formative research methods; iii) cultural concepts of distress (i.e., idioms of distress, explanatory models); iv) target intervention; v) deep structure adaptations (i.e., specific and unspecific elements and in-session techniques); and vi) surface adaptations (i.e., mode of delivery, materials).

Results

Cultural Adaption of STARC-SUD

The adapted elements of the STARC program are documented in Supplement 2, the content of the different sessions of the adapted program is described in Supplement 3.

1. Unspecific Elements

The results of the focus group discussions and therapists' interviews indicated that some refugees were unfamiliar with the Western concept of psychotherapy which suggests that individuals solve mental health problems by themselves (rather than within the family) by consulting a mental health professional. In contrast to this approach, some refugees found it more appropriate to solve mental health problems collectively within the family system. Hence, we included psychoeducation about the concept of Western psychotherapy in the introductory session. Furthermore, the therapists stressed that the approach to talk about mental health problems in a group with other patients needed to be introduced. Therefore, we included psychoeducation about the group setting as a common intervention approach in Western cultures to support and learn from each other in the introductory session.

2. SUD-Specific Elements

Not all refugees shared the concept of SUD as a treatable mental disorder. Consequently, we added information on the Western concept of addiction as a recognized treatable mental disorder and the availability of professional addiction services to the STARC manual. Most refugees stressed that rules and norms differed between the host and home country; the greater availability of substances was perceived as contributing to SUD. The greater societal acceptance of substance use was frequently mentioned as another reason for SUD. Thus, we incorporated information about the substances commonly used in the host and home country, as well as their availability and acceptance in the STARC-SUD program.

Refugees and therapists reported refugee-specific risk factors for SUD, e.g., traumatic experiences in the home countries or during flight, worries about family members that remained in the home country, and not feeling accepted by the host country. Refugee-specific risk factors for SUD were therefore included in the STARC-SUD program.

In addition to these refugee-specific risk factors, refugees mentioned culture-specific protective factors for not developing SUD, such as societal and family norms, and social support. These factors were incorporated into the manual.

3. Other Specific Elements

The therapists reported that some of the male refugees hesitated to play a group dynamic game with a ball of wool to get familiar with other group members in the introductory session. These male refugees perceived the game as more appropriate for women. Hence, we changed the manual instruction recommending to be sensitive to gender-based preferences regarding group games.

Some refugees participating in the pilot groups reported being unfamiliar with the relaxation exercises introduced in the program (breathing exercise and Progressive Muscle Relaxation) to regulate tension or intense feelings. Rather, they preferred more active strategies (e.g., physical exercises and singing). We adapted the program to instruct the therapists to offer both relaxation exercises and alternative active strategies.

According to the therapists' feedback obtained in the interviews, some participants preferred religious statements of encouragement as a strategy to regulate emotions, while others preferred non-religious statements, as they were non-religious or persecuted for religious reasons. Therefore, it was more strongly emphasized in the manual to be mindful in proposing religious rituals, e.g., reading the Koran or Bible, or talking to God or Allah.

4. Treatment Delivery

Some refugees with a high level of education found that the easy language used in the STARC manual appeared unfamiliar to them. Therefore, we added an instruction to the manual that therapists could adapt the complexity of the language according to the language skills and education of the participants.

The therapists reported that the translator needed to have read the manual before the session to translate the content correctly. In addition, therapists emphasized the need of having sufficient time to ensure that all participants correctly understood the translation of the session content, e.g., by asking comprehension questions and providing additional information as needed. A briefing of the translators on the translation procedure before the session might also be helpful. Therefore, we underlined these aspects more strongly in the introductory part of the program.

Discussion

Based on the focus group discussions with Syrian refugees on cultural concepts of SUD and its treatment, we integrated elements relevant for the treatment of SUD in a culturally sensitive way into the STARC program. After piloting the first version of the

STARC-SUD prototype, we further adapted the program based on interviews with the therapists that conducted two STARC-SUD pilot groups.

Unspecific Elements

We found that some of the refugees were unfamiliar with the Western concept to solve mental health problems with a mental health specialist. This finding is in line with the results of previous research showing that the Western concept of psychotherapy, i.e., to consult a mental health professional to talk about mental health problems, may be unfamiliar to people from non-Western cultures (Gopalkrishnan, 2018). Earlier research also revealed that provision of knowledge about (Western) mental health services and how to access them may increase trust in refugees (Duden et al., 2020; Sandhu et al., 2013). Furthermore, we found that the group setting (vs. individual setting) used for the STARC program needed to be introduced in more detail.

Psychoeducation about the Western concept of (psycho-)therapy as a common approach in German healthcare to cope with mental health problems seems important. This may include discussing the approach to solve problems individually in a professional setting with a health care specialist as an alternative or complementing strategy to collectivistic approaches to enhance understanding, acceptance, and adherence to the program.

SUD-Specific Elements

In the focus groups that were conducted prior to the cultural adaptation, refugees outlined several SUD-specific aspects as essential to be incorporated in a culturally sensitive intervention (Lindert et al., 2021). These included different concepts and norms for addiction, as well as for substance use, their availability, and acceptance. The finding that some of the refugees were unfamiliar with Western concepts of addiction as a recognized and treatable mental disorder is in line with the results of earlier qualitiatve research among Afghan populations showing that the concepts of mental disorders, such as depression (Alemi et al., 2016) and posttraumatic stress disorder (Yaser et al., 2016), differed from those reported by Western populations. The acceptance of interventions addressing SUD in refugees might be improved by introducing the Western concept of addiction as a recognized treatable mental disorder, and by discussing differences and similarities with other concepts of addiction. Psychoeducation about commonly used substances, their availability and acceptance in the host and home countries might also increase acceptance and adherence to the intervention. Furthermore, our results indicated that refugee-specific risk and protective factors for SUD needed to be considered to provide a relevant model of the development of SUD, e.g., traumatic experiences or worries about family members.

Other Specific Elements

Gender-specific preferences for dynamic group games needed to be considered in the STARC-SUD program. Previous studies with refugees also reported gender-specific preferences for group therapy content that were related to gender-specific socialization experiences (Kira et al., 2012). These results speak to the importance of conducting gender-separated therapy groups.

We also found that the type of exercises to regulate emotions needed to be chosen culturally sensitively. A study by Somasundaram (2010) indicated that relaxation techniques might be an effective component in treating mental disorders in refugees if they include techniques known and used in the respective culture.

The sensitive use of religious content in the program was another important finding of our study. While some refugees perceived religion as a source of strength, others experienced it as a source of threat. These results indicate the need to consider religious content carefully in mental health interventions for refugees. However, in refugees that perceive religion as a source of strength, religious content in a culturally sensitive intervention might be particularly helpful, as religious believes are an integral part of ones' own understanding of the world in many non-Western cultures (Machleidt, 2019). Consistent with this assumption, relaxation techniques (Somasundaram, 2010) and therapeutic interventions (Hasanović, 2017) including religious content have been perceived as helpful among refuges in previous research.

Treatment Delivery

While the easy language used in the program seemed essential to improve the comprehensiveness of the program content for non-native speakers, it became clear that easy language could appear artificial for high-educated refugees, indicating the need for individual adaption of the used language to the participants of the respective intervention.

We also found that the translations improved if the translators read the program sessions beforehand. These findings are consistent with a previous qualitative study by Duden et al. (2020), which reported that patients and mental health providers were concerned that not everything said had been translated correctly. The quality of the translation could be increased by having interpreters that familiarize themselves with the session content in advance. Our results also indicated that enough time-related resources are needed during the session to ensure that all refugees understood the translated content correctly.

Overall, this study identified a number of necessary adaptions of a therapeutic intervention, developed within Western cultures, to the needs of individuals from other cultural backgrounds. Attention should be payed to the clarification of the underlying concepts. For refugees, it might be an unfamiliar concept that speaking about one's problems in groups is appropriate, and learning from others might have healing effects.

Moreover, if such therapies include skills-based approaches, there is a need to consider their appropriateness from a gender and culture-sensitive perspective.

Our results indicate implications concerning offering support for SUD in refugees. When adapting Western therapeutic approaches to the needs of refugees with SUD, Western concepts of mental disorders underlying the intervention should be discussed, such as the concept of addiction as a recognized and treatable mental disorder. In addition, the different societal norms for substance use, the types of substances, and their availability and acceptance in the host and home countries should be addressed.

Limitations

There are limitations concerning the methodology of our cultural adaptation. The program was culturally adapted by integrating non-Western metaphors, opinions from non-Western cultures about diseases and healing, and easy-to-understand language. Nevertheless, it seems impossible to make psychotherapy a culture-free concept, as it is rooted in the Western culture. The database used for our adaption is limited by only considering male refugees. Future studies need to examine the appropriateness of the program for female refugees. Another limitation is that we did not assess sociodemographic characteristics except age to guarantee confidentiality for the study participants.

Conclusion

According to the results obtained from focus groups (Lindert et al., 2021) and the therapists' interviews, we adapted several elements in a culturally sensitive way. Although the original version of the STARC manual had already been developed culturally sensitively (Koch & Liedl, 2019), further potentially beneficial adaptations could be made from the sources included in the present study. This suggests that qualitative research such as focus groups should be used to inform cultural adaptions of existing interventions to consider the specific needs of a target group, such as refugees with SUD. Further studies might evaluate whether the cultural and SUD-specific adaptions increase the STARC-SUD intervention's acceptance and effectiveness.

Funding: This study was funded as a part of a research network on the prevention and treatment of substance use disorders in refugees (PREPARE, Prevention, and Treatment of Substance Use Disorders in Refugees; BMBF 01EF1805A).

Acknowledgments: We would like to thank Nahid Yakmanesh for reviewing, discussing, and consenting to the proposed manual adaptions. We also thank the STARC-SUD therapists, the participants of the STARC-SUD groups, and the participants of the focus groups for supporting this research.

Competing Interests: The authors have declared that no competing interests exist.

Supplementary Materials

The Supplementary Materials contain the following items (for access see Index of Supplementary Materials below):

- Supplement 1 describes the adaptation steps of the STARC-SUD intervention.
- Supplement 2 summarizes the results of the focus group discussions with refugees and the interviews with therapists, as well as the adaptations of the STARC-SUD intervention decided by consensus.
- Supplement 3 provides an overview of the adapted sessions of the STARC-SUD intervention.

Index of Supplementary Materials

Lotzin, A., Lindert, J., Koch, T., Liedl, A., & Schäfer, I. (2021). *Supplementary materials to "STARC-SUD – Adaptation of a transdiagnostic intervention for refugees with substance use disorders"* [Additional information]. PsychOpen GOLD. https://doi.org/10.23668/psycharchives.5185

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Latest Developments

"Same Same or Adapted?" Therapists' Feedback on the Implementation of Trauma-Focused Cognitive Behavioral Therapy With Unaccompanied Young Refugees

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e5431, https://doi.org/10.32872/cpe.5431

Received: 2020-12-11 • **Accepted:** 2021-06-29 • **Published (VoR):** 2021-11-23

Handling Editor: Cornelia Weise, Philipps-University of Marburg, Marburg, Germany

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Related: This article is part of the CPE Special Issue "Cultural Adaptation of Psychological Interventions", Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: Rates of trauma exposure and posttraumatic stress disorder (PTSD) are high among refugee youth. Although there is a vast evidence base on effective trauma-focused interventions for children and adolescents, there is only limited understanding of how to adapt these interventions for oftentimes severely traumatized young refugees. This study aims to investigate adaptations undertaken during trauma-focused cognitive behavioral therapy (TF-CBT) in a pilot study with unaccompanied refugee minors (URMs).

Method: Written answers on five questions given by N = 9 therapists on N = 16 TF-CBT cases were analysed qualitatively using Mayring's content analysis. The questions were on (1) additional techniques used in the sessions, (2) obstacles to TF-CBT treatment, (3) cultural factors considered and most helpful components for (4) patient and (5) therapist. The categories were built inductively and analysed descriptively.

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Results: In addition to the regular TF-CBT components, added content mostly concerned the so-called "crisis of the week", meaning a more lengthy discussion of struggles and concerns in their daily lives. Few obstacles in treatment were reported, and little cultural factors had to be considered. The implementation of a trauma narrative and the agenda provided by the manual were frequently reported as helpful.

Conclusion: The results of this study indicate that the manualized evidence-based treatment TF-CBT can be used in the culturally heterogeneous population of URMs with minor adaptations. These findings can contribute to future research as well as clinical practice with URMs.

Keywords

TF-CBT, cultural adaptation, refugee, therapist, adolescent

Highlights

- TF-CBT is a promising treatment for PTSD in traumatized refugee minors.
- Necessary adaptations for this target group have not been analysed so far.
- Therapists reported only a few "on the fly" adaptations during a pilot study on TF-CBT.

Unaccompanied refugee minors (URMs) constitute a vulnerable population, firstly due to their various traumatic experiences before, during and after their flight (Reed et al., 2012; Steel et al., 2017), and secondly in terms of severe post-migration stressors (Keles et al., 2018) on their arrival in the host country. It comes as no surprise that the prevalence rates of trauma- and stress-related mental health conditions are higher among URMs compared to youth without a migration background, immigrant samples (Betancourt et al., 2017) or accompanied refugee minors (Bean et al., 2007). A recent meta-analysis on mental illness among refugee minors revealed that 23% report posttraumatic stress disorder (PTSD) (Blackmore et al., 2020).

Current treatment guidelines for treating trauma-related disorders, especially PTSD, recommend trauma-focused cognitive behavioral approaches (International Society for Traumatic Stress Studies [ISTSS], 2019; Rosner et al., 2019) for traumatized children and adolescents. In this context, trauma-focused cognitive behavioral therapy (TF-CBT, e.g. the specific manual by Cohen et al., 2017) has been identified as a gold standard treatment for children and adolescents with PTSD across guidelines and meta-analyses (Gutermann et al., 2016). Experts claim, however, that yet child trauma guidelines focus too little on children's cultural background and possible adaptations (Alisic et al., 2020).

Most evidence-based treatments for PTSD were developed in western societies. They were then increasingly widely implemented and found to be effective in samples with cultures outside of western societies (Ennis et al., 2020). Only a very small number of interventions have been specifically developed and tailored to the needs of URMs, for example the trauma-focused group intervention "Mein Weg" (English "My Way")

(Pfeiffer et al., 2018), which is based on TF-CBT but re-modeled into a group-based low-level intervention for refugees in child welfare programs. The development of this intervention adopted a theory-driven approach for cultural adaptation (Heim & Kohrt, 2019). The theory-driven changes focused mostly on delivery in a group format (e.g. additional group discussions), the language barrier (e.g. changes in materials) and the inclusion of flight and migration specific content (flight route as part of narrative). More commonly, evidence-based trauma-focused treatments are adapted to cultural characteristics of study populations in a data-driven, so-called "bottom-up" approach. These approaches are especially favorable if the question is whether there is a good fit between the evidence-based treatment itself and the new target group, and whether cultural adaptations are necessary to some or all aspects of that specific therapy.

A recent review (Ennis et al., 2020) systematically reviewed research articles on cultural adaptations in trauma-focused CBT approaches with children and adults. The results highlight the complexity of cross-cultural adaptations of psychotherapy due to several reasons such as heterogeneous sources of information (e.g. stakeholders, therapists or patients), the usage of different frameworks for cultural adaptations (if used at all) and different levels of efficacy evaluation. Seven out of the 17 included studies were on cultural adaptations in TF-CBT. They either implemented the treatment with immigrant samples in western countries (e.g. Schottelkorb et al., 2012) or delivered the treatment abroad in the cultural context of the country itself (DRC: McMullen et al., 2013; Jordan: Damra et al., 2014; Zambia: Murray et al., 2013; Tanzania: O'Donnell et al., 2014). One study involved local therapists (Murray et al., 2013) as main source of information for assessing potentially necessary changes to the treatment protocol during treatment delivery, while others used focus groups, surveys, or expert panels ahead of treatment implementation. The most often used source in the studies described in the review by Ennis et al. (2020), which focused on data-driven approaches, were (local) therapists as they might function as a direct mediator between high adherence in the implementation of the manual on the one hand and the individual needs of their patients on the other hand.

There are only two studies on cultural adaptations to the TF-CBT protocol delivered to refugee minors (Schottelkorb et al., 2012; Unterhitzenberger et al., 2019). The refugee population might throw up specific challenges as it represents a heterogeneous population that originates from different countries and cultures. Consequently, this makes an oftentimes preferred "one size fits all" approach even more challenging. The authors of both studies gave only a brief description of marginal changes to the protocol (e.g. translation when needed, tailored psychoeducation, more sessions on trauma narrative). This leaves a gap in the literature on the need for cultural adaptations in TF-CBT for this vulnerable cohort. Especially so-called "on the fly" adaptations of experienced therapists (Heim & Kohrt, 2019) might be crucial to increasing understanding of necessary adaptations to evidence-based trauma-focused treatments such as TF-CBT for URMs.

In our recent pilot study (Unterhitzenberger et al., 2019) on TF-CBT with URMs, we implemented the TF-CBT protocol without prior theory-driven adaptations. The aim was to evaluate the feasibility of TF-CBT for this specific target group. Therapists were instructed to provide the treatment according to the manual, however, also to implement and document any "on the fly" adaptations they made in order to successfully treat the refugee patient. The present study, which was part this pilot study (Unterhitzenberger et al., 2019), aims to increase knowledge on how to adapt TF-CBT to the specific needs of URMs by examining therapists' self-reported cultural adaptations in implementing TF-CBT with URMs in a qualitative study design.

Method

This study is part of a recently published pilot study conducted in Germany between March 2015 and July 2017. For details on the procedure please refer to the main publication (Unterhitzenberger et al., 2019). The participants treated in this pilot study were 26 male URMs (M_{age} = 17.1; *SD* = 1.0; range 15-19) who had been in Germany for an average of 9.8 months (*SD* = 3.9) and who originated from eight different countries in the Middle East and Africa. 22 of them completed treatment. Uncontrolled effect sizes were high for PTSD symptoms at post (*d* = 1.08) and follow-up assessments (*d* = 1.23).

Participants

A total of 9 therapists were taken into account for this analysis. Please see Table 1 for the description of participants' characteristics. Therapists responded to the survey for a total of 16 treatment cases. Unfortunately, we do not have therapist feedback on all the cases treated, as the questionnaire was put together during the ongoing pilot study. All therapists participated in a TF-CBT training by a certified trainer and received biweekly supervision. In addition, one of the manual developers offered case consultation calls once a month. During the project, an expert in psychotherapy with refugees and torture survivors ran a half-day training session attended by all therapists.

https://doi.org/10.32872/cpe.5431

Table 1

Sociodemographic Characteristics of the Participating Therapists (N = 9)

Characteristic	
Age *M* (*SD*)	35 (9.5)
range	29 – 60
Gender *n* (%)	
female	8 (88.9)
CBT therapist *n* (%)	9 (100)
Licensed	6 (66.7)
In training	3 (33.3)
Child and adolescent therapist	1 (11.1)
Adult therapist with additional training for children	8 (88.9)
Clinical experience *n* (%)	
1 to 5 treated cases	2 (25.0)
11 to 20 treated cases	1 (12.5)
21 to 50 treated cases	1 (12.5)
> 50 treated cases	4 (50.0)
TF-CBT cases treated *M* (*SD*)	5.5 (2.99)
range	0 – 20

Note. CBT = cognitive behavioral therapy; TF-CBT = trauma-focused cognitive behavioral therapy; *M* = mean; *SD* = standard deviation.

Intervention

The TF-CBT treatment protocol followed the manual by Cohen et al. (2017). It consists of nine treatment modules on psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, trauma narrative and cognitive processing II, in vivo exposure, conjoint child/caregiver session, and enhancing safety and future skills. Standard TF-CBT involves twelve 90-minute sessions with the child and the caregiver. Usually, the caregiver is a parent, however, for children and adolescents housed in child welfare facilities (like URMs) these are professionals, for instance, social workers. The amount of caregiver involvement depends on the child's age. According to the manual developers, TF-CBT is flexible and culturally sensitive (Cohen et al., 2017). In this pilot study, treatment fidelity was relatively high (62-82%) (Unterhitzenberger et al., 2019). The mean treatment dose was 15 sessions. An interpreter was present in 55% of treatment cases.

Data Collection

After each session, therapists filled out a session checklist for the TF-CBT module addressed in the respective session to report on treatment adherence. After the respon-

ses to the components (yes/no), one item "additional content or techniques" was to be answered openly that was analyzed for this article (Question 1). Furthermore, we conducted a survey among therapists. They were given a questionnaire for each study case at the same day they had completed it. The questionnaire consisted of four Likert-scaled questions and eleven questions on each treatment case. It included questions on the complexity of the disorder, therapeutic relationship, therapist's satisfaction, helpful components and obstacles as well as cultural considerations. For the purpose of this study, we present responses from the following four questions that we deemed to be helpful regarding (cultural) adaptations: "Which component(s) constituted an obstacle in treatment?" (Question 2), "Did you consider cultural factors in this treatment case? If so, which ones?" (Question 3); "Which TF-CBT component(s) helped the patient most?" (Question 4); "Which TF-CBT component(s) was/were especially helpful for you in treatment?" (Question 5).

Data Analysis

The answers were analyzed according to Mayring's qualitative content analysis (Mayring, 2000). We conducted categories in a structured manner. A key component of this process is the coding manual (for an overview see Supplementary Material). The coding manual is developed in three steps: the definition of categories, the derivation of examples from the text, and the addition of rules for coding when necessary. Categories were built inductively, meaning they were derived from the material rather than from a theoretical concept. The coding was done by SH, any uncertainties regarding the coding and coding manual were discussed with JU. The categories were then analyzed quantitatively by percentage of naming. This approach seemed suitable, as many answers were very short or only bullet points. Categories were built separately for each question so there is a coding manual for each question. For Question 1, 242 session checklists were analyzed. For Questions 2 to 5, we analyzed 16 questionnaires from 16 treatment cases. Percentages represent how often one category was named by the answers analyzed for the respective question. Percentages represent data from one question and all categories for the respective question are reported except for Question 1, where we report only categories with percentages ≥ 4.

Results

Additional Content or Techniques

In 150 out of the 242 checklists, the therapists named 172 additional contents or techniques. We coded them in 21 subcategories. The categories named most often were "crisis of the week" (12.2%), psychoeducation (11.3%), cognitive processing and trauma narrative

(each 11.1%). These were followed by relaxation (4.7%), treatment course, grief, and affective modulation (4.1% respectively).

Obstacles in Treatment

Five therapists named obstacles regarding TF-CBT for six cases. Eleven responses categorized in six categories showed the following challenges in implementing TF-CBT: relaxation (36.4%), cognitive processing I and TF-CBT components ahead of trauma narrative (each 18.2%), affective modulation, work sheets and linguistic problems (each 9.1%).

Cultural Factors in Treatment

Nine therapists gave 14 responses that indicate consideration of cultural factors that were assigned to eleven categories: using pride, religion, and metaphors (each 14.3%), simplify language, using strength and respect, culture-specific grief rituals, combination of psychological and somatic complaints, information on the culture-specific image of women, handling of aggressive behavior, culture-specific adaptation of treatment relationship and handling of general cultural controversies (each 7.1%). For six cases, therapists did not describe any cultural considerations. Three of the participants indicated that they possibly did but were not aware of it or did not explicitly do so.

Most Helpful for Patient

Twenty-six responses for 15 treatment cases were given regarding the most helpful TF-CBT components for the patient: trauma narrative (53.9%), cognitive processing (19.2%), psychoeducation, relaxation, conjoint session with patient and caregiver (each 7.7%) and affective modulation (3.9%).

Most Helpful for Therapist

Eight therapists responded to the question about what was most helpful for their work derived from TF-CBT in 22 responses for 13 treatment cases: having an agenda (22.7%), trauma narrative and psychoeducation (each 18.2%), cognitive processing (13.6%), intervision with other TF-CBT therapists (9.1%) and affective modulation, conjoint session, grief modules, and expectation of treatment success (each 4.6%).

Discussion

This is the first study to investigate “on the fly” adaptations by practitioners implementing TF-CBT with an especially vulnerable and diverse population. As one of the first studies, we present qualitative findings from therapists’ adaptations during TF-CBT,

which is a valuable addition to the research field. The overall results suggest that the implementation of TF-CBT is feasible without a tremendous amount of adaptation. In line with other studies on cultural adaptations to trauma-focused treatments, therapists also made changes in the conceptualization of the trauma's effects such as spiritual approaches (Ennis et al., 2020), and tailored materials and language (e.g. usage of metaphors) to the target group.

The additional content or techniques described were mostly TF-CBT components. Consequently, therapists had to repeat some components in later sessions (like psychoeducation before starting the trauma narrative) or brought components forward that were supposed to be carried out later (like affective modulation in the first session to enable some self-efficacy in dealing with PTSD symptoms). This is an approach that is typical for TF-CBT, which is meant to be flexible in the use of its components (Cohen et al., 2017). It is not surprising that dealing with the 'crisis of the week' was the content added most often. In addition to their trauma history, URMs have to deal with daily stressors and post-migration stressors (Keles et al., 2018) such as an unsecure asylum status, discrimination, or language and cultural barriers in the acculturation process. Therefore, we recommend that enhanced problem management related to post-migration stressors should be added as an additional component in TF-CBT ('crisis of the week') for this population.

There were reports of obstacles related to TF-CBT in only one third of cases. Language was named as the only problem in treatment, the other responses referred to components of little help for the respective treatment case. Relaxation was named most often. We recommend, however, to retain this content as part of the treatment as it is considered to be an important part of stabilization ahead of the trauma confrontation and suitable for use across different cultures.

The cultural adaptations named by the therapists were rather diverse. Looking at the data, we can see that most adaptations named were techniques that we would use irregularly throughout treatment, like the meaning of pride, strength or respect that can be included in the cognitive work, trauma narrative or future safety. The use of pride or respect and culture-specific grief rituals could be discussed in the TF-CBT training in order to enable therapists to deliver culturally sensitive treatment for URMs. This specific content might not be necessary for all URMs in treatment though, which means that therapists need to evaluate the inclusion of such culture-specific rituals and concepts for each individual patient independently. Therapists need to be trained to maintain a balance between cultural considerations and an overestimation of cultural aspects as this might lower manual adherence. In addition, suitable metaphors should be provided for different modules.

Even though trauma confrontation with asylum seekers is discussed in a controversial manner in the literature (ter Heide et al., 2016), the therapists named the trauma narrative as the most helpful component for their patients. The factor named most

helpful for therapists was "having an agenda" which is not a TF-CBT component, but a characteristic of manualized CBT approaches. The agenda for every session seems especially helpful when the "crisis of the week" is a very dominant part of the treatment sessions.

There are several limitations which might limit the generalizability of the findings. Unfortunately, Question 3 about cultural adaptations was phrased as a closed, two-stepped question ("Did you consider cultural factors in this treatment case? If so, which ones?"). This might have forced a "yes" or "no" answer and might therefore have biased the results. Furthermore, we were not able to calculate interrater reliability scores for the coding of categories. In addition, there was a lack of objective ratings (e.g. independent raters of videos from treatment sessions). Lastly, we did not assess the therapists' cultural competence or prior experience in transcultural work. Therefore, we cannot rule out that the level of cultural knowledge influenced the actual cultural adaptations.

Conclusion

The present study enhances our knowledge about the implementation of TF-CBT for a culturally diverse sample such as URMs in Germany. Nonetheless, URMs face numerous individual and structural barriers to receiving mental health care interventions tailored to their needs. Within the project "BETTER CARE – Improving mental health care for unaccompanied young refugees through a stepped-care approach" (Rosner et al., 2020) we will implement TF-CBT according to the knowledge gained from the present study. Furthermore, the recommendations discussed can contribute to the implementation of TF-CBT in culturally diverse groups in future research and clinical practice and might help practitioners to overcome barriers in treating young refugees.

Funding: Participant incentives in the pilot study were financed by proFOR+, a funding programme run by the Catholic University of Eichstätt-Ingolstadt. The BETTER CARE trial is funded by the German Ministry of Education and Research (01EF1802A-B).

Acknowledgments: The authors have no additional (i.e., non-financial) support to report.

Competing Interests: The authors have declared that no competing interests exist.

Supplementary Materials

The Supplementary Material contains examples from the coding manual for the questions regarding additional techniques, obstacles to treatment and cultural adaptations (for access see Index of Supplementary Materials below).

Index of Supplementary Materials

Unterhitzenberger, J., Haberstumpf, S., Rosner, R., & Pfeiffer, E. (2021). *Supplementary materials to "“Same same or adapted?” Therapists' feedback on the implementation of trauma-focused cognitive behavioral therapy with unaccompanied young refugees"* [Additional information]. PsychOpen GOLD. https://doi.org/10.23668/psycharchives.5029

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Latest Developments

Reporting Cultural Adaptation in Psychological Trials – The RECAPT criteria

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Clinical Psychology in Europe, 2021, Vol. 3(Special Issue), Article e6351, https://doi.org/10.32872/cpe.6351

Received: 2021-03-18 • **Accepted:** 2021-08-18 • **Published (VoR):** 2021-11-23

Handling Editor: Winfried Rief, Philipps-University of Marburg, Marburg, Germany

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Related: This article is part of the CPE Special Issue "Cultural Adaptation of Psychological Interventions", Guest Editors: Eva Heim & Cornelia Weise, Clinical Psychology in Europe, 3(Special Issue), https://doi.org/10.32872/10.32872/cpe.v3.si

Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: There is a lack of empirical evidence on the level of cultural adaptation required for psychological interventions developed in Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies to be effective for the treatment of common mental disorders among culturally and ethnically diverse groups. This lack of evidence is partly due to insufficient documentation of cultural adaptation in psychological trials. Standardised documentation is needed in order to enhance empirical and meta-analytic evidence.

Process: A "Task force for cultural adaptation of mental health interventions for refugees" was established to harmonise and document the cultural adaptation process across several randomised controlled trials testing psychological interventions for mental health among refugee populations in Germany. Based on the collected experiences, a sub-group of the task force developed the reporting criteria presented in this paper. Thereafter, an online survey with international experts in cultural adaptation of psychological interventions was conducted, including two rounds of feedback.

Results: The consolidation process resulted in eleven reporting criteria to guide and document the process of cultural adaptation of psychological interventions in clinical trials. A template for documenting this process is provided. The eleven criteria are structured along A) Set-up; B) Formative research methods; C) Intervention adaptation; D) Measuring outcomes and implementation.

Conclusions: Reporting on cultural adaptation more consistently in future psychological trials will hopefully improve the quality of evidence and contribute to examining the effect of cultural adaptation on treatment efficacy, feasibility, and acceptability.

Keywords

cultural adaptation, reporting criteria, randomised controlled trials, common mental disorders, psychological interventions

Highlights

- Adaptation starts with defining the target population along cultural and socio-demographic criteria.
- Literature review and formative research are used to define target symptoms, syndromes, needs, and context.
- Using a standardized documentation system to structure the adaptation process is recommended.
- Documentation includes results of formative research and adaptation of treatment elements.

Psychotherapies developed in Western, Educated, Industrialized, Rich, and Democratic (WEIRD; Henrich et al., 2010) societies may not or only partly be relevant to cultural groups or ethnic minorities who differ from the former in terms of cultural values, norms, or illness concepts. Evidence indicates that cultural adaptation of psychological interventions for the treatment of common mental disorders increases their acceptability and efficacy (Benish et al., 2011; Chowdhary et al., 2014; Hall et al., 2016; Harper Shehadeh et al., 2016). There is a large variety of target populations, psychological interventions and settings where cultural adaptation is applied, from low-intensity interventions in humanitarian settings (Perera et al., 2020) to higher-intensity interventions through the internet (Knaevelsrud et al., 2015) or face-to-face (Hinton et al., 2012), to mention only a few. Most cultural adaptation studies use a top-down approach, in which existing psychological interventions developed for one cultural group are adapted for another one. Few studies use a bottom-up approach to develop new interventions based on culturally specific symptoms or syndromes (Hall et al., 2016; Hwang, 2006).

So far, there are no standard criteria for documenting bottom-up and top-down cultural adaptations in clinical trials testing psychological interventions (in short: psychological trials). A more detailed standard documentation is key to obtain more reliable information regarding the effect of cultural adaptation on treatment efficacy, feasibility, and acceptability. In this paper, we suggest a set of reporting criteria for this purpose. First, we outline the theoretical and empirical background. Thereafter, the reporting criteria are introduced. More detailed information on the background, the development of the reporting criteria, and the use of these criteria, can be found in Appendix A (see Supplementary Materials).

Background

In the *Lancet Commission on Culture and Health*, culture is defined as follows: “Culture, then, can be thought of as a set of practices and behaviours defined by customs, habits, language, and geography that groups of individuals share” (Napier et al., 2014, p. 1609).

In Appendix A (Supplementary Materials), we provide additional definitions of culture. These definitions highlight that culture refers to shared systems of understanding and engaging with the world, which extends beyond language and ethnicity to include political, economic, environmental, and other contexts that shape these patterns of shared experience.

For instance, this means that translation from English into Spanish is unlikely to be sufficient to address the needs of residents of Barcelona, Venezuelan refugees in Colombia, and first generation Salvadoreans immigrated to the United States. Conversely, because culture is strongly tied to context, many of the adaptations done for Syrian refugees in urban host communities in Jordan may be helpful for Venezuelan refugees in urban host communities in Colombia, despite the language of adaptation being entirely different. Cultural adaptation, therefore, refers to enabling an intervention to produce its desired psychological effect with a particular group in a specific context.

Several frameworks for cultural adaptation of evidence-based interventions exist (e.g., Applied Mental Health Research [AMHR] Group at Johns Hopkins University, 2013; González Castro et al., 2010; Perera et al., 2020), all of which have been developed mainly for clinical practice. These frameworks have in common that they use stage models which include assessment, selection of the intervention (components), adaptation, piloting, and implementation. Such stage models provide guidance on the process of cultural adaptation (i.e., *how* to adapt). With regard to content of cultural adaptation (i.e., *what* to adapt), several frameworks exist, which are described more in detail in Appendix A (Supplementary Materials).

Empirical evidence from experimental studies is needed to show differential effects of different kinds of adaptations (Heim et al., 2020). Using a standardised documentation system, such as proposed in this paper, is key to meta-analytic evidence that is based on high quality of research. To achieve this aim, it is vital to structure reports on cultural adaptations, and to enhance transparency on *what* was culturally adapted in psychological trials.

Theoretical Framework

Heim and Kohrt (2019) propose a new framework of cultural adaptation that is based on evidence from cultural clinical psychology and psychotherapy research (see the section on Cultural adaptation frameworks in Appendix A, Supplementary Materials). The authors suggest using *cultural concepts of distress (CCD)* as the starting point for cultural adaptation. The term CCD has been introduced into the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5, American Psychiatric Association, 2013) to describe culturally shaped mental health-related phenomena. CCD encompass *idioms of distress* (Nichter, 1981, 2010), *cultural explanations* (Bhui & Bhugra, 2002), and *cultural*

syndromes (Kaiser & Jo Weaver, 2019). Evidence shows that CCD differ from diagnostic categories in DSM and the International Classification of Diseases (Kohrt et al., 2014).

Heim and Kohrt (2019) further suggest using a taxonomy of treatment components proposed by Singla et al. (2017) to structure the cultural adaptation and reporting process. Different taxonomies to dismantle components of psychological interventions have been proposed in literature, e.g., for behaviour change interventions (Michie et al., 2013) or for interventions for children and adolescents (Chorpita & Daleiden, 2009). Based on such blueprints, Singla et al. (2017) proposed a taxonomy to distil the components of psychological interventions for the treatment of common mental disorders (i.e., depression, anxiety, and stress-related mental health issues) in low- and middle-income countries. This taxonomy consists of specific and nonspecific elements, and therapeutic techniques. Elements are therapeutic activities or strategies (e.g., problem solving), whereas techniques are skills that the therapist implements during a session (e.g., role-playing). Specific elements are grounded in specific psychological mechanisms (i.e., behavioural, cognitive, emotional, and interpersonal elements), and nonspecific elements are routed in common factors of psychological interventions (Cuijpers et al., 2019; Wampold, 2007).

Aside from elements and techniques, which refer to *what* is provided in treatment, Singla et al. (2017) describe the *how* (e.g., delivery format), *who* (e.g., non-specialists), *and where* (i.e., setting) of psychological interventions. In cultural adaptation, treatment aspects that are related to *how* content is transmitted, include, e.g., the consideration of different dialects in translation or culture-specific aspects in illustrations that are not directly related to therapeutic elements (e.g., Abi Ramia et al., 2018). In accordance with Resnicow et al. (1999), these are considered as adaptations of the surface (Heim & Kohrt, 2019).

Process for Developing the Reporting Criteria

The Reporting Cultural Adaptation in Psychological Trials (RECAPT) criteria were developed by a “Task force for cultural adaptation of mental health interventions for refugees” in Germany. The aim of this task force was to harmonise and document the cultural adaptation process across eleven randomised controlled trials testing psychological interventions among refugees in Germany (Heim & Knaevelsrud, 2021, this issue). The task force developed a first set of criteria. Thereafter, an expert survey was conducted to seek consensus among international experts in the field of cultural adaptation and global mental health. Twenty-four international experts were invited, of which eleven responded to our survey and provided feedback on the reporting criteria. A second round of feedback was implemented, where the experts provided their comments on the revised criteria. For more details, please refer to Appendix A (Supplementary Materials). The expert survey is provided in Appendix B (Supplementary Materials).

Reporting Criteria

In the following, we propose eleven reporting criteria for future psychological trials with different cultural and ethnic groups. Based on the theoretical and empirical considerations outlined above, the reporting criteria for bottom-up and top-down cultural adaptation in psychological trials are structured along the following categories: A) Set-up; B) Formative research methods; C) Intervention adaptation; D) Measuring outcomes and implementation. An overview of the eleven criteria is shown in Box 1. The last category, measuring outcomes, is kept short, as this is addressed in specific literature (e.g., Leong et al., 2019). However, because measuring outcomes is an integral part of randomised controlled trials, we decided to include it as part of the reporting criteria.

Box 1

Reporting Cultural Adaptation in Psychological Trials (RECAPT): Overview of Criteria

A. Set-up
    Criterion 1: Definition of the target population
    Criterion 2: Team and roles
    Criterion 3: Documentation and monitoring system
    Criterion 4: Documentation of adaptations during trial ("on the fly")
B. Formative research
    Criterion 5: Formative research methods
    Criterion 6: Target symptoms, syndromes, needs, and context
C. Intervention adaptation
    Criterion 7: Specific treatment elements
    Criterion 8: Nonspecific elements and therapeutic techniques
    Criterion 9: Surface adaptations
D. Measuring outcomes and implementation
    Criterion 10: Questionnaires and clinical interviews
    Criterion 11: Implementation measures

We recommend reporting on these criteria, regardless of whether they were implemented or not. These reporting criteria can also be used as a guideline for planning the process of cultural adaptation of an existing intervention (top-down), or the consideration of cultural aspects in the development of new interventions (bottom-up) to be tested in psychological trials. The sequence of the reporting criteria is not fixed, as the process is often iterative; however, we put the sequence in what we considered to be a helpful order (e.g., establishing a documentation system early in the process). For reasons of

word count, the description of each criterion is kept short. More detailed information can be found in the Appendix A (Supplementary Materials).

If possible, we recommend publishing a separate paper on formative research and cultural adaptation alongside the regular papers of a psychological trial (i.e., protocol and outcome paper), as it has been done in several studies (e.g., Abi Ramia et al., 2018). A separate paper allows researchers to provide detailed information on the decision-making process and the different adaptations that were implemented. If it is not possible to publish a separate paper on the formative research and cultural adaptation, it is still recommendable to report on the most important aspects in the protocol or results paper.

A reporting form that can be used for future trials is presented in the Supplementary Materials). For reasons of transparency and replicability, we recommend adding the documentation and monitoring sheet as supplementary material to published papers. The template is structured along the reporting criteria.

A) Set-up

Cultural adaptation of psychological interventions is a complex process which most often includes several stages. Once a psychological trial is completed and results are about to be published, it may be difficult or impossible to reconstruct all the decisions that were made during the cultural adaptation process. For this reason, it is advisable to continuously document this process, and to be explicit about the people involved in decision-making.

Criterion 1: Definition of the Target Population

As described above, culture is a complex construct that cannot be reduced to ethnic groups or race. Many different socio-demographic factors may contribute to one's "culture", such as language, religion, age, migration background, refugee status, gender identity, sexual orientation, and socio-economic status, among others (González Castro et al., 2010; Sue & Sue, 2015). There is large variety with regard to values and norms within geographically or demographically defined groups (e.g., Fischer & Schwartz, 2011; Resnicow et al., 1999), and people may adopt different "cultural identities" in different contexts (Lehman et al., 2004).

Therefore, the first step in cultural adaptation is to clearly define the "unit of analysis", i.e., the target population in the psychological trial (González Castro et al., 2010). The definition and operationalisation of this unit of analysis should be done along the most important criteria that may have an impact on participants' cultural identity and their psychopathology (Betancourt & López, 1993). The unit of analysis may not always be limited to one particular ethnic, language, or even cultural group, i.e., psychological interventions can be culture-sensitive rather than culture-specific. Culture-sensitive interventions may target diverse groups, e.g., migrant populations in high-income countries, and be sensitive to cultural aspects in general rather than adapted

to specific features of one particular group (e.g., Lotzin et al., 2021, this issue; Mewes et al., 2021, this issue).

Criterion 2: Team and Roles

Several guidelines for qualitative research (e.g., Malterud, 2001; Tong et al., 2007) consistently recommend providing information on the personal characteristics of the researchers involved in qualitative studies (e.g., occupation, gender, training and qualifications), as well as information about preconceptions, which represent previous experiences, pre-study beliefs, and motivation. In this sense, we recommend shortly describing the team that was involved in the cultural adaptation process, as well as their roles during the formative research phase and in the decision-making process.

Criterion 3: Documentation and Monitoring System

Documentation is key for transparency and replicability of clinical trials in general, and therefore also for the cultural adaptation process. When documenting the process of cultural adaptation, we suggest providing as much information as possible on CCD, on other relevant aspects in the target population (e.g., specific needs), on the foundations for decisions that were made (e.g., data gathered through focus group discussions), and on the strength of evidence to support such decisions.

Cultural adaptation most often starts with formative research (see below). In formative research, relevant information on the target population is gathered, and representatives of the target population are asked about the relevance and acceptability of the intervention. During this process, many suggestions for changing and adapting parts of the intervention may be made. Some of these suggestions may be absolutely essential, for instance because of ethical considerations, because not doing them may cause harm (e.g., stigmatization, hurting feelings of subgroups), or foster higher attrition rates. Moreover, a strong evidence-base might be a good indicator for the need of an adaptation. On the other hand, there may be changes that are “nice-to-have”, or even controversial, especially if they are based on personal preferences or taste (e.g., Shala et al., 2020).

Criterion 4: Documentation of Adaptations During Trials (“On the Fly”)

In most running trials, some level of adaptation may happen “on the fly”, especially when working with diverse ethnic and cultural groups, for whom we have less empirical evidence on psychological interventions (Unterhitzenberger et al., 2021, this issue). As an example, if a misunderstanding in psychoeducation is discovered, it might be necessary to adapt the wording and, if needed, provide standard translations of such psychoeducation to interpreters for the rest of the trial. One may argue that ideally, such difficulties are discovered in pilot trials that are done exactly for this purpose. However, it is still possible that important information is revealed in the course of running trials,

and documentation and transparency with regard to such “on-the-fly” adaptations may be relevant for a better understanding of trial results and implementation.

In this line of thinking, Chambers and Norton (2016) challenge the assumption of a linear, static process from intervention development (and adaptation) to pilot testing, randomised controlled trial, and implementation. In this linear view that is still prevailing in literature, deviances from manuals are considered to be problematic, as they may threaten treatment fidelity and thus, effectiveness of the intervention. In their publication entitled “The Adaptome - Advancing the Science of Intervention Adaptation”, Chambers and Norton (2016) aim to capture “positive deviance (e.g., where adaptation leads to better outcomes compared to the original trials) as well as circumstances in which program drift was deleterious to intervention effectiveness” (p. 127). Thus, Chambers and colleagues make a case for documenting deviances from originally defined protocols: “By augmenting trial data with practice-based evidence, we can understand much more about what works for whom” (Chambers et al., 2013, p. 6). Using a standard documentation system (RECAPT Template, Supplementary Materials) will enhance transparency on adaptations that were made during trials.

B) Formative Research

Formative research includes the iterative process of gathering relevant information before starting a trial. The process of formative research is ideally reported in a consistent and transparent manner, to ensure replicability and valid interpretation of results. The RECAPT criteria include the *methods* of formative research on the one hand, and the *results* of this process on the other hand.

Criterion 5: Formative Research Methods

Formative research is an iterative process using multiple qualitative and quantitative methods. In the following, we provide suggestions on how to implement this process, thus, on *how to adapt*. In the Supplementary Materials, we provide a Template for documenting the cultural adaptation process. Formative research methods (i.e., literature review, qualitative, quantitative, and mixed methods) can be flexibly used until a level of saturation is reached. Results of this process should highlight the description of the target population’s main characteristics, their most salient symptoms or syndromes and needs, and the feedback gathered on the intervention during the process of cultural adaptation. Although there is no “standard procedure” for top-down or bottom-up cultural adaptation, we suggest reporting on these different stages of formative research.

Formative research normally starts with a *literature review*. Thereafter, researchers may conclude that available evidence on their target population is insufficient for cultural adaptation. *Qualitative and/or quantitative information* on the target population (i.e., main characteristics, symptoms, syndromes, needs) should be gathered where no or insufficient evidence is available, including mixed methods approaches (Shala et al.,

2020; Singla et al., 2014). Quantitative methods include symptoms scales, surveys, or other questionnaires used to describe the target population. Qualitative methods include in-depth interviews with key informants, focus groups, free-list interviews, pile sorting, among others (Cork et al., 2019; Keys et al., 2012).

We recommend using the consolidated criteria for reporting qualitative research (COREQ, Tong et al., 2007), a 32-items checklist for explicit and comprehensive reporting of qualitative studies. It includes participant selection (i.e., selection, method of approach, sample size, reasons for refusing); the setting for data collection (e.g., home, clinic); the method of data collection (i.e., interview guide, recording, duration), and the analysis methods (i.e., how themes were derived from the data).

Once data on the target population is gathered and compiled, interventions are adapted in a bottom-up or top-down approach. This process is accompanied by formative research, as well. And iterative process of adaptation, validation, and piloting is recommended (e.g., Shala et al., 2020). Regardless of the methods chosen in the process of cultural adaptation, documentation is key.

Criterion 6: Target Symptoms, Syndromes, Needs, and Context

This criterion describes the most relevant aspects to consider in cultural adaptation. As outlined above, Heim and Kohrt (2019) suggest using CCD as the pivotal point for cultural adaptation. CCD are distinct from diagnostic categories such as depression, or post-traumatic stress, but in many cases share symptoms with these disorders (e.g., Haroz et al., 2017; Rasmussen et al., 2014). Examples of CCD in literature are spirit possession in Uganda and Zimbabwe (Ertl et al., 2011; Patel et al., 1995), *dhat* in India (i.e., semen loss in urine; Gautham et al., 2008), *hwa-byung* in Korea (i.e., fire/projection of [accumulated] anger into the body; Min & Suh, 2010), or *khyâl attacks* (i.e., wind attacks) in Cambodia (Hinton et al., 2010). Evidence shows that CCD are often associated with symptoms of psychological distress and mental disorders in general. However, it would be erroneous to conclude that CCD are just variations of the same (universal) underlying constructs across cultural groups. In their systematic review on CCD, Kohrt et al. (2014) argue that higher methodological rigour is needed to better understand potential associations and distinctions between CCD and diagnostic categories developed in Western countries. We recommend using an ethnopsychological model to frame the understanding and use of CCDs (Keys et al., 2012; Kohrt & Hruschka, 2010).

Other relevant topics for cultural adaptation may include specific needs in the target population, mental health related stigma, as well as contextual variables such as differential exposure to social determinants of mental health, and access to health systems, and mental health resources (Hook et al., 2021). An example of such a contextual variable is ongoing armed conflict, which requires specific contextual adaptation of psychological interventions (Castro-Camacho et al., 2019).

C) Intervention

In clinical and empirical literature, cultural adaptation of psychological interventions most often implicitly refers to the top-down approach, in which existing psychological interventions developed for one cultural group are adapted for another one (Hall et al., 2016; Hwang, 2006). There is little evidence on psychological interventions adapted in a bottom-up approach to address culture-specific symptoms and syndromes.

One might argue that the development of new interventions does not fall under "adaptation". We counter this argument by stating that psychological interventions for the treatment of distress and mental disorders are a "Western" concept by themselves, as is the empirical evaluation of such interventions through randomised controlled trials. Therefore, the present reporting criteria are applicable not only for trials testing culturally adapted versions of existing interventions, but also newly developed interventions and intervention components that aim to target specific factors among culturally diverse groups.

Psychological interventions and trials to evaluate them share a common set of features, which have been classified by Singla et al. (2017) into four categories: Who (i.e., provider); What (i.e., treatment components); Where (i.e., treatment setting); and How (i.e., training, supervision, treatment delivery). Treatment components can be distilled into i) specific elements that are based on theoretical psychological models; ii) nonspecific elements that are commonly shared by interventions of different theoretical backgrounds; and iii) therapeutic techniques that aim to transmit specific and nonspecific elements (see Theoretical framework above). This taxonomy provides a helpful grid to support the cultural adaptation of intervention, as it specifies the different levels of an intervention. Other frameworks (e.g., Bernal et al., 1995; Bernal & Sáez-Santiago, 2006) have listed elements for cultural adaptation without putting them into a functional relationship. Accordingly, we structured our reporting criteria along the taxonomy by Singla et al. (2017).

The template provided in the Supplementary Materials can be used for documenting cultural and contextual adaptations, evidence to support each decision, and suggestions from the research team.

Criterion 7: Specific Treatment Elements

Most psychological trials have used manuals or protocols as unit of analysis (Chorpita & Daleiden, 2009). Manuals most often focus on one particular diagnosis and use a series of elements for the treatment of this disorder (e.g., psychoeducation, exposition, cognitive restructuring, relapse prevention) for their treatment. Transdiagnostic interventions combine treatment elements to address a broader symptom spectrum instead of one particular diagnosis, with promising effect sizes (Newby et al., 2013). As an example, the Common Elements Treatment Approach (CETA, Murray et al., 2014), applies evidence-based treatment elements depending on the specific symptomatology of

the patient. Other examples are Problem Management Plus (PM+, Dawson et al., 2015) developed by World Health Organization (WHO), or the Unified Protocol for Emotional Disorders (Barlow et al., 2004).

As mentioned in the Theoretical framework (see above), single treatment components can be distilled from such manuals, and several authors advocate reporting on treatment components (rather than manuals) in randomised controlled trials. In the process of cultural adaptation, this distillation may be even more relevant. In psychological trials with diverse ethnic and cultural groups, it may be important to provide some empirically or theoretically based rationale for the selection, omission or adaptation of each of the specific treatment elements. In addition, explicit decisions to leave specific elements unchanged should be reported, as well (Böttche et al., 2021, this issue).

The mental health Cultural Adaptation and Contextualization for Implementation (mhCACI) procedure begins with identification of the mechanisms of action as the first step in order to inform the literature review, formative work, and other steps (Sangraula et al., 2021). The literature review and formative work can be used to determine which specific treatment elements and other mechanisms of action will best fit with the culture and context. Alternatively, the literature review and formative work can be used to select which type of intervention will fit best and is mostly likely to undergo successful adaptation. If the CCD, community needs, and context are clearly defined, this will inform which interventions would not require heavy adaptation for implementation, which is especially important when rapid deployment is needed such as during humanitarian emergencies.

Criterion 8: Nonspecific Elements and Therapeutic Techniques

Nonspecific elements refer to components that are universal to all treatments, also known as “common factors” (Cuijpers et al., 2019; Wampold, 2007). One important common factor is the provision of a convincing treatment rationale. Psychological interventions ideally provide explanations that differ from the patient’s views, but that are not too discrepant from the patient’s intuitive assumptions as to be rejected (Wampold, 2007). This suggests trying to find common ground between the treatment’s hypothesized mechanism of action (including both specific and nonspecific elements) and the patient’s explanatory model. For treatment adherence and compliance, it is vital that patients understand and to some point share the rationale behind the treatment. The treatment rationale is ideally dovetailed with cultural explanations and idioms of distress that are part of CCD (Hwang, 2006; Rathod et al., 2019). CCD may include beliefs and assumptions that require to be challenged when providing the treatment rationale.

In addition, it may be relevant to consider culture-specific notions of stigma, and the way how mental health-related stigma threatens the life domains that “matter most” (Yang et al., 2014) to members of a specific cultural group (e.g., marriage, employment, social networks). Intervention adaptation should include consideration of "what matters

most" because this will influence stigma and motivation of those delivering the intervention (Kohrt, Turner, et al., 2020). Documentation of how adaptations address what matters most further demonstrates the rigor of the approach.

We also recommend to report on the reflections that have guided the choice, omission, or adaptation of *therapeutic techniques*, such as role-playing, goal setting, or homework (Singla et al., 2017).

Criterion 9: Surface Adaptations

Surface structure adaptations aim to enhance acceptability of an intervention through matching materials, channels and settings to the target population (Resnicow et al., 1999). Such surface adaptations correspond to the *How* and *Where* in the taxonomy suggested by Singla et al. (2017). There is much evidence on such surface adaptations of psychological interventions (Chowdhary et al., 2014; Chu & Leino, 2017; Harper Shehadeh et al., 2016).

Cultural and contextual factors may determine the channels through which the treatment components are provided, e.g. group-based as opposed to individual treatment (Epping-Jordan et al., 2016; Sangraula et al., 2018; Verdeli et al., 2003), or internet-based interventions (Naslund et al., 2017) that are increasingly tested and applied among diverse ethnic and cultural groups. Reporting should include considerations that have been made with regard to such different modes of delivery.

Interventions (both self-help and face-to-face) may include materials such as texts, illustrations, case examples, flyers, audio files, videos, etc. Standards exist for the translation of assessments and materials (e.g., van Ommeren et al., 1999). Several studies report that it is often difficult to draw the line between translation and adaptation, as these two are closely intertwined (Ramaiya et al., 2017; Shala et al., 2020). For pragmatic reasons, it is often not possible to document all the decisions that were made during the process of translation and language editing, especially if the decisions are merely questions of style or grammar. However, some decisions might be relevant to be documented in the cultural adaptation monitoring sheet. As an example, metaphors are often culture-specific and cannot be translated literally (Rechsteiner et al., 2020). It might therefore make sense to report on how specific metaphors in the intervention were translated or adapted.

D) Measuring Outcomes and Implementation

As outlined above, there is considerable cultural variation in symptom expression. In clinical trials testing psychological interventions among diverse ethnic and cultural groups, it is important to account for this cultural validation by using validated instruments.

Criterion 10: Questionnaires and Clinical Interviews

When conducting clinical trials with culturally diverse populations, it is vital to provide information on the extent to which outcome measures (i.e., questionnaires and clinical interviews) were translated, (culturally) adapted, and validated.

There are standard criteria for the translation, adaptation, and validation of questionnaires. As an example, Wild et al. (2005) and van Ommeren et al. (1999) provided principles of good practice for the translation and cultural adaptation process for patient-reported outcomes. In addition, standard psychometric methods for the cross-cultural validation of questionnaires and measurement invariance have been developed (e.g., Byrne et al., 1989; Chen, 2008; Milfont & Fischer, 2010; Vandenberg & Lance, 2000). Several standard questionnaires have been used for application among diverse cultural and ethnic groups, e.g., the Patient Health Questionnaire (Kroenke & Spitzer, 2002), the Generalised Anxiety Disorder scale (Spitzer et al., 2006), the Posttraumatic Diagnostic Scale (Foa et al., 1997), the General Health Questionnaire (Goldberg, 1972), or the WHO Disability Assessment Scale (Ustun et al., 2010), to mention only a few.

The validity of questionnaires can be enhanced by incorporating CCD, and particularly idioms of distress. Another option is the use of client-generated outcome measures, such as the Psychological Outcome Profiles instrument (PSYCHLOPS, Ashworth et al., 2004), which has been validated in several countries (e.g., Czachowski et al., 2011; Héðinsson et al., 2013). Another client-generated outcome measure is the Personal Questionnaire (Elliott et al., 2016).

Most trials use self-report questionnaires as their primary outcome measure. Clinical interviews are of course more labour-intensive, but the diagnostic accuracy might be higher (Ferrari et al., 2013), especially among diverse cultural and ethnic groups. If the planned outcome measure for the psychological trial is a clinical interview (e.g., the Structured Clinical Interview for DSM-5, SCID-5-CV; First et al., 2016), it is recommended to integrate a culture-sensitive interview, such as the *Cultural Formulation Interview* in DSM-5 (American Psychiatric Association, 2013). Training interviewers in culture-sensitive assessments is important, in order to avoid misdiagnosis. And it is relevant to report on interviewer training and interrater reliability with regard to cultural competence.

Criteria 11: Implementation Measures

In addition to measuring outcomes, the implementation process should be documented, as well. Without documenting implementation, it is difficult to determine if an unsuccessful intervention is due to the intervention not being effective or lack of fidelity when delivering the intervention (Jordans & Kohrt, 2020; Kohrt, El Chammay, et al., 2020). Moreover, assessing implementation is vital to determine that the cultural adaptations were actually enacted in delivery of the intervention. Criterion 11 refers to the *Who* and *How* criteria in the taxonomy by Singla et al. (2017).

In addition to fidelity, competency of providers is important to evaluate. Competency tools now exist that can be modified based by the culture and context for a psychological intervention (Kohrt, Schafer, et al., 2020); these address both competency in nonspecific treatment factors (Kohrt et al., 2015) and culturally adapted competencies in treatment specific factors, such as for PM+ (Pedersen et al., in press).

Quality Rating

Currently there are no standards for ranking of cultural adaptation quality. We propose for preliminary use that cultural adaptation studies that only report on 4 or fewer of the criteria be consider 'low quality' of reporting. Studies that are 5-8 criteria be identified as 'moderate quality' of reporting. Finally, studies that clearly document 9-11 criteria be considered 'high quality'. These rankings are subject to change as more documentation occurs on adaptation and further research is conducted about what aspects of adaptation matter most for successfully alleviating suffering across cultures and context around the world.

Concluding Remarks

In this paper, we propose a set of reporting criteria for cultural adaptation in clinical trials which test psychological interventions among diverse cultural and ethnic groups. Although these reporting criteria were primarily developed for treatments of common mental disorders, they may be used also for other kinds of interventions, such as prevention or mental health promotion.

The suggested set of criteria was compiled based on the authors' experiences and current literature. Although not exhaustive, the criteria are comprehensive and may be used for top-down and bottom-up cultural adaptation (Hall et al., 2016; Hwang, 2006). They can be used to guide the process of cultural adaptation, as well as for documentation. That said, it is likely that not all of these criteria are relevant for all trials conducted in this field of research. In this sense, the use and the sequence can be adapted flexibly to the needs of researchers. A template for documenting the process and results of cultural adaptation can be found in the Supplementary Materials.

Reporting on cultural adaptation more consistently in future psychological trials will hopefully improve the quality of evidence and contribute to examining the effect of cultural adaptation on treatment efficacy, feasibility, and acceptability.

Funding: The project that led to the development of the reporting criteria and the paper was funded by the German Federal Ministry of Education and Research (Nr 01EF1806H).

Acknowledgments: We would like to thank Dr. Kenneth Carswell for his valuable contributions to the manuscript.

Competing Interests: Eva Heim and Cornelia Weise are both Guest Editors of this Special Issue of Clinical Psychology in Europe but played no editorial role in this particular article or intervened in any form in the peer review process.

Supplementary Materials

The Supplementary Materials contain the following items (for access see Index of Supplementary Materials below):

- **Appendices**
  - *Appendix A* provides additional information on definitions of culture, cultural adaptation literature, the process for developing the RECAPT criteria, and detailed information on each criterion.
  - *Appendix B* shows the expert survey used for developing the RECAPT criteria.
- **RECAPT Template**
  A template for documenting the cultural adaptation process that was developed by the "Task force for cultural adaptation of mental health interventions for refugees". A documented version for better understanding is provided, along with an empty template in Word format that can be used for future studies.

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Clinical Psychology in Europe (CPE) is the official journal of the European Association of Clinical Psychology and Psychological Treatment (EACLIPT).

PsychOpen GOLD is a publishing service by Leibniz Institute for Psychology (ZPID), Germany.