

Contextual adaptation and piloting of *Group Integrative Adapt Therapy (IAT-G)* amongst Rohingya refugees living in Bangladesh

Mahmuda Mahmuda^{1*}, Mohammad Abdul Awal Miah^{2*}, Mohamed Elshazly³, Sanjida Khan⁴, Alvin Kuwei Tay⁵ & Peter Ventevogel⁶

¹MS, Public Health and Nutrition Unit, UNHCR Cox's Bazar, Bangladesh, ²MPhil, Perdana University, Centre for Research Excellence (PUCRE), Selangor, Malaysia, ³MD, MSc, ABPsc, IMMHPs, Public Health and Nutrition Unit, UNHCR Cox's Bazar, Bangladesh, ⁴MS, Department of Psychology, Jagannath University, Dhaka, Bangladesh, ⁵PhD, School of Psychiatry, Faculty of Medicine, University of New South Wales, Australia, ⁶MD, PhD, Public Health Section, United Nations High Commissioner for Refugees, Geneva, Switzerland

*Both first authors contributed equally.

Abstract

A main gap in the delivery of mental health and psychosocial (MHPSS) services to Rohingya refugees in Cox's Bazar district in Bangladesh is the limited coverage of psychotherapeutic interventions. There is a shortage of mental health professionals who can provide culturally adapted and linguistically appropriate psychotherapeutic interventions that are congruent with the refugee experience. This article describes preliminary work on training Bangladeshi psychologists and para-professionals in applying a novel group-based psychological intervention for refugees, *Group Integrative Adapt Therapy (IAT-G)*. This is a pragmatic, eclectic and transdiagnostic approach, based on the *Adaptation and Development After Persecution and Trauma (ADAPT)* model. It aims to help refugees to develop resilience and capacities for managing maladaptive reactions to trauma and post-migration living difficulties. This paper describes the key strategies and challenges during the first phase of the project.

Activities included an extensive desk review, a one-week training workshop with competency assessments, cultural adaptation of the treatment manual and assessment measures, training on digital literacy and electronic data collection and a blended supervisory model (involving onsite and online sessions). It proved to be generally feasible but not easy to introduce IAT-G in this population.

Keywords: adaptation and development after persecution and trauma (adapt) model, group integrative adapt therapy (IAT-G), mental health and psychosocial support, Rohingya, refugee

KEY IMPLICATIONS FOR PRACTICE

- The introduction of a brief scalable psychological intervention within an acute and ongoing emergency was feasible, but faced considerable challenges including high staff turnover.
- Implementation involves multiple components including stakeholder engagement, contextual adaptation of tools and materials, training and supervision and setting up a monitoring system.
- Setting up a supervision is of critical importance but can be complicated in the context of an unfolding emergency.

INTRODUCTION

Over 70.8 million persons have been exposed to mass conflict and displacement in the contemporary world, the largest number since World War II (United Nations High Commissioner for Refugees, 2019). The psychological needs of these populations are significant: over one in five are estimated to have a mental health condition (Charlson, van Ommeren, Flaxman, Cornett, Whiteford, & Saxena, 2019). Conventional psychological interventions (individual psychotherapies conducted by specialists) are often not feasible in low-resource settings where most refugees and

Address for correspondence: Mahmuda Mahmuda, Public Health and Nutrition Unit, United Nations High Commissioner for Refugees (UNHCR), Cox's Bazar, Bangladesh. E-mail: mahmuda@unhcr.org

Address for correspondence: Mohammad Abdul Awal Miah, Adjunct senior Lecturer, Perdana University, Centre for Research Excellence (PUCRE), Selangor, Malaysia. E-mail: awalcp@yahoo.com

Submitted: 10 July 2019 **Revised:** 21 August 2019
Accepted: 14 October 2019 **Published:** 29 November 2019

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

How to cite this article: Mahmuda, M., Miah, M. A. A., Elshazly, M., Khan, S., Tay, A. K., & Ventevogel, P. (2019). Contextual adaptation and piloting of *Group Integrative Adapt Therapy (IAT-G)* amongst Rohingya refugees living in Bangladesh. *Intervention* 17(2), 149-159.

Access this article online

Quick Response Code:



Website:

www.interventionjournal.org

DOI:

10.4103/INTV.INTV_48_19

other forcibly displaced people reside. Existing specialised human resources, such as psychologists and psychiatrists, are often limited in such settings, and existing health systems, including mental health services, are often overwhelmed or unavailable for refugees (e.g. due to distance, cost) (Silove, Ventevogel, & Rees, 2017). An effective and cost-efficient way to make psychosocial interventions available and accessible to refugees is to train non-specialised staff working in different sectors such as health and protection programmes in delivering basic psychotherapeutic interventions. In recent years, a substantial body of studies has demonstrated the effectiveness of brief and innovative treatment approaches for common mental disorders in populations affected by conflict such as WHO Problem Management Plus (PM+) (Dawson, Harper, Tay, Rahman, Schafer, & van Ommeren, 2015; Rahman et al., 2016, 2019), Interpersonal Therapy for Depression (Bolton et al., 2007) and Common Elements Treatment Approach (CETA) (Bass et al., 2016; Murray et al., 2018). However, these efforts have not yet translated into widespread use or integration into existing service delivery structures in humanitarian settings in low- and middle-income countries facing a massive influx of refugees.

We believe that there are various reasons for this ‘implementation gap’. First, even though these treatments are brief and can be delivered by lay counsellors, they often focus on individual treatment which limits the extent of coverage at a population level. Second, persisting stigma and concerns about being labelled with a mental disorder continue to discourage accessing services. Third, focusing only on *symptoms* of mental disorders (depression, anxiety) reduces the contextual meaning and acceptability of therapies in the absence of a broader engagement with the psychosocial and cultural context in which these symptoms were produced and in the absence of attempts to promote adaptive capacity to cope with the challenges of the new environment. Fourth, it is often challenging to integrate interventions in routine support systems and existing health due to obstacles related to institutional factors, funding, skills, advocacy, community acceptance, burn-out and lack of supervision.

In order to mitigate some of these challenges, Integrative ADAPT Therapy (IAT) was developed (Tay et al., 2019d). This is a psychological treatment for addressing common mental health problems and building adaptation and resilience in vulnerable populations. The approach is based on the Adaptation and Development after Persecution and Trauma (ADAPT) model, which postulates that the sequence of events associated with becoming a refugee causes disruptions to the underlying systems (‘pillars’) that support psychosocial wellbeing: safety/security, bonds/networks, access to justice, roles/identities and existential meaning (Silove, 2013). IAT explicitly links disturbances in these pillars to the symptoms that refugees may experience. The method has been piloted among Rohingya refugees in Malaysia (Tay et al., 2019d), but as far as we know no research has been done on Group Integrative Adapt Therapy (IAT-G) or any other brief psychotherapeutic intervention in the Rohingya refugee context in Bangladesh.

The Rohingya refugee crisis is one of the largest acute population displacements in current history. The United Nations High Commissioner for Refugees (UNHCR) identifies mental health and psychosocial support (MHPSS) in the Rohingya setting as one of the priorities (United Nations High Commissioner for Refugees, 2018) and formulated three broad goals for the response: 1) integration of mental health into the general refugee health care system (Tarannum, Elshazly, Harlass, & Ventevogel, 2019); 2) setting up brief and scalable psychotherapeutic intervention, such as IAT and Interpersonal Therapy (UNHCR, 2018); and 3) strengthening community-based psychosocial support (Uddin & Hasna, 2019). Related to the second goal (scalable psychological interventions), UNHCR Bangladesh invited a group of mental health professionals and researchers (MAAM, SK and AKT) to pilot an adapted form of IAT-G amongst Rohingya refugees living in Bangladesh. This paper aims to document and discuss the various components of this ongoing project to introduce IAT-G for Rohingya refugees in Bangladesh: 1) Preparation, 2) Adaptation, 3) Training, 4) Supervision, 5) Pilot and 6) Implementation.

Before describing the various components, we provide a brief introduction to IAT-G and its theoretical foundations. The work described in this paper is part of an ongoing project to build capacity in IAT in the Rohingya context in Bangladesh. Ethical permission for the study conducted in Cox’s Bazar (CXB) refugee camps in Bangladesh was provided by the Bangladesh Medical Research Council in Dhaka.

Theoretical foundations of IAT-G

The theoretical background, initial development and piloting of IAT have been described elsewhere (Tay et al., 2019d). In brief, IAT is grounded in the ADAPT model (Tay & Silove, 2017). According to the ADAPT model, the myriad of psychosocial disruptions caused by mass conflict can be organized into five core pillars: supporting safety/security; interpersonal bonds and networks; justice; identities and roles; and existential meaning (Silove, 2013). For example, in relation to Pillar 1 (safety/security), the model postulates that exposure to repeated or sustained conditions of threat and insecurity initially generates normative levels of fear which, when extending beyond the individual’s capacity to adapt, manifests in posttraumatic stress disorder (PTSD) and other forms of clinical anxiety (Tay, Rees, Chen, Kareth, & Silove, 2015a). Multiple traumatic losses and separations (Pillar II) related to violence, when unmitigated, can lead to complicated forms of grief and separation anxiety (Silove, Momartin, Marnane, Steel, & Manicavasagar, 2010; Tay Rees, Chen, Kareth, & Silove, 2016). Exposure to gross human rights violations (torture, sexual abuse, massacres) engenders a deep and persisting sense of injustice (Pillar III) which can lead to normative levels of anger which may become dysfunctional, manifesting in inappropriate aggression (Rees & Silove, 2011; Silove et al., 2017; Tay, Rees, Chen, Kareth, & Silove, 2015b). Erosion or loss of roles and identities (Pillar IV) leads to identity confusion, and depending on the context, feelings of marginalisation and anomie (Tay, Rees, Tam,

Kareth, & Silove, 2019a). Disruption of systems of meaning in the social, cultural, political and/or spiritual/religious domains of life (Pillar V) can lead to a sense of incoherence and existential despair (Basoglu et al., 2005).

IAT-G has several advantages over conventional one-on-one psychotherapies: First, group therapy familiarizes participants with the process, destigmatising psychotherapeutic treatments by normalising distress and creating a foundation of trust and rapport, thereby reducing the clinical resources required for individual therapy sessions. Second, rather than being symptom-focused, IAT-G uses the group setting to help participants understand and cope with their symptoms and attempts to overcome stigma and concerns about mental disorders and facilitate participation. Third, the group format leads to broader coverage compared to traditional one-on-one psychotherapies. Fourth, IAT-G authenticates the refugee's experience by tailoring the intervention to the lived experience of psychosocial disruption and the culture and context of each group. Fifth, the intervention incorporates cognitive-behavioural and problem-solving techniques that are known to be effective and amenable to task shifting to trained counsellors who act as group facilitators from refugee groups. Sixth, the integrated approach adds to the contextual validity of the intervention by focusing on key issues surrounding the legacy of cumulative challenges refugees commonly face, the impact of these experiences on the self and family and the potential to use self-help strategies to overcoming ongoing obstacles. A key emphasis of IAT is to ensure that the 'scaffold of the therapy' is fully contextualized according to the culture and specifics (e.g., local conditions, terminology, idiomatic expressions) of the refugee experience of each group within their historical and psychosocial context.

Within the described framework, the treatment components are modified serially and applied to assist refugees in addressing the core challenges pertaining to each of the five ADAPT domains. The broad components of IAT include psychoeducation, story-telling (narrating stressful events in a chronological manner), problem-solving, relaxation, emotion regulation, cognitive re-appraisal, strengthening social support and meaning making (Tay, Miah, Khan, Badrudduza, Balasundaram, & Silove, 2019c).

Component 1: Preparation

Review of existing information

UNHCR commissioned one of the authors (AKT) to do an extensive desk review providing an in-depth understanding of the context and culture of Rohingya refugees and their views on MHPSS (Tay et al., 2019e). Additionally, stakeholder consultations were organized with trainee providers, supervisors and organisational staff from UNHCR and partner organisations in CXB to get information about the broader care delivery system for the Rohingya refugees in that setting. Key challenges included limited familiarity of Bangladeshi mental health providers with the Rohingya language, culture, their help-seeking behaviour and their migration and traumatic history. The terms for mental health in the Rohingya language have limited

correspondence with the professional vocabulary for emotional, cognitive and behavioural disorders. This knowledge helped the authors to develop and design the IAT programme considering the culture, context, migration history, idioms of distress, help-seeking behaviour and traditional healing methods. We also paid attention to past sequential trauma exposure and post-migration living stressors to mobilize and build the capacity, skills and resilience in Rohingya refugees

Setting up the IAT Bangladesh team and trainers

The expatriate team was led by AKT, the developer of IAT and consultant for UNHCR, and two Bangladeshi clinical psychologists (MAAM and SK) who are IAT master trainers based in Malaysia. The team has conducted extensive pilot work (qualitative research, epidemiological surveys, randomized controlled trials) including the training of 28 IAT lay counsellors from both Myanmar ethnic and Rohingya communities as well as the adaptation and piloting of IAT amongst Rohingya refugees in Malaysia since 2015 (Tay et al., 2019d).

Selection of candidate trainees

The candidate trainees were selected by (MM and MES) involving four organisations currently providing either health or community-based protection services/activities. Criteria for selection included: level of education (at least high school); proficiency in Bangla, preferably the Chittagonian dialect, and English; previous experience working with the Rohingya refugees in MHPSS or related capacities is desirable; motivation and commitment, personal attributes and interpersonal skills; basic awareness of ethical principles; and ability to understand the basic concepts necessary for implementing the intervention.

Table 1 reports the demographic characteristics of the IAT trainee provider group. Twenty-three (eighteen women and five men) candidates were selected by UNHCR and four partner agencies participated in the full-time onsite training workshop. All trainees were proficient in Bangla. Five of them could speak Rohingya and the Chittagonian dialect fluently and all had basic English knowledge. The majority of the trainees ($n = 16$) had completed graduation in psychology and eight completed a postgraduate degree and training in a specialized field of psychology (e.g. clinical/counselling/education psychology). Over half the trainees ($n = 13$; 57%) had at least six months of work experience in MHPSS-related sectors involving the Rohingya community in CXB district and over one third ($n = 8$; 35%) had up to twelve months of relevant work experience prior to the training. The trainees were recruited from four UNHCR partner organisations including Technical Assistance Incorporated (TAI), Gonoshasthaya Kendra (GK), Research Training and Management International (RTMI) and Building Resources Across Communities (BRAC).

Component 2: Adaptation of IAT tools and psychometric measures

The IAT manual and psychometric tools were adapted for the Rohingya refugee population living in Malaysia (Tay

Table 1: Reports the demographic characteristics of 23 trainee providers who participated in the onsite IAT training workshop

Variables		N	%
Gender	Male	5	22
	Female	18	78
Educational Background	Completed postgraduate degree(s)	19	83
	Completed honors degree(s)	2	9
	Completed undergraduate degree (s)	2	9
Field of concentration	Psychology	16	70
	Other	7	30
Previous experience working with the Rohingya community	0-6 months	13	57
	7-12 months	8	35
	1 year or more	2	9
UNHCR partner organizations	TAI	6	26
	GK	3	13
	RTMI	7	30
	BRAC	6	26
	UNHCR	1	4

et al., 2019d). Further adaptation and refinements were done for Rohingya refugees across CXB sites in Bangladesh. Based on our experience, this population is markedly less literate than the Rohingya refugees in Malaysia. Twenty-seven participants (including AKT, MAAM, SK and MM) who had experience of working in Rohingya refugee camps in CXB participated in the adaptation process of IAT tools during workshop and practicing phase.

ADAPT meter

The ADAPT meter is a tool used to assess the distress level to each pillar to see the change in their emotional difficulties. This was modified in the context of emotional reactions to each pillar for Rohingya refugees in the camps.

Coping cards

We developed and adapted illustrative coping cards for the Rohingya participants in Bangladesh as their literacy level is very low. The purpose of the coping cards was to understand IAT sessions focusing on ADAPT Pillars which were based on their own stories and culture and how they can cope with the normative and clinical reactions to each pillar. We divided five groups among the IAT counsellors who developed a story of each ADAPT pillar based on their experience in their home country as well as in the camps. The five stories were reviewed by a team of experts in MHPSS and IAT and subsequently, a designer developed the coping cards. The pictorial coping cards were tested with the beneficiaries in the field and further refinements were made (Figure 1).

Adaptation of psychometric tools in Rohingya dialect

Humanitarian Emergency Settings Perceived Needs Scale (HESPER) (World Health Organization & King's College London, 2011), Patient Health Questionnaire-9 (Kroenke, Spitzer, & Williams, 2001), Posttraumatic Stress Disorder-8 (Hansen Andersen, Armour, Elklit, Palic, & Mackrill, 2010), Generalized Anxiety Disorder (GAD) (Spitzer, Kroenke, Williams, & Löwe, 2006), World Health Organization Disability Assessment Schedule (WHODAS) 2.0 (Ustun et al., 2010), Harvard Trauma Questionnaire (HTQ) (Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992), Adaptive Stress Index (ASI) (Tay, Rees, Tam, Karath, & Silove, 2019b), Complicated Persistent Bereavement Disorder (PCBD) (Tay, Rees, Chen, Karath, Mohsin, & Silove, 2015c), Connor-Davidson Resilience Scale (CDRS) (Connor & Davidson, 2003) were translated from English to Bengali language in our previous study (Tay et al., 2019d). These psychometric tools were adapted to the context of CXB during three workshops. In the first workshop, 31 participants (including AKT, MAAM, SK and MM) attended to further adaptation of the Bangla version of psychometric tools to check idiom of distress, languages and irrelevant of any items considering Rohingya culture and the camps setting in Bangladesh.

A second workshop was undertaken to translate screening and baseline measures from Bengali into the Rohingya language using the Bengali script. A total of 25 MHPSS staff who had experience with Rohingya refugees were present in the workshop. Rohingya versions of screening tools (PHQ-9, PTSD-8 and WHODAS) and outcome tools (HESPER, GAD-7, ASI-24, HTQ, PCBD and CDRS) were tested with 25 and 19 Rohingya refugees respectively in different camps at the piloting phase. The internal consistency of both screening and outcome measures was assessed. It showed good inter-rater reliability for PHQ-9 ($\alpha = 0.804$), PTSD-8 ($\alpha = 0.818$), WHODAS ($\alpha = 0.855$), HESPER ($\alpha = 0.913$), GAD-7 ($\alpha = 0.817$), ASI-24 ($\alpha = 0.939$), HTQ ($\alpha = 0.955$), PCBD ($\alpha = 0.929$) and CDRS ($\alpha = 0.936$). Fifteen IAT counsellors and five Independent Assessors (IAs) did cognitive testing individually with the refugees to understand the distress terms for each item. In order to better understand the answer patterns to items of the psychometric measures, we developed a pictorial response pattern where there were different sizes of circle which denoted the extent of the problem. After that, a final workshop was conducted with IAT counsellors and IAs to make further refinements to the psychometric tools for assessing their actual mental health conditions. After piloting, we got feedback from them that participants were overburdened with large number of questionnaires of the outcome measures (128 items in total). Therefore, the research team decided to use a six-item scale named Brief Resilience Scale (BRS) (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008) to assess resilience instead of CDRS and removed HESPER from the outcome measures. In this workshop, BRS was adapted following the same procedure mentioned above. The adapted version of BRS showed high internal consistency ($\alpha = 0.87$) in further piloting with 20 Rohingya participants. In relation to



Figure 1: The coping cards as developed for Rohingya refugees in Bangladesh

response pattern, we changed the red colour of illustration of this as some of the Rohingya refugees were perceived as a symbol of the torture and killing at their home country by authorities.

Component 3: Training of counsellors and assessors

Training of counsellors

Ten-day onsite IAT training workshop

The onsite training included both didactic (classroom training) and practical (field visits) sessions and was conducted in Bangla and English, involving 23 IAT candidate providers over the course of ten days. The standardized

IAT training workshop (see Box 1) was developed by AKT, based on a manualized treatment. It has been used to train over fifty providers in different countries. Drawing on our previous experience in training lay Rohingya counsellors in Malaysia, we made adjustments to the training in Bangladesh, considering the more advanced levels of experience and education of this group, noting that additional support was provided to the four para-counsellors who had minimal knowledge and experience in mental health or counselling compared to the remaining trainees.

The training workshop was conducted in three broad phases combining both didactic and practical elements. In the first phase, the training commenced with a broad

Box 1. OUTLINE OF CONTENT AREAS COVERED IN IAT TRAINING WORKSHOP

- Research and Practice in Refugee Mental Health
- Mental Health Problems in Refugee Populations
- Psychological and Psychosocial Treatments in Refugees
- The ADAPT model: Bridging the gap between individual and psychosocial responses in refugees
- Integrated ADAPT Therapy
- IAT background and theory
- IAT adapted to Rohingya Muslims (idioms of distress, culturally specific terminology and Rohingyas' mental health lexicon)
- IAT components and administration (role-play, practice IAT components)
- Piloting IAT with Rohingya refugees in Cox's Bazar: Naturalistic assessment of feasibility and acceptability of IAT
- Culturally adapted mental health and psychosocial assessment tools
- Safety and security protocol for field personnel
- Key issues in relation to ethics, professionalism and fidelity of intervention trials with refugees
- Gender based and intimate partner violence in refugees.

overview of the foundations of refugee mental health including the epidemiology of mental health and psychosocial problems in refugee/displaced populations, comorbidity issues, the psychosocial reactions to conflict and displacement, the ecological framework of refugee adaptation, the current treatment approaches for comorbid psychopathology in refugees and the relevance of culture and context to treatment. Additional topics included the culture, language, terminology and context of the Rohingya refugees with a particular emphasis on the Rohingya conceptualisation of the self, locally identified explanatory models of distress, local idioms of distress, help-seeking behaviour and traditional healing methods.

In the second phase, we covered the core principles of the ADAPT model and IAT; fostering resilience and adaptive capacity in refugee communities; the constituent treatment components of IAT; adapting and contextualising treatment strategies and tools according to the refugee experience; and the delivery of IAT to refugees. For ease of understanding and application, each treatment component was disaggregated into key steps. For example, the problem-solving component includes four key steps: 1. identify minimum three problems/challenges related to the ADAPT pillars, 2. explore coping strategies in relation to each problem area, 3. explore potential barriers to overcome each problem area and 4. explore potential solutions to address or minimize the barriers to each problem area. Simulated sessions were conducted (under the supervision of master trainers) in a group setting in which two trainees (one acting as a client and the other provider) delivered a specific component of IAT followed by group feedback. All trainees were allowed additional time to practice each treatment component independently under the supervision of master trainers, local supervisor and team leader.

In the final phase, all trainees were required to participate in field visits to the refugee camps in CXB. The trainee provider team conducted ten informal IAT sessions in the Rohingya language with refugees living in Camp 4 over two field visits. The master trainers, local supervisor and team leader were present during the sessions as observers.

General observations from post-training field visits

During the first field visit in Kutupalong refugee camp immediately following the training, we observed that most trainees demonstrated a basic understanding of IAT and the constituent treatment strategies as reflected in their attempts at delivering these strategies during informal sessions with refugee clients. Each trainee practised at least two of the listed strategies with at least one client. The practice sessions highlighted several practical issues such as limited availability of physical space when conducting therapy sessions and this compromised the privacy of some sessions. Language barriers during the initial pilot phase led to lack of understanding, confusion about the intervention, missing steps. The five IAT trainees who were fluent in the Chittagonian dialect indicated informally that they felt 'reasonably confident' in delivering IAT in the Rohingya language, while the remaining 18 who had only a basic understanding of the Rohingya language did not feel confident in delivering IAT in the local language. The expatriate team suggested several strategies (e.g. audio-record sessions conducted in the Rohingya language) aimed at assisting the trainees in their understanding of the Rohingya language.

IAT knowledge test

All 23 trainee providers completed the knowledge test (within 45 minutes). The tests were graded by two independent examiners. The majority of the trainees achieved 75% pass rate (18, 78%) and five (22%) scored below the threshold (test score range: 61–93).

IAT competency evaluation

All trainees were required to complete the IAT Competency Evaluation consisting of a written knowledge-based test (Stage I) (conducted following onsite training) followed by general and IAT-specific clinical skills evaluation (Stages II and III) completed over the course of the project. For the knowledge test, 75% pass rate was required, and for the skills-based assessments, 80% of the items needed to be rated by supervisors as 'pass/

Table 2: Frequency of endorsement of post-training evaluation items (N=22)

Post-training evaluation items	N	%	N	%	N	%
	Somewhat agree		Strongly agree		Disagree	
1. IAT a useful psychosocial intervention for refugees	1	4.5%	21	95.5%	0	0
2. I have learnt new tools that could be of use in my work with refugees	13	59.1%	9	40.9%	0	0
3. The training has adequately prepared me for the IAT project	3	13.6%	19	86.4%	0	0
4. The training had a good mix of presentations and exercises	2	9.1%	20	90.9%	0	0
5. The training was well worth the time spent	12	54.5%	10	45.5%	0	0

excellent' at each stage. The trainees have to achieve score a '3' (excellent) for at least 50% of the items in both the general counselling skills and IAT-specific clinical skills components to be qualified as an IAT master trainer.

Post-training evaluation

Twenty-two trainees completed a brief post-training evaluation on the final day of the training (see Table 2). There was a high level of agreement amongst the trainees in relation to IAT being a useful intervention for refugees providing them with new tools in their work with refugees. The majority of the trainee participants felt that the training struck a good balance between classroom lectures and practical exercises and that the training provided them with a good foundation for their role in the IAT project.

Training of independent assessment team

A parallel training workshop was conducted by one member of the training team with four assessors independent of the intervention provider team. The assessors are employed as para-counsellors for UNHCR partner agencies. The training focused on the design, recruitment, methodology, process, data collection, data entry and data management in relation to the intervention study.

During the practice sessions, we identified several discordant items between two assessors in the ratings of several screening and assessment tools including the HESPER, GAD-7, PCBD, ASI-24, HTQ, CDRS and WHODAS. The following practice sessions produced a sound level of inter-rater reliability of 90% between four assessors who conducted the assessments in pairs. There was a perfect agreement for PHQ-9, PTSD-8, HESPER, BRS, and ASI-24 ($\kappa = 1, p < 0.05$). We got nearly perfect agreement for GAD ($\kappa = 0.872, p < 0.05$), HTQ ($\kappa = 0.847, p < 0.05$), PCBD ($\kappa = 0.926, p < 0.05$) and CDRS ($\kappa = 0.850, p < 0.05$). Substantial agreement was observed for WHODAS ($\kappa = 0.753, p < 0.05$).

Training in electronic data collection

Additionally, a three-day training was conducted aimed at orienting on data collection and field testing for the quick tap survey application. Basic concepts about electronic data collection in research were presented to the participants. The main advantages of this form of data collection are that it is less likely to miss items (some items are mandatory and have to be completed before submission) and it is easy to calculate the scores of screening

questionnaires to identify the eligible participants for IAT programme.

The data collectors were trained in issues around confidentiality and data protection. After logging in to the quick tap app in the smartphone or tablet, they could download the screening, baseline questionnaires, post-treatment and three months follow-up questionnaires. Data can be collected offline – which is important because in the camps the network coverage is low – to be sent later to the research investigators by synchronisation when internet connection becomes available. The database in the smartphone/tablet is password protected. During the classroom-based training sessions, they practised in pairs with their smartphones. Subsequently, a two-day field testing with the screening and baseline psychometric tools was done in the camps. In the following four weeks, the data collectors practised the use of the electronic devices in routine work. The screened tools were used with 249 beneficiaries and baselines measures were taken from 87 participants. This helped data collectors to become more confident with electronic data collection. The completion time of screening tools for collecting data was 15–20 minutes and for baseline assessment was 50–60 minutes.

Component 4: Supervision

Supervision is a critical element in capacity building. Initial training needs to be followed by continuous supervision to enable further professional development of staff, to ensure fidelity to the treatment model and to discuss complicated situations (Kohrt & Bhardwaj 2019; van der Veer, de Jong, & Lansens, 2004). Initially, a peer group supervision approach was used, allocating the trainees to four peer supervision groups according to their respective organisation, supplemented by onsite supervision by a supervisor based in CXB who was an MHPSS expert whenever appropriate. The local supervisors provided general feedback in relation to basic counselling skills including building rapport, maintaining eye contact, using empathetic statements, paraphrasing and reiterating. All trainees were required to attend weekly supervision meetings at their respective organisation.

The outcome of this model was not satisfactory because of difficulties such as organising regular weekly meetings due to busy work schedules of the counsellors in the camps, geographical distance of each counsellor's office in the camps. To overcome this problem, we developed another supervision model in which the IAT Master Trainer (MAAM, a clinical psychologist) provided online

Table 3: Percentage of basic counselling skills (N=17)

Basic counselling skills	Poor/Fail	Pass	Excellent
Established rapport	0%	29.4%	70.6%
Listen attentively	0%	29.4%	70.6%
Paraphrasing	17.6%	76.5%	5.9%
Use of open-ended questions	11.8%	70.6%	17.6%
Use of empathetic statement	17.6%	58.8%	23.5%
Explain confidentially issues	5.9%	64.7%	29.4%
Culturally sensitive	5.9%	82.4%	11.8%
Engaging/motivating client	11.8%	76.5%	11.8%
Appropriate use of Language	0%	76.5%	23.5%

Table 4: Percentage of IAT group specific skills (N=8) according three categories

IAT-G specific group skills	Poor/Fail	Pass	Excellent
Group leadership skills	0%	75%	25%
Setting group rules	25%	50%	25%
Encourage group participation	0%	75%	25%
Manage group conflict	0%	75%	25%
Understand group dynamics	0%	100%	0%

Table 5: Percentage of IAT strategies according to global clinical skills appraisal criteria

IAT strategies	Poor/Fail	Pass	Excellent	Did not apply
Psycho-education	0%	64.7%	35.3%	0%
Story telling	35.3%	58.8%	0%	5.9%
Problem solving	29.4%	41.2%	29.4%	0%
Emotion regulation	0%	88.2%	11.8%	0%
Stress management (controlled breathing)	0%	76.5%	17.6%	5.9%
Cognitive reappraisal	52.9%	47.1%	0%	0%
Strengthen social support	0%	58.8%	0%	41.2%

supervision to each counsellor individually fortnightly through video calls such as Skype/Zoom/Messenger. This worked better despite some challenges such as poor network, no electricity, urgent other activities and sudden visitors visits which interfered with the supervision meetings. In some instances, supervision sessions were conducted after office hours.

Component 5: Piloting IAT

Before commencing the main study practising IAT sessions, psychometric tools were used from July 2018 to January 2019 during a pilot phase when counsellors practised both individual and group IAT sessions. Moreover, they practised specific techniques of IAT to their general clients. IAT counsellors and assessors also applied psychometric tools using the hard copy and later on through electronic devices.

The planned timeline for this phase was two months. However, it took around six months. Some challenges in this stage were related to limited confidence and clinical

skills in IAT counsellors for IAT (see Tables 3–5) and delay in the adaptation process. Moreover, some partner organisations were not fully committed to doing IAT as their staff were busy with their general activities. Bad weather (rain) also caused serious delays in access to the field.

Assessing core competencies and clinical skills related to IAT (stage 2)

Confidence and clinical skills were assessed among 17 counsellors during their IAT sessions in the CXB different camps. We evaluated 17 counsellors out of 23, because two of them left the job, one was not present in the supervision session due to sickness and other one was excluded even though she was included as independent assessor for her low performance. We observed nine individual and eight group sessions. We evaluated basic counselling skills, group-specific skills and IAT-specific techniques of the IAT providers which are shown in Tables 3, 4 and 5, respectively.

Almost half of the IAT providers (47%) conducted IAT group session. Most of them did reasonably well. See the following percentage of IAT-specific group skills in Table 4. IAT-specific components following the global clinical skills appraisal criteria and scoring guide which are shown in Table 5. All providers are now able to provide psychoeducation, relaxation, emotion regulation and strengthen social support techniques effectively. However, some of the providers still need to improve storytelling, problem solving and in particular cognitive reappraisal techniques.

It was also reported that in the piloting stage for IAT sessions, counsellors practised any IAT strategies with 116 clients in the 390 individual sessions and with 58 groups in the 235 group IAT sessions

Over half of the trainees endorsed IAT as being a practical, systematic, meaningful and appropriate framework for assisting refugees in identifying the problems they face and applying problem-solving approach to these issues. In particular, IAT is appropriate for refugees with low literacy skills and educational levels as it applies contextualized treatment strategies drawing on rich pictorial illustrations, metaphors and analogies (e.g. rebuilding the five ADAPT pillars of the ‘happy house’). Others reported that it is very difficult to engage some clients in the process of problem-solving strategies because of their repeated failures of problem-solving attempts. One of the strategies of IAT (trauma narrative) was excluded, as counsellors reported that they could not share the traumatic events sequentially. They also felt difficulties to apply cognitive reappraisal techniques to help clients to think differently. We developed a user-friendly ‘thinking differently’ worksheet with some pictures and examples which helped them to apply easily.

FUTURE IMPLEMENTATION

The service delivery phase started in February 2019. Since then IAT counsellors are providing IAT individual and

group sessions under expert supervision. Participants in this phase are given detailed information about IAT and verbal or audio recording consent is taken prior to screening and those found to be eligible are asked if they wish to participate in the intervention. Those who meet criteria for at least one disorder (depression or PTSD) with a moderate or severe level of functional impairment are enrolled in either IAT individual or IAT-G programme. Strict provisions of privacy and confidentiality are maintained in all sessions. Written notes are taken during sessions with clients' permission. Any information recorded that could identify are kept confidential and are not disclosed to anyone not directly involved in this project without their permission except as required by law.

The IAT experts collaborate closely with UNHCR Bangladesh. In particular, two members of the UNHCR MHPSS team (which includes experienced psychologists and a psychiatrist) or its implementing partners will provide support to the referral clients. The team also identified potential referral pathways include general medical services, sexual and gender-based violence and protection service offered by different NGOs with partnership with UNHCR.

Rohingya clients will be monitored through assessment pre-treatment, post-treatment and at follow up after three months. Qualitative measures will continue to be collected for further process evaluation. In a later stage, we plan to report on these data to see acceptability, feasibility and effectiveness of IAT-G which might help in implementation and scale up in the refugee settings.

DISCUSSION

The introduction of IAT in the Rohingya emergency is promising but has faced many challenges. At the beginning of the project, language barriers were the most important. Out of 23 participants, only five had sufficient knowledge of the Rohingya language. This is not specific for our project but is a common issue in CXB where most of the staff of partners are from other parts of Bangladesh (Elshazly, Budosan, Mahmudul Alam, Tarannum, & Ventevogel, 2019). Later, through audio recording and adaptation of tools the facilitators improved their language skills. Despite the strong dedication of the project team, there remain several key challenges including budget and funding constraints, limitations of partner organisations and lack of motivation amongst staff. Considering the high attrition of staff in order to render IAT sustainable in the long term, there is a need to task shift IAT to community volunteers.

Supervision is key to building and sustaining clinical competency (Murray et al., 2014; Verdelli, Clougherty, & Sonmez, 2016). Peer supervision proved to be challenging. We decided it will be continued but it was impossible to make it happen within different organisations and distant camp locations. Alternatively, there were many difficulties in arranging weekly online supervision with expat trainers and trainees. Organisations had different opinions and limitations on arranging it in their offices with sufficient

internet connection. After long discussions and negotiation, finally it is happening.

Other challenges include a high turnover of employees, lack of commitment by partner organisations and staff to IAT, security problems due to community violence, delaying arrangement of refreshment, ongoing stigma surrounding counselling, refugees prioritize basic needs over mental health services.

Based on our experiences as important lessons we can formulate various points we would have done differently. First of all, we could better have started with training a group of local coordinators/supervisors before training the general participants. Having a well-prepared group of supervisors who could act as local champions and as intermediaries with their organisations would have facilitated several of the implementation challenges we faced. Second, the fact that we worked with trainees from multiple organisations has both advantages and disadvantages. An obvious advantage is that it will help in creating a broad network of service providers in IAT across the emergency, instead of having the intervention limited to only one organisation. However, working with multiple organisations, each with their own strategies and priorities, also makes a project like ours vulnerable. We believe that stronger and more comprehensive efforts to create buy-in of all stakeholders would have been beneficial. For example, brief introduction/orientation should be arranged for senior management team of partner organisations about the project, including an explicit endorsement of commitment of each organisation about time investments of participating staff and required resources. Thirdly, it is important to take measures to promote individual commitment of trainees. The realities of high staff turnover and competing priorities in the midst of a chaotic emergency response in a remote part of a country have to be accepted, but strong efforts are needed to select those trainees who have a willingness to learn and a commitment to the cause of the project.

LIMITATIONS

We consider some limitations of the study. First of all, the implementation challenges (high staff turnover among trainees, low organisational buy-in and challenges with access) caused delays and reduced the number of clients seen. Overcoming language difficulties among counsellors was one of the biggest challenges for conducting counselling sessions in the Rohingya language.

Moreover, at this stage we cannot make conclusions whether IAT-G has a positive impact on clients. We will know more when we have the data on outcome measure before and after treatment, but even then we cannot be sure which part of the change can be attributed to IAT and which part to spontaneous recovery or contextual changes. To answer that question a fully powered randomized controlled trial will be required. We assume that IAT will do well among Rohingya refugees because of its cultural and contextual adaptation in the refugee context, but we have no clear indications to what extent IAT techniques are equivalent or superior to any other techniques.

CONCLUSIONS

Despite the above-mentioned limitations, this project demonstrates that the introduction of a group-based psychotherapy in the midst of a chaotic emergency is possible, but it takes time and dedication. Significant attention needs to be paid to contextual conditions related to stakeholder commitment, organisation of supervision and time management. The lessons learnt are not unique for our project. Many points have been mentioned elsewhere, such as the importance of the proper selection of providers of psychological care, addressing low motivation of health workers and other staff, mitigating of risk for interference with existing task of health workers and the need to create a local cadre of supervisors and champions (Betancourt & Chambers, 2016; Greene et al., 2019; Murray et al., 2011; Patel et al., 2010). Such issues are however still too rarely explicitly discussed in the context of research papers in global mental health, perhaps because research projects are usually the work with smaller groups of staff that are dedicated and motivated to the project and often receive financial and other incentives. When designing psychosocial programmes for scaling up in major emergency settings with high staff turnover, it may be better to invest from the beginning in training lay counsellors from the refugee community which may have the best chances for sustainability (Munodawafa, Lund, & Schneider, 2017). We believe that projects like ours may contribute to a much needed shift in emphasis in global mental health research from effectiveness research in relatively well-controlled circumstances to implementation research in routine care in less than ideal circumstances.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

- Basoglu, M., Livanou, M., Crnobaric, C., Franciskovic, T., Suljic, E., Duric, D., & Vranesic, M. (2005). Psychiatric and cognitive effects of war in former Yugoslavia: Association of lack of redress for trauma and posttraumatic stress reactions. *Journal of the American Medical Association*, 294(5), 580-590. doi: 10.1001/jama.294.5.580
- Bass, J., Murray, S. M., Mohammed, T. A., Bunn, M., Gorman, W., Ahmed, A. M. A., & Bolton, P. (2016). A randomized controlled trial of a trauma-informed support, skills, and psychoeducation intervention for survivors of torture and related trauma in Kurdistan, Northern Iraq. *Global Health: Science and Practice*, 4(3), 452-466.
- Betancourt, T. S., & Chambers, D. A. (2016). Optimizing an era of global mental health implementation science. *JAMA Psychiatry*, 73(2), 99-100.
- Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., & Verdelli, H. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: A randomized controlled trial. *Journal of the American Medical Association*, 298(5), 519-527.
- Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet* (published online June 10, 2019). doi: 10.1016/S0140-6736(19) 30934-1.
- Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depression and Anxiety*, 18(2), 76-82.
- Dawson, K. B., Harper, R. A., Tay, M., Rahman, A. K., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): A WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry*, 14(3), 354-357.
- Elshazly, M., Budosan, B., Mahmudul Alam, A. N. M., Tarannum, N., & Ventevogel, P. (2019). Challenges and opportunities for Rohingya MHPSS programming. *Intervention*, 17(2), 197-205.
- Greene, M. C., Rees, S., Likindikoki, S., Bonz, A. G., Joscelyne, A., Kaysen, D., & Tol, W. A. (2019). Developing an integrated intervention to address intimate partner violence and psychological distress in Congolese refugee women in Tanzania. *Conflict and Health*, 13, 38. doi: 10.1186/s13031-019-0222-0
- Hansen, M., Andersen, T. E., Armour, C., Elklit, A., Palic, S., & Mackrill, T. (2010). PTSD-8: A short PTSD inventory. *Clinical Practice and Epidemiology in Mental Health: Clinical Practice & Epidemiology in Mental Health*, 6, 101. doi:10.2174/1745017901006010101
- Kohrt, B. A., & Bhardwaj, A. (2019). Considerations for training and supervision in global mental health. In: D. J. Stein, J. K. Bass, & S. G. Hofmann (Eds.), *Global Mental Health and Psychotherapy: Adapting Psychotherapy for Low-and Middle-Income Countries* (pp. 47-65). London: Academic Press.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and post-traumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis*, 180(2), 111-116.
- Munodawafa, M., Lund, C., & Schneider, M. (2017). A process evaluation exploring the lay counsellor experience of delivering a task shared psycho-social intervention for perinatal depression in Khayelitsha, South Africa. *BMC Psychiatry*, 17(1), 236.
- Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdelli, H. (2011). Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers. *International Journal of Mental Health Systems*, 5(1), 30. doi: 10.1186/1752-4458-5-30
- Murray, L. K., Tol, W., Jordans, M., Sabir, G., Amin, A. M., Bolton, P., & Thornicroft, G. (2014). Dissemination and implementation of evidence-based mental health interventions in post-conflict, low-resource settings. *Intervention*, 12(S1), 94-112.
- Murray, L. K., Hall, B. J., Dorsey, S., Ugueto, A. M., Puffer, E. S., Sim, A., . . . Bolton, P. A. (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health*, 5, e16. doi: 10.1017/gmh.2018.
- Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., & Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. *Lancet*, 376(9758), 2086-2095.
- Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., & van Ommeren, M. (2016). Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: A randomized clinical trial. *Journal of the American Medical Association*, 316(24), 2609-2617. doi:10.1001/jama.2016.17165
- Rahman, A., Khan, M. N., Hamdani, S. U., Chiumento, A., Akhtar, P., Nazir, H., & van Ommeren, M. (2019). Effectiveness of a brief group psychological intervention for women in a post-conflict setting in Pakistan: A single-blind, cluster, randomised controlled trial. *Lancet*, 393, 1733-1744.
- Rees, S., & Silove, D. (2011). Sakit Hati: A state of chronic mental distress related to resentment and anger amongst West Papuan refugees exposed to persecution. *Social Science & Medicine*, 73(1), 103-110. doi:10.1016/j.socscimed.2011.05.004
- Silove, D. (2013). The ADAPT model: A conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention*, 11(3), 37-48.

- Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry, 16*(2), 130-139. doi: 10.1002/wps.20438
- Silove, D., Momartin, S., Marnane, C., Steel, Z., & Manicavasagar, V. (2010). Adult separation anxiety disorder among war-affected Bosnian refugees: Comorbidity with PTSD and associations with dimensions of trauma. *Journal of Traumatic Stress, 23*(1), 169-172. doi:10.1002/jts.20490
- Silove, D. M., Tay, A. K., Steel, Z., Tam, N., Soares, Z., Soares, C., & Rees, S. (2017). Symptoms of post-traumatic stress disorder, severe psychological distress, explosive anger and grief amongst partners of survivors of high levels of trauma in post-conflict Timor-Leste. *Psychological Medicine, 47*(1), 149-159. doi:10.1017/s0033291716002233
- Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097.
- Tarannum, S., Elshazly, M., Harlass, S., & Ventevogel, P. (2019). Integrating mental health in Rohingya refugee settings in Bangladesh: Experiences of UNHCR. *Intervention, 17*(2), this issue.
- Tay, A. K., & Silove, D. (2017). The ADAPT model: Bridging the gap between psychosocial and individual responses to mass violence and refugee trauma. *Epidemiology and Psychiatric Sciences, 26*(2), 142-145.
- Tay, A. K., Rees, S., Chen, J., Kareth, M., & Silove, D. (2015a). The coherence and correlates of intermittent explosive disorder amongst West Papuan refugees displaced to Papua New Guinea. *Journal of Affective Disorders, 177*, 86-94. doi:org/10.1016/j.jad.2015.02.009
- Tay, A. K., Rees, S., Chen, J., Kareth, M., & Silove, D. (2015b). Pathways involving traumatic losses, worry about family, adult separation anxiety and posttraumatic stress symptoms amongst refugees from West Papua. *Journal of Anxiety Disorders, 35*, 1-8. doi: 10.1016/j.janxdis.2015.07.001
- Tay, A. K., Rees, S., Chen, J., Kareth, M., Mohsin, M., & Silove, D. (2015c). The Refugee-Mental Health Assessment Package (R-MHAP): rationale, development and first-stage testing amongst West Papuan refugees. *International Journal of Mental Health Systems, 9*(1), 29.
- Tay, A. K., Rees, S., Chen, J., Kareth, M., & Silove, D. (2016). Factorial structure of complicated grief: Associations with loss-related traumatic events and psychosocial impacts of mass conflict amongst West Papuan refugees. *Social Psychiatry and Psychiatric Epidemiology, 51*(3), 395-406.
- Tay, A. K., Rees, S., Tam, N., Kareth, M., & Silove, D. (2019a). Defining a combined constellation of complicated bereavement and PTSD and the psychosocial correlates associated with the pattern amongst refugees from West Papua. *Psychological Medicine, 49*(9), 1481-1489. doi: 10.1017/s0033291718002027
- Tay, A. K., Rees, S., Tam, N., Kareth, M., & Silove, D. (2019b). Developing a measure of adaptive stress arising from the psychosocial disruptions experienced by refugees based on a sample of displaced persons from West Papua. *International Journal of Methods in Psychiatric Research, 28*(1). doi:10.1002/mpr.1770
- Tay, A., Miah, M. A. A., Khan, S., Badrudduza, M., Alam, R., Balasundaram, S., . . . Silove, D. (2019c). Implementing Integrative Adapt Therapy with Rohingya refugees in Malaysia: A training-implementation model involving lay counsellors. *Intervention, 17*(2), 267-277.
- Tay, A. K., Miah, M. A. A., Khan, S., Badrudduza, M., Morgan, K., Balasundaram, S., & Silove, D. (2019d). Theoretical background, first stage development and adaptation of a novel Integrative Adapt Therapy (IAT) for refugees. *Epidemiology and Psychiatric Sciences, 1-8*. doi:10.1017/S2045796019000416
- Tay, A. K., Riley, A., Islam, R., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2019e). The culture, mental health and psychosocial wellbeing of Rohingya refugees: A systematic review. *Epidemiology and Psychiatric Sciences, 28*(5), 489-494. doi:10.1017/S2045796019000192
- Uddin, A., & Hasna, S.A. (2019). The story of a Rohingya refugee: becoming a community psychosocial volunteer (CPV). *Intervention, 17*(2), 296-300.
- United Nations High Commissioner for Refugees. (2018). *Strategic plan for Mental Health and Psychosocial Support (MHPSS) for UNHCR's Rohingya refugee response in Cox's Bazar*.
- United Nations High Commissioner for Refugees. (2019). *Figures at a glance*. Available at <https://www.unhcr.org/figures-at-a-glance.html>.
- Ustun, T. B., Chatterji, S., Kostanjsek, N., Rehm, J., Kennedy, C., Epping-Jordan, J., & Pull, C. (2010). Developing the World Health Organization disability assessment schedule 2.0. *Bulletin of the World Health Organization, 88*(11), 815-823.
- van der Veer, G., de Jong, K., & Lansen, J. (2004). Clinical supervision for counsellors in areas of armed conflict. *Intervention, 2*(2), 118-128.
- Verdeli, H., Clougherty, K., & Sonmez, N. (2016). *Training in Interpersonal Psychotherapy (IPT) in Lebanon*. Unpublished report. Amman/ New York.
- World Health Organization & King's College London. (2011). *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with scale*. Geneva: World Health Organization.