Field Report

Implementing *Integrative Adapt Therapy* with Rohingya refugees in Malaysia: a training-implementation model involving lay counsellors

Alvin Kuowei Tay[1*], Mohammad Abdul Awal Miah[2*], Sanjida Khan[3], Mohammad Badrudduza[4], Rofique Alam[4], Susheela Balasundaram[5], Susan Rees[1], Karen Morgan[2] & Derrick Silove[6]

[1]PhD, School of Psychiatry, Faculty of Medicine, University of New South Wales, Australia, [2]MPhil, Perdana University-Centre for Research Excellence (PU-CRE), Selangor, Malaysia, [3]MS, Department of Psychology, Jagannath University, Dhaka, Bangladesh, [4]BA, School of Psychiatry, Faculty of Medicine, University of New South Wales, Australia, [5]MBBS, Health Unit, United Nations High Commissioner for Refugees (UNHCR), Malaysia, [6]MD, School of Psychiatry, Faculty of Medicine, University of New South Wales, Australia,

*Both first authors contributed equally.

Abstract

Contemporary scalable psychological interventions utilise task-shifting approaches that enable non-specialists such as social workers, nurses and lay persons to deliver structured interventions after a brief training and ongoing supervision by professionals. This field report describes a training-implementation approach we used to train lay counsellors to implement a psychological intervention, Integrative Adapt Therapy (IAT), with Rohingya Refugees in Malaysia. IAT is a theoretically guided programme based on the Adaptation and Development After Persecution and Trauma (ADAPT) model. Unlike existing cognitive behavioural treatment (CBT)-based interventions, IAT helps refugees trace their emotional and behavioural problems to the underlying psychosocial disruptions (reflected in the core ADAPT 'Pillars') they experience. We assessed implementation outcomes by conducting a focus group with the twelve lay IAT counsellors who completed a training workshop followed by six-month supervised implementation of the IAT programme with Rohingya refugees. The implementation outcomes focused on the value and benefits of the programme to the counsellors' clients and broader community, implementation challenges, cultural acceptability, and recommendations for improvement in training. There was a strong agreement amongst the counsellors that both the clients and they themselves benefited from the programme. Furthermore, the general consensus was that the clients reported improvements in their relationships with people (ADAPT Pillar 2: Bonds and Networks), in having a more realistic view about their Roles and Identities (Pillar 4) and in gaining a sense of purpose and meaning in life (Pillar 5: Existential Meaning). In addition, the focus group agreed that the programme fitted well with the culture and values of the Rohingya people. Implementation challenges include ensuring that the intervention team reflects gender balance, that the programme is sustainable and refining strategies to facilitate programme attendance and adherence.

Keywords: cognitive behavioural therapy, intervention, psychological treatment, refugee

Introduction

In recent years, a range of brief psychological interventions have been developed for treating common mental health symptoms amongst refugees located in settings with limited resources (Singla, Kohrt, Murray, Anand, Chorpita, & Patel, 2017; Stein, Bass, & Hofmann, 2019). Typically, such therapies use task-shifting approaches that enable non-specialists such as social workers, nurses and lay persons to deliver structured interventions after a brief training and ongoing supervision by professionals. In this field report, we describe a training-implementation model in which a brief training workshop was conducted with lay counsellors followed by six-month supervised implementation of a psychological intervention programme, Integrative Adapt Therapy (IAT) specifically designed for refugees. Informed by the Adaptation and Development after Persecution and Trauma (ADAPT) model, IAT is designed not only to help refugees develop strategies to cope with symptoms, but also

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Address for correspondence: Alvin Kuowei Tay, PhD, School of Psychiatry, Faculty of Medicine, University of New South Wales, Australia. e-mail: alvin.tay@unsw.edu.au

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to allow them to understand how symptoms are linked to the refugee experience. The ADAPT model provides the framework for helping refugees make sense of their emotional and behavioural reactions following upheaval, migration, displacement, social and cultural change, and resettlement.

The Adaptation and Development after Persecution and Trauma (ADAPT) model

The theoretical underpinnings and cultural adaptation of the ADAPT model (Silove, 2013) and IAT (Tay, Rees, Tam, Kareth, & Silove, 2019) have been described elsewhere. In brief, the ADAPT model (Silove, 2013) on which IAT is grounded focuses on the challenges that survivors confront that arise from the disruption of five key psychosocial systems that putatively support mental health in stable societies (Tay & Silove, 2016). These psychosocial systems or 'pillars' include 1. safety/security, 2. interpersonal bonds and networks, 3. justice, 4. identities and roles and 5. existential meaning. The ADAPT theory extends understanding of the refugee experience beyond the focus on trauma exposure and ongoing living difficulties (Miller & Rasmussen, 2010). According to the model, the psychosocial effects of trauma and ongoing stressors are influenced by the extent to which background psychosocial support systems (we refer these as the five 'pillars') are undermined as a result of the refugee experience which spans across phases of persecution, flight, temporary asylum and permanent resettlement.

Amongst refugees from West Papua, a measure of the ADAPT psychosocial pillars was found to exert both moderating and mediating effects on trauma and post--migration stressors in pathways leading to post-traumatic stress disorder (PTSD) symptoms (Tay, Rees, Chan, Kareth, & Silove, 2015). The ADAPT model extends beyond mental health symptoms to the capacity of individuals to withstand the challenges of the refugee experience reflected in the concept of resilience (Panter-Brick, Goodman, Tol, & Eggerman, 2011; Somasundaram & Sivayokan, 2013; Ssenyonga, Owens, & Olema, 2013; Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011). Figure 1 shows schematically the pathways involving the ADAPT Pillars, trauma exposure, Postmigration Living Difficulties (PMLDs), leading to symptoms of common mental disorders (CMDs). Drawing on this model, IAT focuses on helping refugees link their emotional and behavioural problems with the underlying psychosocial disruptions

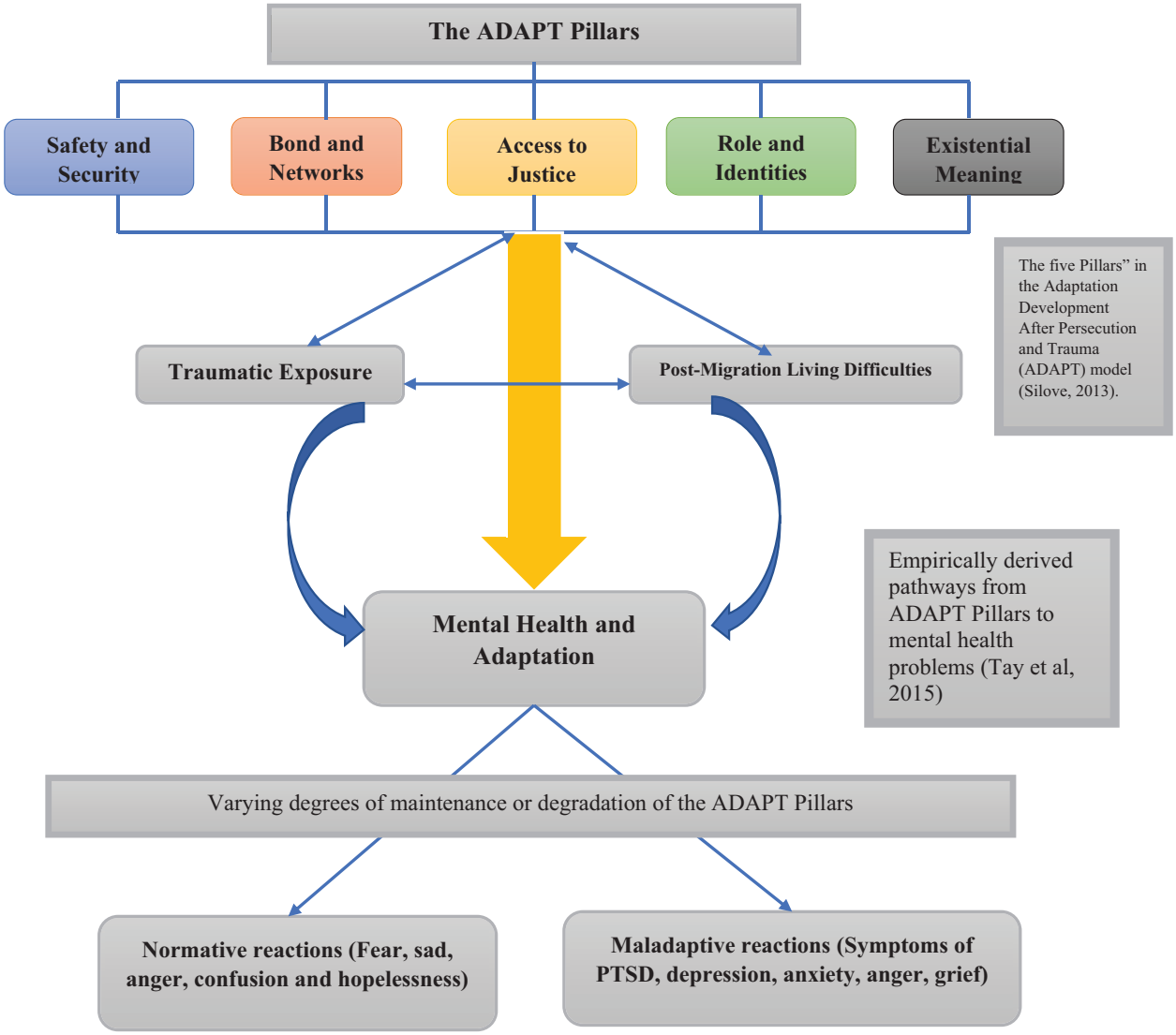

Figure 1: Pathways leading from trauma exposure, post-migration living difficulties (PMLDs) to symptoms of common mental disorders (CMDs)

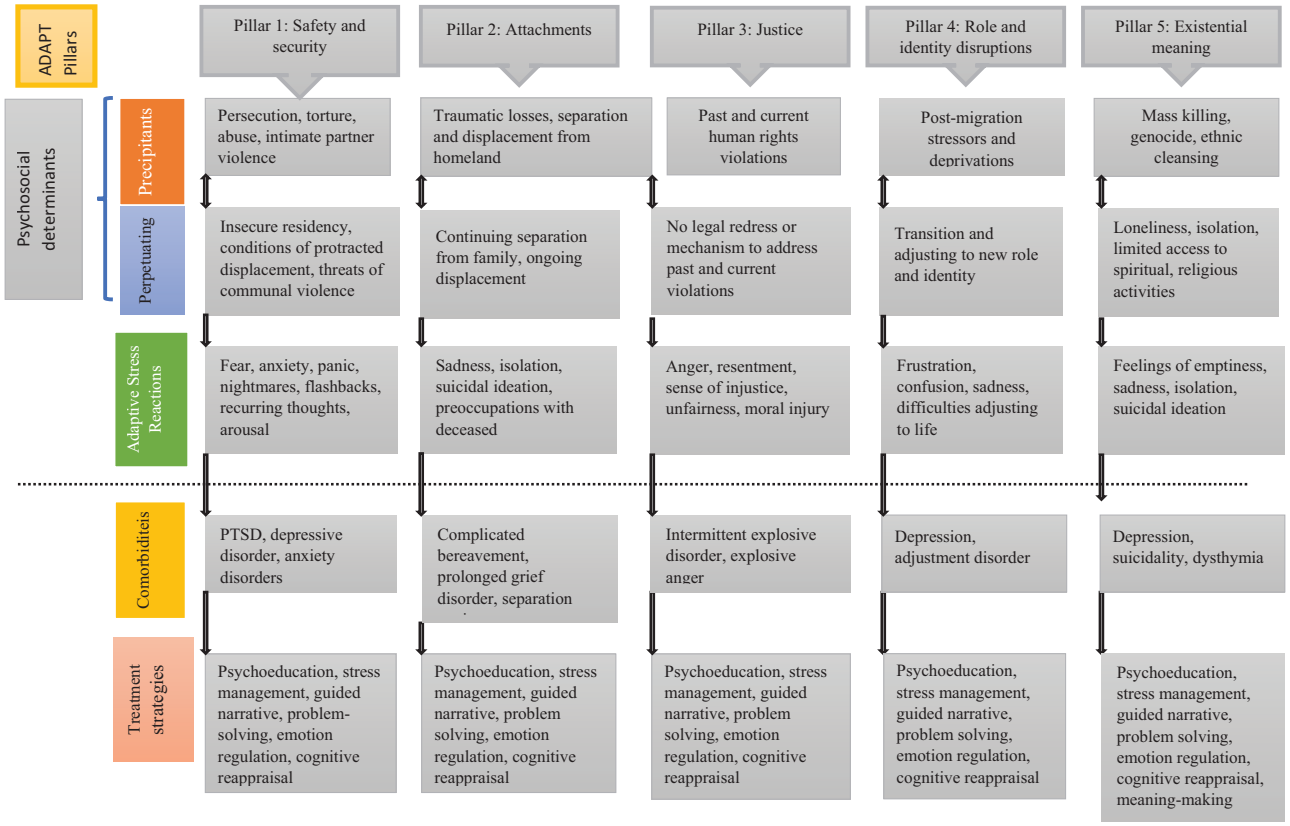

Figure 2: Process of case formulation, functional analysis, and treatment involving the pathways from trauma exposure to adaptive stress (AS) (Tay et al., 2018) to common mental disorders (CMDs) in IAT

Box 1. Rohingya terms for problems related to post-traumatic stress symptoms

- Recurrent thoughts or memories of the event (Hub beshi dorer gotona mone phoron)
- The event is happening again (Moneoy de gotona eyan abar gothedde)
- Nightmares (Horaf khoyab aiyee)
- Emotional or physical reactions when reminded of the event (Gotona gin monot foirle aatgori dilor majhe musiyot oy)
- Avoiding activities that remind you of the event (Hamortun aari thaha jiyon dukkor gotona monot gori de)
- Avoiding thoughts or feelings associated with the event (Indilla cinta/fikirtun aari thaha jiyon dukkor gotona monot gori de)
- Feeling startled (Ene groom oijon ba chomki chomki udon)
- Feeling on guard (Jette ette ushiyari thaha).

they experience as reflected in the five universal ADAPT pillars. They serve as a comprehensive framework in which mental health strategies are taught to help refugees address their problems.

Figure 2 outlines the process of case formulation, functional analysis and treatment involving the pathways from trauma exposure to adaptive stress (AS) to CMDs in IAT.

A training-implementation approach to IAT involving lay Rohingya counsellors in Malaysia

Contextualising and adapting IAT during a lay training workshop with Rohingya workers

We conducted a ten-day training workshop with 12 lay counsellors (referred to as IAT trainee providers) from the Rohingya community who were recruited for this project. Details of training and supervision have been reported in a companion paper in this special issue focusing on training health workers in implementing IAT group intervention with Rohingya refugees in the emergency setting of Cox's Bazaar (see Mahmuda, Miah, Elshazly, Khan, Tay, & Ventevogel, 2019). The workshop was facilitated two the bilingual Bengali- and Rohingya-speaking clinical psychologists (authors, MAAM, SK). Both are master trainers and supervisors (mental health specialists) trained by AKT, the developer of IAT. The first half of the workshop focused on understanding the mental health and psychosocial problems experienced by the Rohingya, drawing on a recent comprehensive UNHCR report on the culture and mental health of Rohingya refugees (Tay et al., 2018). Box 1 presents the key terms used by Rohingya people to describe mental health symptoms analogous to the contemporary definition of PTSD.

Furthermore, the workshop explored the Rohingya belief systems about mental health, help-seeking behaviour and idioms of distress (Tay et al., 2018).

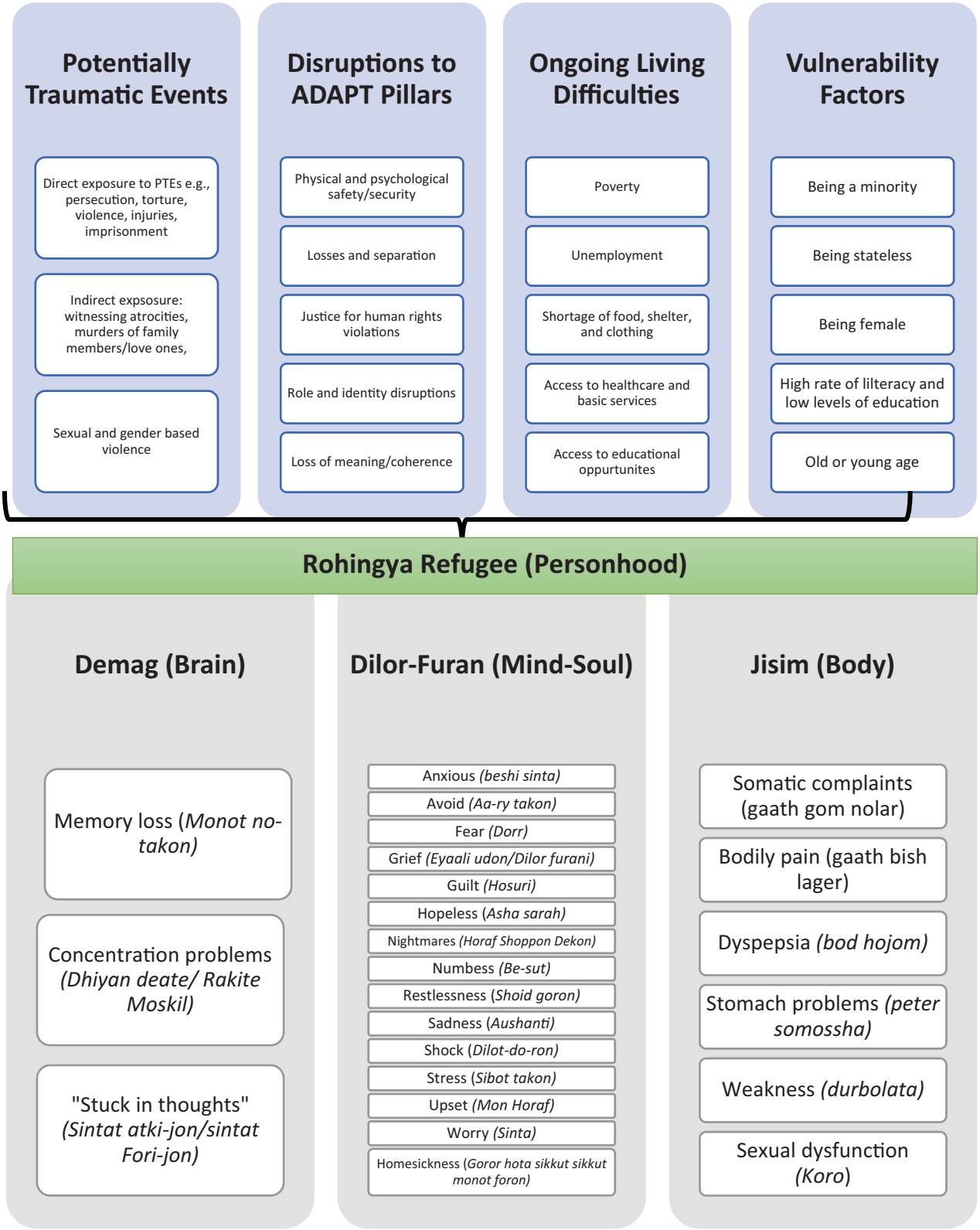

Figure 3: Rohingya's conceptualisation of personhood and how the refugee trauma and experience impact on their health and emotional wellbeing (adapted from Tay et al., 2018)

Drawing on the Rohingya's explanatory model of personhood and illness, the lay counsellor made meaningful connections between trauma, PMLDs, the disrupted ADAPT pillars, vulnerability factors impacting on the brain, memory loss, concentration problems, 'stuck in thoughts', the mind-soul (anxiety, avoidance, sadness, grief) and the body (somatic problems, bodily pain, stomach problems, sexual dysfunction) which remain interconnected components. Figure 3 presents the Rohingya's conceptualisation of personhood and how the refugee experience impacts on their health and emotional wellbeing.

Box 2. The basic outline of the IAT programme

- Session 1: Introduction to the ADAPT model, the IAT programme, and setting the agenda
- Session 2: Learning ways to feel safe again (ADAPT Pillar 1: Safety and Security)
- Session 3: Coping with losses and separations (ADAPT Pillar II: Bonds and Networks)
- Session 4: Managing anger and issues of justice (ADAPT Pillar III: Access to Justice)
- Session 5: Coping with changes in roles and identities (ADAPT Pillar IV: Roles and Identities)
- Session 6: Living a meaningful life (ADAPT Pillar V: Existential Meaning)

Format, content, structure and length of the IAT programme

The individual IAT format involves six-weekly 45-minute sessions. Each session is structured thematically with sessions 2 to 6 focusing on the five ADAPT pillars in sequence (session 1 focusing on introducing psychoeducation, normalization, building rapport, introducing the ADAPT Pillars, the IAT programme, and clarification). Because IAT is designed to be flexible and that although most refugees experience disruptions in virtually all five pillars, some pillars may be afforded greater salience depending on the individual refugee experience. To direct the therapy to the most salient issues for maximum benefits, we apply a simple exercise where lay counsellors use the 'ADAPT matrix' (see Box 2) to set an agenda based on identified priorities to be addressed throughout the programme. Box 2 presents the basic outline of the IAT programme.

Implementing IAT by lay counsellors with Rohingya refugees following training

During the six-month period of training and implementation, the 12 IAT trainee counsellors delivered individual IAT sessions to a total number of 115 Rohingya refugees under the guidance and support of their assigned clinical supervisors (AKT, MAAM and SK).

In the first session, the counsellor builds rapport with the client by way of introducing him/herself, followed by discussion about the benefits and goals of the programme, confidentiality issues, clarifying expectations and obtaining consent. The session ends with the counsellor setting an agenda for the subsequent sessions by identifying the main (three) problems relating to each pillar to be addressed, using the ADAPT matrix. Specifically, within the ADAPT matrix, the provider maps out the disruptions of each ADAPT pillar and how these have led to current problems; and what strategies are used by the person to cope with the present situation. This brief exercise helps to extend rapport with the person and to determine the key areas of intervention in subsequent sessions.

For consistency and ease of delivery, the format of each IAT session follows a particular sequence of steps that commence with pre-therapy progress review; exploring the relevant ADAPT pillar and the underlying disruptions; linking emotional and behavioural problems/symptoms to these disruptions within the ADAPT framework; introducing and practising mental health techniques; addressing identified problems with the techniques taught; monitoring and recording outcomes; summarising and reviewing the session; and assigning homework for the next session.

Applying cross-cutting mental health strategies across ADAPT pillars

The new wave of 'scalable psychological interventions' frequently draws on a package of evidence-based mental health strategies that are amenable to non-specialists and lay workers and have the potential to be scaled up across populations. In designing the IAT programme, we draw on an eclectic mix of techniques with the aim of identifying the most effective and optimal strategies that can be taught to lay counsellors to address the relevant symptoms/disruptions underlying each ADAPT pillar. Unlike the existing CBT-based approaches, the strategies embedded in the IAT programme are melded with the ADAPT theory and contextualised around the five pillars such that they are learnt and applied organically by individuals who instinctively resonate with these notions through their experience. We describe the manualised process that lay workers will deliver to address the underlying problems refugees experience in relation to the ADAPT pillars. The strategies are empirically derived psychotherapeutic techniques we selected because of their flexibility (applicable to any of the ADAPT pillars), their demonstrated effectiveness, and their amenability to task-shifting.

Psychoeducation about the ADAPT model and the IAT programme

Considering that the Rohingya (and other refugee groups in general) have limited literacy skills and education, efforts were made to simplify key concepts and principles of the programme. Accordingly, we use a metaphor that analogises the ADAPT model to a 'Happy House' and the ADAPT pillars to the foundations that support the house. Each pillar is fundamental to the integrity of the house and the process of rebuilding these pillars is likened to recovery from adversities. In this instance, refugees frequently made reference to their makeshift houses in Bangladesh they built with bamboo. The counsellor frames the ADAPT model in non-stigmatising language of positive mental health supported by the ADAPT pillars without explicitly referring to mental health symptoms or overcoming these symptoms as the starting premise. In this way, refugees are able to make immediate links between their experience of the ADAPT pillars and the problems they experienced and are currently experiencing in a manner that helps them understand these connections through a comprehensive

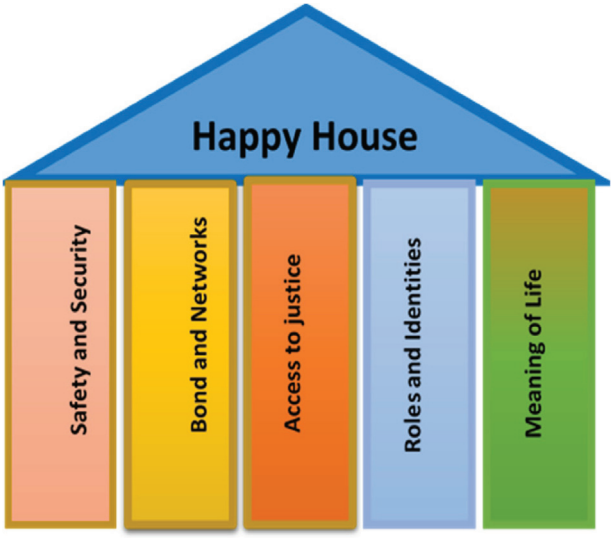

Figure 4: The ADAPT-inspired Happy House for providing psychoeducation in terms of ADAPT pillars

framework. Figures 4 and 5 shows the key psychoeducational tool, the ADAPT-inspired Happy House, used in the IAT programme.

Trauma narrative

To help refugees narrate their traumatic experiences according to the ADAPT pillars in a coherent and chronological manner, we include a modified form of exposure drawing on techniques of narrative exposure therapy and in vivo exposure (Schauer, Neuner, & Elbert, 2011). Refugees are assisted in narrating their experience chronologically as if they were tracing the stream of a river. Additional caution is taken not to delve into the details of the traumatic events, but rather to help refugees narrate their experiences in a coherent manner. This technique has proven to be helpful, feasible and safe with the Rohingya (and other groups) as it is not designed to achieve full exposure through the reconsolidation of traumatic memories, hence the naming of the technique. The question remains whether this or other techniques are collectively needed to achieve the positive improvement overall symptom outcomes as shown in our RCT.

Problem-solving

Problem-solving is the most frequently used evidence-based technique in existing scalable psychological approaches such as Problem Management Plus (Dawson et al., 2015), Self-Help Plus (Epping-Jordan et al., 2016) and the Common Elements Treatment Approach (CETA) (Murray et al., 2014). Within the IAT programme, refugees are first sensitised to the links between their problems/symptoms and the ADAPT pillars followed by learning problem-solving steps in overcoming these problems. Specifically, following the conventional steps in problem-solving and using the ADAPT matrix, refugees first identify the main three challenges they face in relation to each ADAPT pillar: the barriers to overcoming problems, coping/safety behaviours they currently engage in, and practical solutions that they can achieve given the available resources and their circumstances.

Stress management

We adapted the commonly used stress management strategies involving relaxation techniques using culturally relevant metaphors. The two techniques that were well received by the Rohingya are controlled breathing and a modified form of progressive muscle relaxation. The techniques are delivered in the Rohingya language using locally salient analogies and illustrations to help refugees manage their stress.

Emotion regulation

We recognise that emotion dysregulation may act as an impediment to therapy with refugees, and as such we include this technique to help refugees explore and identify their core emotions and recognise how these emotions are linked to their refugee experience, and how the failure to identify and address these emotions appropriately may contribute to, and perpetuate, their problems/symptoms. The counsellor uses a purpose-built 'Emotion Pie' to help refugees apportion their emotions (using different colours), connecting these with the ADAPT pillars and teaching them how to approach (rather than avoid and/or suppress) these emotions in a more adaptive and healthy way. The techniques used involve accepting and letting go feelings without judgment, normalising distress, and, re-appraising the situation and underlying emotional responses to that situation. Using a bundle of rubber bands, the counsellor likens the elasticity of rubber to the oscillations of emotions and how particular strategies can be used to disentangle the bundle of tightly bound rubber bands.

For example, a common set of emotions experienced by the Rohingya are extreme fear, anxiety, sadness, grief and anger, which are readily connected to the concurrent erosion of the ADAPT pillars. A refugee experiencing anger outbursts may then be helped to understand and recognise the trigger(s) and evaluate the proportionality of these outbursts to the gravity of the situation, and what strategies can be used to mitigate this response in the future.

Cognitive reappraisal

Using cognitive reappraisal, the counsellor helps refugees identify their unhelpful thoughts and how reframing these thoughts differently can address their problems in relation to the ADAPT pillars. For example, a refugee (former physician) reporting feelings of frustration and depression because of not being able to practise medicine is assisted in understanding the gap between his expectations and reality, and how choosing an alternative path (e.g. community volunteer) may help him fulfil his aspirations in another way.

Meaning making

To help refugees re-acquire a sense of meaning and purpose in life following mass conflict and

Figure 5: Coping cards used in the IAT programme

persecution, we include a step-by-step meaning-making strategy based on the three principles of logotherapy: creativity, experience, and attitude. Logotherapy was originally designed for WWII Holocaust survivors (Frankl, 1963). The key components of this strategy involve recognising the will to survive, acceptance, practising gratitude and appreciation, giving hope and committing to a life worth living. This strategy was regarded to be helpful given that many refugees experience a loss of faith in humanity as a result of their experience.

The IAT programme includes two additional (optional) strategies – strengthening social support and behavioural activation. Both have proven to be effective for addressing CMDs in the general and refugee populations.

Boxes 3 and 4 present the steps where the above-mentioned cross-cutting strategies are drawn together and delivered in

Box 3. A step-by-step description of an IAT session focusing on ADAPT Pillar IV (Roles and Identities)

- Summarise last week's session and review the progress thus far
- Remind client about the ADAPT Pillars and the focus of this session. Explain to client how change in their role and identity can lead to stress, frustration, confusion, sadness, depression
- Explore the current problems/symptoms/emotions experienced by the client underlying disruptions in Roles and Identities, the coping strategies and barriers to achieve positive change using the ADAPT matrix
- Introduce and practice mental health techniques to help client address the problems/symptoms/emotions underlying disruptions in Roles and Identities
- Summarise the session
- Assign homework and the designated coping card for this session

Box 4. Integrating cross-cutting mental health strategies to address problems related to Roles and Identities (ADAPT Pillar IV)

- **Psychoeducation:** The counsellor commences with the session focusing on the ADAPT Pillar IV, Roles and Identities. The counsellor describes: "This involves changes in our lives. Sometimes we perceive these changes as being negative because they involve elements that we see as bad. These changes may involve the loss of our 'old role' and the beginning of a 'new role'. This can make frustrated, distressed and confused. For example, a man who worked as a schoolteacher in his home country, suddenly found himself not being able to work in the new country as a teacher where he settled as a refugee.
- **Trauma narrative:** Client is assisted in identifying significant stressful life events related to disruptions in roles and identities and narrating these experiences in a coherent and chronological manner using the 'River Stream' technique. Feelings of anxiety and distress are normalized during this session by using simple stress management strategies.
- **Emotion regulation:** Client is guided through the process of identifying and labelling their emotions/feelings using the 'Happy Tree', a purpose-built pictorial representation. During this process, client is taught to evaluate the situation and their reactions to that situation differently, and accepting these feelings without judgment or attributing blame to themselves.
- **Problem-solving:** Using the ADAPT matrix, client is guided through the following steps: first, identify at least three problems focusing on disruptions in roles and identities; the counsellor then helps the client explore the problems/symptoms/emotions underlying the disruptions. Next, the client shares their coping strategies and barriers to change followed by brainstorming possible solutions. Following a cost and benefit analysis of the solutions, the client adopts a solution or solutions; finally, an action plan and commitment are made to implement the solution(s) in a step-by-step manner.
- **Cognitive reappraisal:** Client is taught how thoughts, feelings and behaviour are interconnected. A list of negative/unhelpful thoughts/beliefs is generated around roles and identities (Pillar IV) followed by re-examination of these thoughts (e.g. by taking on the perspectives of other people), and how they can think differently. Further, client looks at the pros and cons of adopting a particular way(s) of thinking and he/she is encouraged to adopt positive thinking.
- **Relaxation:** Client is introduced to the concepts and practice of progressive muscular relaxation and controlled breathing exercises. These exercises are combined with culturally relevant metaphors and analogies to help clients manage their stress better.

a systematic and integrative fashion to address the most relevant ADAPT pillars.

Coping cards

The IAT programme incorporates a set of purpose-built coping cards using culturally rich illustrations that reflect the five ADAPT pillars. The coping cards were co-designed with the refugee community who provided input from their own experiences as refugees.

Psychosocial assessment tools

We use the purpose-designed 'ADAPT Meter' to gauge therapy progress from session to session. This monitoring tool helps counsellors monitor change in adaptive stress in relation to the ADAPT pillars at the end of each session. Post-therapy auditing of the clinical notes indicated that the tool is sensitive to change and indicative of positive improvement during and after IAT sessions. In addition, we used the Adaptive Stress Index (ASI) (Tay et al., 2019), an empirically derived set of scales that measure AS in relation to each of the five ADAPT pillars. The five scales of ASI relating to the five ADAPT Pillars have been subjected to rigorous psychometric and qualitative testing in several epidemiological surveys with refugees.

Assessing implementation outcomes of the IAT programme by counsellors

Following the six-month period of supervised training-implementation, we conducted a focus group with the 12

Table 1: Summary of implementation outcomes amongst 12 Rohingya counsellors in Malaysia

Implementation outcomes	Summary terms	Number of persons who agreed ($n = 12$)
Is IAT a good programme?	The skills counsellors learn from IAT are useful in their own life	10
	Structure of the programme was useful to the counsellor; easy to follow	9
	The benefits of the programme extend beyond clients – to the counsellors themselves	7
	Melding strategies with the ADAPT pillars is a unique characteristic and strength of the programme	9
	The IAT programme is empowering	8
	The programme is flexible and can be tailored to clients' psychosocial needs	10
What benefits does it have for clients?	The programme is practical and helps the client – both the exercises and the skills taught	9
	People appreciate the programme	10
	The programme helps clients address unhelpful thoughts, emotions/feelings, behaviour	7
	The programme is easily understood and the ADAPT pillars make meaningful sense to people	8
What are the challenges in programme implementation?	Poor attendance at and/or commitment to therapy sessions	12
	IAT duration is too long	5
	It is difficult to deliver to the Rohingya people	3
	Lack of awareness about the programme	8
	Difficult to explain to people what the programme is about	2
	Some strategies are difficult for clients to learn and apply *Prompt: which techniques? (Name all 7 techniques)*	5
	Cognitive reappraisal is the most difficult skill for clients to grasp and practice	10
	Guided imagery for relaxation is difficult for clients to grasp and practice	11
Which techniques work best for clients? *Prompt: which techniques? (Name all 7 techniques)*	Emotion regulation skills are most helpful for clients	10
	Problem solving is most helpful for clients	10
What are the positive improvements in clients?	The client is more open to talk about the problems as the sessions progress	10
	Overall positive change in clients – sensitised to their problems, feelings, and better able at dealing with their problems	8
	Feeling safe in their environment (ADAPT Pillar I)	7
	Improved relationships with people (ADAPT Pillar II)	9
	Coping better with anger and resentment (ADAPT Pillar III)	10
	Accepting and having more a realistic view about their current role (ADAPT Pillar IV)	10
	Gaining a sense of purpose and a positive outlook about future (ADAPT Pillar V)	9
Is the programme well adapted to the culture?	Need to make further adjustments to the programme to fit the local context	2
	Need to make further changes to the programme according to local languages	1
	The programme fits with the values and culture of the people	12
Is the training workshop good?	The workshop is well conducted	10
	The workshop strikes a good balance between theory and practice	9
	The workshop is too long	5
	The workshop is too short	2
	The workshop is not useful	0
How can we improve the training and/or the programme?	Create a physical, permanent centre for therapy	10
	Create a scalable training programme for lay health workers	8
	Create more awareness about the IAT programme in the community	8
	Reduce the number of sessions for clients	2
	Create a programme for children and adolescent refugees	12
	Improve referral system	5
	Improve client attendance	8
	Provide more funding	6
	Scale up the programme for refugees in Malaysia	10

lay counsellors. To assess programme implementation, we presented the group with a list of statements associated with the key outcomes of interest: Is IAT a good programme? What benefits does it have for clients? What are the challenges in programme implementation? What are the positive improvements in clients? Is the programme well adapted to the culture? Is the training workshop good? How can we improve the training and/or the programme? Participants were then asked to indicate they agreed or disagreed with each statement.

Table 1 summarises the implementation outcomes amongst Rohingya IAT counsellors in Malaysia. In summary, the majority of the counsellors agreed that the programme was flexible and could be readily tailored to clients' psychosocial needs. The counsellors also found the skills taught in the programme to be helpful in their own lives. There was a high level of agreement that both the skills and exercises taught in the programme helped the clients and people showed appreciation for the programme.

In relation to the challenges associated with programme delivery, poor attendance and a lack of commitment to therapy sessions were the main barriers. Furthermore, there was strong agreement that both cognitive appraisal and guided imagery for relaxation were the most difficult strategies for the Rohingya to grasp and practise at the initial stage. For cognitive appraisal, the reason was that the clients were often unaware of, and not customized to self-introspection and adopting, alternative ways of thinking when confronted with their problems. All counsellors agreed that using guided imagery for relaxation was difficult for the Rohingya as they showed difficulties in conceptualising and applying the scripted imagery as a de-arousal technique. Both problem-solving and emotion regulation techniques were considered to be the most helpful and effective strategies for the Rohingya.

There was general agreement that positive change was evident amongst the clients following the six-week programme where improvements were observed gradually over time in coping with feelings of anxiety and fear (ADAPT Pillar 1), in relationships with people (ADAPT Pillar 2), in managing anger and resentment (ADAPT Pillar 3), in coping with transition issues and having a more realistic view about their current role (ADAPT Pillar 4), and in fostering a sense of purpose and meaning in their lives (ADAPT Pillar 5). All counsellors agreed that the programme fitted well with the culture and values of the Rohingya. There was strong agreement that the training workshop was well conducted and achieved a good balance between theory and practice. The counsellors agreed that there was a need to create a similar programme for children and young people and to scale up the programme for all refugees in Malaysia.

Further challenges in implementation

During the initial training and implementation phase, additional efforts were made to ensure that the lay counsellors understood both the theoretical and practical aspects of the programme and how to address problems/symptoms associated with the ADAPT Pillars using the mental health strategies taught. As most Rohingya people have limited education and literacy skills, using the ADAPT pillars as the starting premise upon which further skills are built made intuitive sense to the refugees, as opposed to focusing on treating mental health symptoms *per se*. Furthermore, the use of culturally relevant and content-rich analogies, metaphors and pictorial representations facilitated comprehension and uptake of the programme. Finally, the gender imbalance of the Rohingya community in Malaysia as a result of the greater proportion of men than women seeking asylum represents a challenge for the programme team to ensure gender balance of lay counsellors on our team. The gender issue is important to be considered given that, within the Rohingya community and the Muslim society, because of cultural, stigma, and other reasons, men are less inclined to seek help or counselling from women and vice versa.

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Conflicts of interest

There are no conflicts of interest.

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