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Article

Cultural Adaptation of a Low-Intensity Group Psychological Intervention for Syrian Refugees

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Abstract

Given the increasing use of low-intensity psychological interventions in humanitarian mental health and psychosocial support work, more attention is needed to strengthen the intersection between evidence-based interventions and cultural contextualisation. Undertaking the process of cultural adaptation ensures the appropriateness and acceptability of psychological interventions in these contexts. We present the process and results of conducting a cultural adaptation for the Group Problem Management Plus (GroupPM+) intervention, for Syrian refugees across two contexts; Jordan in camp settings and Turkey in urban settings. The first step of the adaptation was to conduct a rapid qualitative assessment following the Design, Implementation, Monitoring and Evaluation model proceeded by cognitive interviews and a workshop designed to apply changes according to the Bernal framework. Based on the results, a total of 82 changes were proposed across the intervention manual, training, supervision and implementation protocols. Changes ranged from minor amendments to terminology to broader changes to how metaphors, stories and illustrations are presented during the intervention. Additionally, two substantial adaptations were suggested: (1) the addition of a session designed to enhance family engagement, and (2) the development of a male case study. Changes were incorporated prior to the implementation of the GroupPM+ intervention in Jordan and Turkey.

Key implications for practice

- The use of cultural adaptation frameworks provide guidance towards a systematic process for tailoring interventions for use in novel contexts, ensuring appropriateness and acceptability of psychological interventions in low and middle income countries.
- Adaptation frameworks should not only consider cultural idioms, but should also seek to explore contextual factors to support programming that addresses a broad range of needs and links to existing services.
- Further exploration is needed to strengthen the intersection between evidence-based interventions and cultural contextualisation.

Keywords: cultural adaptation, Jordan, psychological intervention, Syrian refugees, Turkey

Introduction

The prevalence of common mental disorders such as depression and anxiety increases more than double in a humanitarian crisis (Charlson et al., 2019). Globally, more than 70% of people who need mental health services lack access to care (Alonso et al., 2018). This situation is worse

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in low- and middle-income countries (LMICs) affected by humanitarian emergencies where existing financial and human resources are limited, and basic health services stretched beyond capacity (Ventevogel et al., 2015; Wainberg et al., 2017). There is a strong evidence base for therapies that are effective in the treatment of common mental health conditions (Barbui et al., 2020). However, these treatments require the expertise of trained and experienced therapists, making them difficult to scale in humanitarian settings (Bass et al., 2013). The delivery of scalable psychological interventions using a task-shifting model – or the process of delegating tasks to less specialised workers – is an effective approach to improve access to mental health services in humanitarian settings (Barbui et al., 2020; Eaton et al., 2011; Singla et al., 2017). They are brief, basic and transdiagnostic, meaning they are recommended for people presenting with a range of common mental health conditions (World Health Organization, 2017).

In scaling up evidence-based psychological interventions in different regions, it is optimal to adapt the intervention to the specific context in which it is to be delivered. Cultural adaptation is " . . . the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture and context in such a way that is compatible with the client's cultural patterns, meanings and values" (Bernal et al., 2009, p. 362). Adapting an intervention to the needs of a population in a specific cultural context ensures that the intervention remains effective and relevant for that population (Bernal & Scharrón-del-Río, 2001). Studies have shown that adapted psychological interventions are more effective than non-adapted interventions (Benish et al., 2011; Hall et al., 2016), which may be attributed to increased acceptability and comprehension of the intervention material (Chowdhary et al., 2014). A systematic review showed that greater cultural adaptation of minimally guided or self-help interventions were associated with higher effectiveness in reducing depression and anxiety symptoms (Shehadeh et al., 2016). Such findings indicate the ethical imperative of adapting interventions in low resource settings (Perera et al., 2020).

Although much attention is given to adapting interventions to local cultural norms and expectations, there is also a need for adaptation to accommodate the specific needs of other contextual factors. One of the major public health issues in LMICs today is addressing the mental health issues of refugees. Post-migration stressors are associated with adverse mental health outcomes among refugees (Steel et al., 2011; Tinghög et al., 2017). Refugees in camp settings face specific ongoing post-migration stressors including poor-quality accommodation, restricted movement and employment opportunities and uncertain access to food and water (Rasmussen et al., 2010; Yalim & Kim, 2018). Concerns about security and high levels of poverty and gender-based violence have been reported among refugees in camp settings (Al-Rousan et al., 2018). Studies comparing the experiences of refugees in urban and camp settings have found lower levels of help-seeking among refugees in camp settings experiencing distress and high levels of hopelessness contributed toward these difficulties in accessing services (International Medical Corps, 2017). Adaptations of psychological interventions need to take such contextual factors to accessing services into consideration to remain appropriate and effective for refugee groups in camp settings.

The aim of this study was to adapt a scalable psychological intervention for Syrian refugees in urban and camp settings. This process is illustrated through the adaptation of Group Problem Management Plus (GroupPM+) for use with Syrian refugees in a camp setting in Jordan and in an urban community setting in Istanbul. The immediate need to conduct an adaptation of GroupPM+ for Syrian refugees in a camp setting was to prepare for controlled trials of GroupPM+ in the Azraq refugee camp in Jordan (Akhtar et al., 2020) and in the Sultanbeyli district in Istanbul, Turkey (Uygun et al., 2020). Problem Management Plus (PM+) was developed by the World Health Organization (WHO) to provide a brief, transdiagnostic intervention to reduce anxiety and depression in people affected by adversity (Dawson et al., 2015). Across five weekly sessions, it teaches skills in stress management, problem management, behavioural activation and skills to strengthen social support (World Health Organization, 2016). It has been proven to effectively reduce psychological distress in both individual (Bryant et al., 2017; Rahman et al., 2016) and group formats (Rahman, 2019). GroupPM+ sessions are conducted by two facilitators, and occur in groups of eight to 10 people, with each session lasting 120 minutes.

Methods

Setting

Syrians who fled the conflict in their homeland have sought refuge in neighbouring countries. Turkey hosts the highest number with 3,616,735 registered refugees (United Nations High Commissioner for Refugees, 2020b), most of whom reside in community settings (DGMM, 2020). Jordan hosts more than 600,000 Syrian refugees, who have fled conflict and uncertainty in their homeland (United Nations High Commissioner for Refugees, 2020b). International Medical Corps (IMC) is active throughout the country providing mental health and psychosocial support (MHPSS) to Syrian refugees in camp, and non-camp locations consisting of community, and urban settings.

Whilst GroupPM+ has been validated for use in Pakistan and Nepal (Rahman et al., 2019; Sangraula et al., 2020), its applicability to the Jordan and Turkey contexts have not yet been explored. Further, it has not been validated for use in a refugee camp context. Rapid qualitative assessments (RQAs) were conducted to gain a thorough understanding of the needs and cultural nuances of Syrian refugees, to inform the cultural adaptation of the intervention protocol for these settings. The RQA utilised the Design, Implementation, Monitoring and Evaluation (DIME) model (Applied Mental Health Research Group, 2013). Further, we ensured that the methodology encompassed the requisite components outlined in the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007). The process was

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implemented by the MHPSS teams at the IMC Jordan country office and the Refugees Association in Turkey. The International Federation of the Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support based at Danish Red Cross led the implementation of the process in both countries.

In accordance with the DIME model, the RQA was conducted using three phases of qualitative data collection: (1) free list (FL) interviews, (2) key informant interviews (KIIs) and (3) focus groups discussions (FGDs; Applied Mental Health Research Group, 2013). All three phases were conducted in Jordan by native Arabic speakers. Data was collected over a 3-week period in two refugee camps (Zaatari and Azraq) and in five urban settlements, Irbid, Amman, Zarqa, Mafraq and Ma'an governorates. All participants were adult Syrian refugees (≥18 years old) living in Jordan in camp or community locations. In Turkey, interviews were also conducted by native Arabic speakers with additional KIIs conducted in Turkish. Data were collected over a 6-week period in Istanbul. All participants were adult Syrian refugees and Turkish citizens (≥18 years old) residing in Istanbul.

In both sites, consent was solicited by reading aloud the consent form and asking respondents to sign or mark their agreement on the form. All participants were informed that their answers would remain confidential and that no identifying information would be collected. Participants had the right to withdraw from the interview or group discussion at any time with no negative consequences.

The interview tools were developed in English and then translated to Arabic and back-translated. After discussion with Syrian and Jordanian/Turkish representatives, we decided to use local bilingual health providers experienced in working with translation and back-translation to accommodate the local Syrian idioms used in Jordan and Turkey. An explicit decision was made to not use formally trained linguists for this task, as their translations did not optimally reflect the idioms of refugees, many of whom did not have extensive formal education. In Jordan, 14 staff (two per location) were trained over the course of 2 days. The 14 trainees were Jordanian IMC staff working in the field of MHPSS who were native Arabic speakers and fluent in English. The training familiarised staff with the various interview proformas, and covered communication skill, interviewing techniques and referral pathways. During the training, trainees were instructed to check the accuracy of the translation against the meaning of each question being asked. Trainees were invited to provide feedback on any changes to the questions needed to ensure cultural appropriateness and acceptance. In Turkey, the interview materials were additionally translated and back-translated to Turkish. Twenty research assistants took part in the study as either interviewers or note-takers. The training provided information about GroupPM+, communication skills, qualitative interviewing techniques, including note-taking guidance, RQA methods and the study procedures. In both sites, ethics approval was received from local authorities.

Free List Interviews

Free list (FL) interviews utilised a structured format to provide an overview of a given topic. The FL aimed to identify problems faced by the Syrian population in both countries and coping strategies commonly employed at both the individual and community levels. The primary question asked was: *"What are all the problems that affect Syrian refugees living in Jordan/Turkey?"* Interviewers asked the respondent to provide a short description of each mental health-related problem identified. Interviewers then asked respondents to identify key informants who they consider to be knowledgeable on the topics raised. Respondents were also asked to list all the important daily tasks and activities Syrian refugees regularly do to care for themselves, their families and their community. Data collected was segregated for men, women and children to identify unique coping skills of these populations.

Key Informant Interviews

The purpose of the key informant interviews (KII) was to gather in-depth information about the problems and coping strategies mentioned during the FL interviews. KII participants were identified from the FL interview respondents and included Syrian refugee community members, mental health care service providers and mental health policy makers. Additionally, service providers and policy makers were selected based on their level of expertise. Psychosocial problems identified during FL interviews were explored in a semi-structured way. Priority was given to problems frequently mentioned or that were not already well understood during the FL exercise. KIIs were conducted in a closed, private and comfortable location based on convenience to the participant.

The KIIs focused on the following aspects of the three most commonly noted mental health and psychosocial wellbeing-related problems selected from the FL exercise:

(a) the characteristics and symptoms of the problem;
(b) the perceived causes;
(c) the effects on those having the problems, and on others close to them;
(d) coping methods predominantly implemented by the Syrian refugee community to address such problems, and
(e) help-seeking behaviours and potential deterrents or barriers to help-seeking (in Jordan).

Focus Group Discussions

Focus group discussions (FGDs) are built on information gathered during FL and KIIs. All FGDs were segregated by gender and the facilitator's gender was matched accordingly. In Jordan, the FGDs were designed to focus on coping strategies employed by Syrian refugees, help-seeking behaviour and the gathering of initial impressions of PM+. FGDs were facilitated by one interviewer who was paired with a note-taker. Participants were asked direct questions about the suitability of PM+, along with adaptation considerations, such as: "*Would people prefer a group-based or an*

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individual intervention?" and "*Who could be good providers of peer support?*" Eight FGDs were conducted across two camps and two urban locations. In Turkey, FGDs were designed to inform about the activities Syrian refugees do to care for themselves, their families and the communities. Two FGDs were conducted (one male, one female) in Sultanbeyli, Istanbul.

Cognitive Interviews and Adaptation Workshop

Cognitive interviews in individual and group formats were conducted to determine appropriateness of language and content (Willis, 2004). The purpose of cognitive interviews is to understand how people mentally process information related to specific features of questionnaires and interventions (Willis, 1999). Related to the study at hand, cognitive interviews were employed to understand the mental processes that participants would use when presented with the content and strategies of the GroupPM+ intervention. As the adaptation process was meant to encompass Syrian refugees living in common transitory countries, cognitive interviews were chosen to be conducted in Turkey only, as the results were considered generalisable across contexts. Sections of the manual presented in the cognitive interviews were preselected based on elements of the Bernal framework of language, persons, metaphors, content, concepts, goals, methods and context used (Bernal et al., 2009; Bernal & Sáez-Santiago, 2006; Chowdhary et al., 2014). Participants were asked to comment on text and illustrations, and their relevance, and acceptability. The adaptation workshop, as the final step in the adaptation process, presented the overall recommended changes gathered from the RQA and cognitive interviews to key stakeholders and representatives from Jordan/Turkey. Key stakeholders included persons from the WHO, academic institutions, civil society and staff from non-governmental organisations (NGO) with programme design and implementation experience working with Syrian refugees. The workshop provided a forum for final adaptations to be decided upon for use in the manual and eventual implementation in these contexts.

Data Analysis

Analyses followed the six steps proposed by Braun and Clarke (2006) and data were thematically analysed by using both inductive and deductive approaches. Interviews were first transcribed and were further translated into English by the bilingual field assistants in Turkey. The authors then read and reread the translated documents to familiarise themselves with data. Analysis in Jordan was completed in Arabic. Separately, they coded the relevant texts into brief phrases or words, known as codes. To establish a unified codebook, codes were compared and any inconsistencies were resolved between the authors. Two authors from each country (Jordan: AA, RB; Turkey, GK, ZI) discussed and resolved any discrepancies between coding of themes. Hereafter, themes and subthemes were extracted. Each theme was clearly described and named. The final results include main themes with respective examples from the data.

Results

Results from Jordan

Demographics

Overall, there were 103 participants in the RQA. There were 27 participants (14 male, 13 female) in the FLs, 24 (14 male, 10 female) in the KIIs and 52 in the FGDs (four groups of males and four of females). Syrian refugee participants of the FLs/KIIs/FGDs were recruited through community outreach efforts. Additionally, health professionals who took part in the KIIs were recruited through the mental health working group in Jordan.

Free Listing Interviews

The three most prominent problems identified in Jordan were: (1) emotional and psychological distress, (2) abuse of women and children and (3) work-related problems. Work problems were primarily related to working conditions, financial aspects and work-status. Work-related problems mentioned for both Syrians in the community and those residing in camps, included long work hours in harsh conditions (e.g. working in fields for 12+ hours a day) and child labour. These working conditions gave rise to distress related to their disdain with the remuneration. Additionally, many Syrians in both community and camp settings did not have legal working permits which allowed for exploitation from employers. Violence against women and children were reportedly caused by: (1) widowed women being subjected to abuse, (2) gender norms being violated as women need to work to support the family and (3) children needing to work to assist the family financial situation. Lastly, psychological and emotional distress was caused by uncertainty of the future, inability to secure even the most basic human needs and harsh living conditions. In the urban communities, levels of psychological distress were reported at higher rates, as were difficulties in forming social relationships. Living conditions were significantly more challenging in camp locations relative to urban sites.

Focus Group Discussions and Key Informant Interviews

Information was also gathered on the activities that Syrian refugees currently do to help manage such problems. In camps, emphasis was placed on engagement in informal education opportunities, recreational activities and sports. For Syrians in urban settings, coping activities centred on volunteer work, family gatherings and solitary activities (e.g. watching television). Older persons were perceived to be especially vulnerable in Jordan, as they were said to prioritise the needs of other family members over their own needs for healthcare. This means they generally do not access necessary treatments for the management of chronic conditions, and this places them at risk of poor health outcomes. Interestingly, older persons were reportedly highly respected and were identified as potentially suitable PM+ facilitators. Group discussion among community members was viewed as normal to support wellbeing.

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Respondents indicated that they primarily sought health care for both physical and psychological needs from the NGO community in both urban and camp settings. In addition, Syrians indicated that they were likely to seek help from other community members. Sources of help in the community included parents, older persons and family members. Respondents indicated problems with these sources of help included potential discrimination by NGO services or community members not being able to help sufficiently. Barriers to accessing professional services for health were said to be due to services not being accessible, and a general shortage of services in some urban areas. Furthermore, respondents stated that feeling hopeless and helpless were further barriers to help seeking. For problems related to mental health specifically, discrimination was raised as a primary barrier to seeking help, along with the perception of there being no permanent solutions for mental health issues.

PM+ Intervention

The PM+ intervention was discussed in both the KIIs and FGDs. The possibility of implementing the intervention was primarily met with positive feedback from respondents. The majority of participants noted that the intervention would be helpful in widening the reach of MHPSS services to reach as many community members as possible; this would be the primary benefit to providing services in a group format as opposed to the individual format. Key informants also believed that PM+ could be well integrated into primary health services for both local populations and refugee populations, and that it would be possible to scale-up the intervention and provide services throughout Jordan in the way of primary health centres.

When discussing the individual versus group PM+ intervention, participants in seven of the eight FGDs (88%) collectively indicated that they would prefer to attend a group format. Participants also noted that if highly personal information is to be divulged which may not be relevant to the full group, the individual version would be preferable. A small proportion of participants attending the FGDs ($n = 12$, 23%) indicated preference for the individual format due to the perceived sensitivity of issues that may be discussed in the sessions. Responses from the KIIs indicated that a group format would be more appropriate due to its inadvertent impact of social support.

There were some concerns related to psychological interventions, including PM+ in group formats. Mainly, how would such an intervention be able to support persons with practical problems, such as job seeking? Some respondents believed that such an intervention alone without more tangible support for income generation and job seeking would not be sufficient to manage the complex problems faced by Syrian refugees in Jordan. Additionally, accessibility was frequently mentioned as a challenge if Group PM+ was going to be implemented in urban settings due to transportation and other access barriers.

Results from Turkey

Demographics

The overall sample consisted of 58 adult participants. There were 24 (13 female, 11 male) participants in the FLs, 20 participants (10 female, 10 male) in FGDs and 14 participants (10 female, four male) in KIIs.

Free Listing Interviews

Problems mentioned by Syrians in Turkey included: (1) economic problems, (2) social and family-related problems and (3) emotional and psychological distress. Economic problems were mostly related to working conditions such as not having legal working permits, working for long hours, earning less salary than Turkish employees and workplace maltreatment. Unemployment was reported to have a profound impact on psychological wellbeing. Social and family-related problems were the second frequently mentioned category. As for social problems, language barriers were most notably reported by the respondents. Language emerges as an important barrier for employment, access to social/health care services and integration into Turkish society. Family-related problems were mainly related to children and marital relations. Child-related problems included concerns over children not continuing their education mainly due to economic problems, and bullying and discrimination toward Syrian students at schools. Marital problems were caused by domestic violence and change in gender roles. Emotional and psychological problems were reported as anxiety, aggression and feelings of loneliness. These problems were related to lack of meaning in their life and premigration traumatic experiences.

The most frequently reported activities to cope with these problems were spending time with family, doing outdoor activities, engaging in religious activities, continuing education, learning Turkish, providing and asking for emotional and instrumental support. In FGDs, similar themes emerged. Only for women, new ways of coping included reappraisal, doing housework as a distraction and accepting their husbands' behaviours.

Focus Group Discussions and Key Informant Interviews

The identified key informants and other professionals working in this area in various organisations were contacted for the KIIs. The causes of economic, social and family-related and emotional problems were identified as related to post-migration living circumstances (e.g. high cost of living, limited resources, problems in the education system, lack of integration policies and change in gender roles), unwillingness to learn Turkish language and customs and war-related problems such as separation from family members. Not speaking the language was a major problem that led to lack of interaction with Turkish people and problems communicating socially and at official institutions, such as at hospitals when seeking medical treatment. Even though the Ministry of Health had been working on increasing the number of Arabic–Turkish translators at hospitals, not every

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hospital had a translator and the respondents stated this made it difficult for them to access healthcare. Further, problems were found to be related to prejudice against Syrian refugees. Many Syrian refugees feel discriminated against, mainly related to employment issues and lack of protection of their rights. In general, all these reported problems appeared to have various impacts on Syrians such as psychological distress, communication and integration difficulties and family conflict.

The ways Syrian refugees cope with these problems were reported to be seeking financial and practical support from organisations and social media, seeking information about their rights and attending language courses. The future direction that can be taken to manage these problems were suggested to be enabling Syrian refugees to use their qualifications in the jobs that they are working, engaging in cultural and integration-oriented activities, forming awareness projects to inform refugees about their rights, forming various governmental policies and learning about how to manage limited financial resources. As a response to the language problem which appears as a barrier to utilising health care services, participants suggested that government-run health care centres employ a higher number of translators and Syrian doctors. Moreover, participants indicated that better coordination between institutions such as NGOs and primary health care centres should be established.

PM+ Intervention

GroupPM+ was generally viewed positively by respondents. However, the respondents stated that supervision and setting a cut-off (for the severity of distress) for recruitment would be necessary. The potential benefits of GroupPM+ were identified as the formation of social support between the participants and the provision of skills to promote emotion regulation. The respondents mentioned that the challenges would be sustaining continuity, scheduling suitable times for the sessions partly due to the long working hours of men, finding a child-friendly place for the participants' children when the parents are in the session and stigma toward psychological support programmes. The potential GroupPM+ trainers were suggested to be experienced in MHPSS, have necessary skills to be a facilitator such as leadership skills and good communication skills, be without severe psychological problems, be informed about the Syrian culture and war-related situations and be an Arab. Moreover, community centres, governmental and nongovernmental institutions were suggested to be potential places where GroupPM+ could be implemented, and emphasis was put on ensuring such places were accessible.

Cognitive Interviews and Adaptation Workshop

In total, five cognitive interviews were conducted in Turkey with health professionals working with Syrian refugees and two FGDs were held directly with Syrian refugees (six female, five male). Overall, 82 suggestions for changes were made in accordance with the Bernal framework; four changes were proposed related to language, 114 for persons, eight for metaphors, two for content, nine for concepts, 10 for goals, 11 for methods and 24 for context; eight suggested modifications were not included because of local advice from health providers that these local modifications would alter the fundamental intervention protocol. These suggestions were presented at the adaptation workshop and consensus was built regarding necessary adaptations. Table 1 presents examples of changes that were made. There were a number of specific changes suggested, such as changing a specific word (e.g. client) to a more culturally appropriate word (e.g. participant), as well as general changes to the approach of the programme including specific concepts in training and supervision sessions to support facilitators. Additionally, there were two substantial suggestions for changes to the programme which were incorporated during the proceeding adaptation process. Firstly, to establish trust and rapport between the GroupPM+ facilitators and participants, an introductory session was proposed to allow for families to meet and ask any questions they have about the intervention. Secondly, the creation of a separate case study was strongly suggested for males, as the current case study was more aligned with females in the Syrian community.

Discussion

Interestingly, across Jordan and Turkey three similar core issues were identified. Emotional and psychological distress was mentioned as one of the three core problems facing Syrians. Distress in refugees in Jordan centred on uncertainties around their future and difficulties meeting basic needs. In Turkey, Syrians noted premigration traumatic experiences to be a primary factor in their experience of distress. This discrepancy might be explained by differences in area of origin of respondents. Syrians who have fled to Turkey are predominantly from West and North Syrian governorates, whereas Syrians in Jordan often have fled from southern governorates of Syria. Whilst Syria as a whole has been prone to egregious atrocities, western Syria has been particularly marked by the civil war and subsequent prolonged conflict. REACH (2019) estimates that in Aleppo alone, there were approximately 35,722 damaged and destroyed buildings since the start of the conflict up to 2016, compared to 1,503 in Daraa in 2017.

Living in a camp setting appears to coincide with increased reporting of social support, with those in urban settings reporting more difficulties in forming social relationships. The perceived social support reported in camp settings might be due to the close proximity of inhabitants. The United Nations High Commissioner for Refugees (UNHCR) has designed both Zata'ari and Azraq refugee camps with the aim of creating a sense of community. In Zata'ari, this meant allowing residents to select their neighbours and make refurbishments to their caravans. In Azraq, this is demonstrated through the "village" approach which separates the camp into quadrants aimed to increase a sense of community ownership (UNHCR, 2017, 2020a). The careful planning of camps seems to pay off with an increase in perceived belongingness among members. Those residing in urban contexts do not enjoy the same level of proximity to their

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Table 1: *Example of Changes Made in Accordance with the Bernal Framework*

Domain	Implementation	Rationale	Relevant for
Language	Change the term "psychological" intervention to "life skills or training". For Syrians, the decision was to change it to "idaara".	Concern over using the term mental or psychological as this will dissuade people from attending the intervention. The term was stigmatising and considered a taboo, or a deficiency/personal short-coming.	Adaptation, training and implementation
Persons	Add suggestions of appropriate verbal and physical reinforcement in sessions: For women: Listening, touching (putting a hand on someone's shoulder), eye contact, wiping tears. For men: No for any touching. Smiling and showing understanding and kindness are acceptable.	Directions for nonverbal skills for the PM+ helpers too generic and needed to be specifically adapted to Syrian culture.	Adaptation, training
Metaphor	Insert activities that participants may enjoy and remove irrelevant activities: Example: remove "collecting wood and water".	Turkish cognitive interview respondents came to consensus that the listed activities are not relevant in the community. Suggested changes were preparing meals and washing dishes.	Adaptation
Content	Remove the example of yoga as a relaxing technique and replace with the following suggestions: listening to music or, listen to the Quran and praying.	Yoga is inappropriate. Some women in the cognitive interviews did not know what yoga was and said it is not common in Syrian culture.	Adaptation
Concept	Expand on the examples of adversity – the suggested examples were agreed to, but it would be helpful to expand, with examples about difficulties in relationships.	Men see that women may have changed and kids seem older because of the experiences they have faced.	Implementation
Goals	Change possible solutions of goals from eating to something about children eating or another example that is not about eating.	Some men stop eating when they are stressed. Their mindset would be "how can they eat when their family is unable to eat regularly?"	Adaptation
Methods	Related to the use of PSYCHLOPS in group sessions; develop work sheets for facilitators to summarise participants' problems for easy overview of reported problems.	If facilitator sits with everyone's responses, this becomes a lot of paperwork to manage during the group. Important to avoid looking like you are more interested in paperwork than participants.	Adaptation, training, implementation
Context	Stress referral skills and knowledge in training and country specific adaptations to ensure feasibility.	The facilitators should have experience in referring to specialists to help manage problems beyond the scope of PM+	Training, implementation

PM+, Problem Management Plus. PSYCHLOPS, Psychological Outcomes Profile

Syrian counterparts and thus might be at increased risk of facing discrimination from the host community they regularly interact with. In Turkey, the experience of discrimination was frequently reported.

Syrians living in camp settings are more likely to enjoy easier access to services, as NGOs are based directly in the camp and camp management is responsible for ensuring that necessary services are provided. Additionally, camps are often closed geographical areas allowing for easier access to services without needing to compete with host populations. This appears to be reflected in the findings as those living in camps reported utilising structured activities as a source of coping such as engagements in informal education, recreational activities and sports, whereas those in urban contexts reported utilising more solitary activities as a source of coping and relying on family support. Furthermore, all staff operating in camps are Arabic speaking as the camps were located in Jordan. Syrians residing in Turkey faced additional barriers accessing care and reported experiencing discrimination due to their inability to speak Turkish. Due to government regulations on healthcare providers, many persons providing services to Syrians are Turkish and operate through the use of translators. This was reported to pose an additional barrier to care and led respondents to request Arabic speaking facilitators for the proposed intervention.

Despite the potential ease of access to services that was reportedly found within the camp setting, harsh living conditions were noted as a significant source of distress. Similarly, for those living in urban settings, primary problems identified in both Turkey and Jordan were economic and work-related issues. In Jordan in particular, the abuse of women and children was named as a primary concern among respondents, whereas respondents based in Turkey referenced domestic violence against women as a consequence of greater social upheavals and changes in gender norms. These findings pose significant challenges for the potential implementation of a low-intensity psychological intervention focused on problem-solving strategies. Finding gainful employment free from exploitation and preventing domestic violence are often not problems that can be easily solved. The creators of GroupPM+ acknowledged the array of adversities faced by conflict-affected populations and utilise the term *management* to signify teaching skills to deal with stress arising from stressors rather than solution of stressors themselves. This is important in contexts where unemployment or lack of housing is a reality that is not readily

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solved. It is also important to recognise that enhancing the mental health of refugees would be achieved by provision of additional psychosocial services, as well as improvements in housing, employment, connection with family and friends and government policies that promote their acculturation and acceptance into the host communities.

Limitations

There were a number of limitations in the present study. First, cognitive interviews were only conducted in Turkey and not in Jordan. The results of the cognitive interviews and subsequent adaptations may therefore reflect the views of those residing in urban settings more than those residing in camps. The results of the RQA conducted in Jordan were combined with the information gathered in Turkey during the cognitive interviews, and with similarities reported in core issues facing the two populations this would have helped to reduce bias. In addition, the majority of adaptations made to the intervention to align with Syrian culture would have been applicable in both contexts. Second, the adapted versions of the manualised intervention were prepared for use in upcoming trials and the effectiveness in comparison to the direct translation was not able to be determined (Akhtar et al., 2020; Sijbrandij et al., 2017; Uygun et al., 2020). Third, in Jordan the interviewers for the RQA were Jordanian which may have impacted the level of comfort that participants had in openly sharing their views on their current situation. Fourth, the RQA and cultural adaptation were conducted prior to the COVID-19 pandemic. The pandemic has had a substantial impact in humanitarian contexts in terms of daily life stressors as well as service delivery. Given the current situation, local perspectives on needs and barriers faced during the pandemic would allow for further adaptation. Finally, we recognise that there are alternate cultural frameworks that could be applied to understand the local needs and intervention adaptations (Bernal & Adames, 2017; Gonzales, 2017). We adapted the Bernal framework because after discussion with local health providers it was agreed that this was an appropriate framework for the cultural adaptation process. Relatedly, we note that there has been criticism of how qualitative research is reported, and this has been supported by systematic reviews of qualitative studies that have highlighted the lack of detailed, transparent reporting of qualitative study processes (Shehadeh et al., 2016). We recognise that further detail could have been obtained by deeper investigation of cultural idioms of distress in the Syrian refugees, particularly with regard to issues of concern including suicide, grief and children's mental health (Heim & Kohrt, 2019).

Conclusion

Recent years have seen an increase in investment into the development and evaluation of low-intensity psychological interventions in humanitarian contexts. Whilst cultural adaptation is widely acknowledged to be an essential component of contextualisation, little research has been focused on identifying a systematic process for adaptation. Further, most adaptations are often conducted at the country level, meaning additional resource allocation is needed and replicability of findings across settings cannot be guaranteed. We present a framework for adaptation that focused on displaced Syrians more broadly across two contexts. The adaptation process led to the identification of minor and major amendments to the intervention, supervision and training protocols needed to ensure the acceptability and relevance of the GroupPM+ intervention to Syrians in Jordan and Turkey.

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Conflicts of interest

There are no conflicts of interest.

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