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ORIGINAL ARTICLE

WILEY

"Online delivery gave me privacy and distance from others": feasibility trial and qualitative evaluation of an online intervention for refugees and asylum seekers; LTP + EMDR G-TEP

Safa Kemal Kaptan[1] | Filippo Varese[1,2] | Betul Yilmaz[1] | Panoraia Andriopoulou[3] | Nusrat Husain[1]

[1]Division of Psychology and Mental Health, Faculty of Biology, Medicine and Health, School of Health Sciences, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK

[2]Complex Trauma and Resilience Research Unit, Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

[3]Hellenic Open University, Patras, Greece

Correspondence
Safa Kemal Kaptan, Division of Psychology and Mental Health, Faculty of Biology, Medicine and Health, School of Health Sciences, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK.
Emails: safa.kaptan@manchester.ac.uk; safakemalkaptan@gmail.com

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Abstract

Rates of mental health difficulties are high among refugees and asylum seekers who are parents, which makes their family members vulnerable to further negative outcomes such as behavioural problems or withdrawal. Maternal health and responsive parenting can stimulate the well-being of family members. However, displaced parents may fail to fulfil this role due to their own personal emotional issues. This current study is the first trial that tested the acceptability and feasibility of a remote multi-component parenting intervention for refugees and asylum seekers: Learning Through Play and EMDR Group Traumatic Episode Protocol. The study was a single-arm feasibility trial with an embedded qualitative component, and took place in the UK. We recruited caregivers of children under three years of age and offered eight sessions of a remote group Learning Through Play parenting intervention and Eye Movement Desensitisation Reprocessing Group Traumatic Episode Protocol (LTP+ EMDR G-TEP). We administered assessments, including the Parenting Sense of Competence Scale, International Trauma Questionnaire, Generalized Anxiety Disorder-7 and Patient Health Questionnaire-9, followed by qualitative interviews. Of the 16 participants approached, 14 consented and were eligible to participate. Both qualitative and quantitative results showed the acceptability and feasibility of the intervention based on a recruitment rate of 88% of eligible participants and a 78% attendance rate for all sessions. Participants showed improvements in all outcome measures, an increase in parental self-esteem and a reduction in mental health symptoms. Findings also suggest that remote interventions are promising as a scalable approach for displaced families.

Contributing authors: Filippo Varese (filippo.varese@manchester.ac.uk), Betul Yilmaz (betul.yilmaz@manchester.ac.uk), Panoraia Andriopoulou (andriopoulou.panoraia@ac.eap.gr), Nusrat Husain (nusrat.husain@manchester.ac.uk).

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KEYWORDS
COVID-related stress, EMDR G-TEP, mental health, parenting, refugees, remote intervention, scaling up

1 | INTRODUCTION

The development of interventions for refugees and asylum seekers is an increasingly important issue in global health, owing to the high prevalence of depression, anxiety, trauma and the considerable negative repercussions for both caregivers and children (Blackmore et al., 2020; Turrini et al., 2017). With over 89 million people worldwide classed as forcibly displaced, and 41% of them being children (UNHCR, 2021), there is increasing concern that the mental health of younger generations is being adversely affected by a low level of psychological well-being and family functioning (Bryant et al., 2018).

Common factors associated with mental health difficulties in these groups include not only pre-migration challenges, but also post-resettlement worries (Bogic et al., 2012). These factors amplify stress and also have an adverse impact on coping strategies, which puts individuals at high risk of developing further mental health difficulties (Lindert et al., 2009). Furthermore, the recent COVID-19 pandemic created further adversities for people from displaced backgrounds, who had already experienced significant trauma. Recent studies have reported that COVID-19 significantly exacerbates the ongoing mental health difficulties and leads to increased rates of depression, anxiety and trauma among refugees (Kizilhan & Noll-Hussong, 2020).

The challenges faced by forcibly displaced individuals can become even more complex when the individuals are also parents of young children due to the adverse impacts of challenges on parenting practices and, thus, on early childhood development (Back Nielsen et al., 2019). Though the term "parent" is used, this could be any primary caregiver, as due to the nature of displacement and conflict, many children are raised by those who are not their biological parents.

Recent studies have reported that maternal depression is high in this population (Ahmed et al., 2017; Stevenson et al., 2019) and often leaves caregivers unable to provide the care for family members, leading to long-lasting impacts on the mental health of children (Bronstein & Montgomery, 2011). Further studies have also associated mental health difficulties with harsh parenting practices (Sim et al., 2018), reflected as withdrawal (Song et al., 2014), conduct problems (Bryant et al., 2018), low academic performance (Aghajafari et al., 2020), higher levels of distress in adulthood (Kamis, 2021), behavioural problems (Manning & Gregoire, 2009) and attachment difficulties in childhood (van Ee et al., 2016). Conversely, a responsive family environment and a caregiver's good mental health have been shown to enhance the overall well-being of children in the perinatal period (Fazel et al., 2012; Roncallo et al., 2018).

The existing evidence suggests that parenting interventions are one of the most important preventative strategies to reduce negative developmental trajectories among family members (Jeong et al., 2021; Zhang et al., 2021). Improvements in parenting skills or positive family functioning are considered the key underlying mechanisms in preventing further challenges, including child psychiatric disorders (Vostanis et al., 2006), risky behaviours (Caldwell et al., 2010) and drug misuse (Calafat et al., 2014; Montgomery et al., 2008). Parenting interventions with forcibly displaced persons have already shown promising results in both child- and parent-related outcomes (Gillespie et al., 2022; Renzaho & Vignjevic, 2011). However, given the complex nature of refugee life, previous studies have highlighted the necessity for integrated interventions that focus not only on parenting practices but also on maternal mental health to strengthen the positive impact of parenting programmes by reducing the stress experienced by caregivers (Christodoulou et al., 2019; Miller et al., 2020; Moran et al., 2004).

Despite the high prevalence of mental health difficulties, refugees and asylum seekers show relatively low use of mental health services in their host countries due to several barriers (Satinsky et al., 2019). The barriers associated with reduced help-seeking behaviours are challenging to overcome. They include a high level of stigma (Kiselev et al., 2020), lack of culturally appropriate services (de Anstiss et al., 2009), personal perceptions that time will heal symptoms (Fuhr et al., 2019) and other institutional barriers such as lack of collaboration between organisations in service delivery (Salami et al., 2019).

Low rates of service utilisation and challenges suggest that there is no "one-size-fits-all" approach for displaced populations. Hence,

Implications for practice and policy

- The current trial is the first to evaluate an online parenting intervention for refugees and asylum seekers, and it appears to be a feasible approach and an effective tool for engaging with displaced populations.
- It is possible that once the effectiveness is fully established, the LTP+ EMDR G-TEP intervention has the potential to increase the capacity of service providers by allowing them to use the intervention in their settings.
- The diversity of participants regarding nationality and the amount of time spent in the UK supports the versatility of the intervention.
- Since it is the first time that an online parenting intervention for refugees and asylum seekers has been evaluated, further research is needed to extend the evidence for displaced groups.

different approaches for different groups should be tested and promoted (Sanders et al., 2021). Previous literature on refugee populations showed promising and encouraging results regarding the use of technologies (Burchert et al., 2019; Liem et al., 2021), which support the World Health Organization's (WHO) plan to enhance service accessibility for disadvantaged groups using digital and online methods (WHO, 2017). The demand for mental health services is also rapidly increasing and outstripping the resources of mental health providers around the world (World Health Organization, 2021). Online services are one way to increase the capacity to provide more time-effective care to people in need. However, until recently, the delivery of online parenting interventions to displaced groups remained an under-researched area.

The current study aimed to evaluate the feasibility and acceptability of an online intervention for parent refugees and asylum seekers with young children. The Learning Through Play and Eye Movement Desensitization and Reprocessing Group Traumatic Episode Protocol (LTP + EMDR G-TEP) has a multi-focus—to improve parents' mental health and to increase their knowledge of early childhood development. To the best of our knowledge, this is the first study focusing on the feasibility of a remote parenting intervention and the remote EMDR G-TEP intervention for parent refugees and asylum seekers. This study will provide an insight into a larger clinical trial to evaluate the potential efficacy of this integrated treatment approach.

2 | METHODS

We reported the current trial according to several guidelines; the CONSORT extension for randomised pilot and feasibility trials (Eldridge, Chan, et al., 2016) and consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups (Tong et al., 2007). Please see Appendices S1–S3 for checklists. The study is registered on ISRCTN (ISRCTN71853873). The study received ethics approval from the University of Manchester's Research Ethics Committee 3 and was funded by the Turkish Embassy Education Counsellor's Office.

2.1 | Study design

There is a large volume of published studies describing the role of feasibility trials to identify barriers and facilitators in the delivery of the planned interventions (Eldridge, Lancaster, et al., 2016). The current trial was a single-group feasibility trial with a qualitative and quantitative evaluation. The study used quantitative outcomes to assess potential benefits, while qualitative interviews aimed to understand participants' experiences and perspectives of taking part in the intervention. The study was conducted in the UK, and all participants received the remote-delivered sessions for 8 weeks.

2.2 | Participants

The trial aimed to recruit 14 participants. There was no formal sample size calculation as the current study intends to inform future randomised controlled trials. The sample size was chosen after several considerations, including consultation with researchers involved in similar studies, developers of the treatment manuals and community members, and was also based on previous studies (Ballard et al., 2018; Lakkis et al., 2020). The inclusion criteria for this study were as follows: women aged over 18 years, a biological or primary caregiver of a child under the age of three years, able to read and understand English, having access to the internet and a smart device, having refugee or asylum seeker status in the UK, and being registered with a general practitioner (GP). Participants were reimbursed for their time and commitment.

2.3 | The intervention

The intervention is an eight-session remote group intervention that utilised two protocols: Learning Through Play (LTP; Hincks, 2002) and Eye Movement Desensitization and Reprocessing Group Traumatic Episode Protocol (Shapiro, 2013).

Learning through play was first developed in Canada by the Toronto Public Health department and later revised by The Hincks-Dellcrest Centre (2002), and culturally adapted versions have been assessed through several RCTs in many low- and middle-income countries (Husain et al., 2017; Notiar et al., 2021). The LTP intervention follows the principles of attachment theory and includes a pictorial calendar, which makes the programme literacy friendly. The pictorial calendar, which depicts eight stages of child development, illustrates play activities and is intended to promote parenting knowledge of early childhood development from birth to three years in a culturally adapted format. LTP is a relatively low-cost intervention as it only requires homemade tools to perform play activities that are shown in the pictorial calendar, which makes it feasible in low-resource settings. The LTP programme comprises child development under five categories: a sense of self, physical development, relationships, understanding about the world and language development. The sessions can be delivered in a variety of formats by a variety of non-specialist staff with relevant training in the treatment manual.

The second component of the integrated intervention was EMDR G-TEP, which is a brief and effective protocol to process traumatic experiences with ongoing stress. The protocol is relatively new but is being used more widely around the world, and accumulating research evidence has shown it to be efficacious (Kaptan, Dursun, et al., 2021). The protocol follows the theoretical principles of adaptive information processing (AIP), which conceptualises that stress occurs because of unprocessed or disturbing memories. However, Group EMDR is far more practical than individual EMDR with applications with large groups, families as well as remote interventions (Maxfield, 2021). It is suitable for a wide range of groups, including children and adults, and is culture-friendly due to the possibilities

for confidential expression through drawings as well as writing. The protocol aims to reduce traumatic stress by promoting resilience and adaptive processing. However, to our knowledge, the existing G-TEP literature has been restricted to the use of face-to-face sessions.

In this trial, online-delivered EMDR G-TEP was utilised to support participants and equip them with skills to reduce the impact of traumatic experiences, thus helping them become more effective in their parental role.

2.4 | Facilitators, intervention delivery and fidelity

Two members of the research team who were trained in the intervention manuals delivered the intervention. One of the facilitators shared similar cultural background characteristics with some of the participants. The facilitators used a detailed intervention manual and checklist (Shapiro & Moench, 2020) that included continuous supervision to ensure fidelity. The intervention consisted of eight sessions, and the average length of each group session was 60–90 min. The first seven sessions focused on the LTP component and early child development. The last session was devoted to EMDR G-TEP and processing stressful memories. Following the findings of our pretrial qualitative study (Kaptan et al., 2022), it was deemed necessary that the current sample needed time to understand the G-TEP worksheet. Therefore, participants practised the EMDR G-TEP worksheet starting from the third session to help them prepare for the last session. During the final session, which was delivered in smaller groups of four, participants chose and targeted a stressful event that was related to the COVID-19 pandemic. The details of the intervention can be seen in our protocol paper (Kaptan, Varese, et al., 2021).

2.5 | Measures

The Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989) is a widely used, 17-item self-report scale designed to measure perceived parenting ability, efficacy and satisfaction. The scale has high internal consistency for mothers with young children, reported as 0.78 (Karp et al., 2015).

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is an 18-item scale that yields a total stress score. In this trial, the scale assessed the level of stress and its timeline. In the current sample, the internal consistency was 0.80 and 0.94 for the post-traumatic stress disorder (PTSD) and disturbances in self-organisation (DSO) subscales, respectively (Vallières et al., 2018).

The Generalized Anxiety Disorder 7-item scale (GAD-7; Swinson, 2006) is a measure of anxiety. The scale has seven items with cut-offs of 5, 10 and 15 indicating mild, moderate and severe anxiety levels, respectively. GAD-7 has a strong internal consistency of 0.89 for the general population (Löwe et al., 2008).

The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) includes nine items to assess the severity of depressive symptoms based on DSM-IV criteria. The total score ranges from 0 to 27. The internal consistency in the current sample was 0.89.

The Dissociative Experiences Scale-II (DES-II; Bernstein Carlson & Putnam, 1993) includes 29 items that measure an individual's tendency for dissociation. Scores range from 0% to 100% to indicate the frequency of dissociative experiences. In the present study, the scale was used to examine the risk of dissociation during the sessions. No participants scored above the cut-off point. The internal consistency in the present study was 0.92.

The Client Satisfaction Questionnaire (CSQ-8) is an 8-item, valid and reliable tool that measures the extent to which individuals are satisfied with the care they have received (Larsen et al., 1979). The total score ranges from 8 to 32, and higher scores indicate more satisfaction.

A self-report questionnaire was used to record demographic details such as resident status, time in the UK, employment, nationality, education level, marital status, age, gender, number of children, total household income and the contact details of the GP.

Upon completion of the intervention, we conducted post-intervention one-to-one semi-structured online interviews to explore participants' experiences of the intervention. The interviews followed a semi-structured topic guide to explore various aspects of the intervention, including its content, delivery, acceptability and barriers or facilitators to implementation.

2.6 | Feasibility indicators

We assessed the feasibility and the acceptability of the intervention through several variables—recruitment rate and speed (number of participants contacted, source of recruitment), attendance of sessions, completeness of the outcome measures and average time needed to complete measures at each data point, and dropout rates (a record for each session, reasons for withdrawal). The acceptability of the intervention was measured using the satisfaction tool (CSQ-8) and qualitative interviews.

2.7 | Data analysis

We analysed quantitative data using Reliable Change Index (RCI) and Clinically Significant Change (CSC) (Jacobson & Truax, 1991; Morley & Dowzer, 2014). RCI is a statistical method to measure whether changes in individuals' outcome scores are reliable and clinically significant (Guhn et al., 2014) when the sample is small. To do so, for each tool, means and standard deviations of pre- and post-scores and reliability of scales are used (Zahra & Hedge, 2010) and an RCI score with a magnitude of 1.96 in either direction is considered to show reliable change at the $p < .05$ level.

We also employed thematic analysis (TA; Braun & Clarke, 2006) to analyse qualitative data. TA comprises six steps, beginning with data familiarisation in step 1 and the generation of initial codes in step 2. The analysis moves on to the third and fourth steps, which

include detecting shared meanings and organising them into themes. The themes are finalised and written in step 5 and step 6.

3 | RESULTS

3.1 | Sample characteristics

Of the 16 participants approached, 14 mothers gave informed consent and met the inclusion criteria. The age of mothers ranged from 24 to 49 years, with a mean of 33.24 years. Seven mothers were married, and 11 were not employed. Among the participants, the average time in the UK was 3.8 years and the average number of years of education was 10.35 years. Please see Table 1 for more details.

3.2 | Feasibility results

Of the 16 participants invited, 14 agreed to take part in the study (88%). The recruitment was completed within 17 days from the day of the initial advertisement. The highest yielding recruitment source was charities (50%), followed by friends' referrals (43%) and adverts through social media (7%).

All participants attended a one-to-one information session. After the information session, participants were sent the baseline tools. On average, participants took four days to return the completed pre-assessment tools ($M = 3.63$, $SD = 1.49$). Five of the participants struggled with completing the tools and requested further help. Following this, one-to-one meetings were scheduled with all participants to ensure they completed the tools correctly. On average, most participants took fewer than seven days to return the completed post-intervention tools ($M = 6.77$, $SD = 2.53$).

All participants completed the study and assessment tools at each data collection point (100%). The overall attendance was high, with 11 participants (78%) attending all eight sessions, while the remaining three (22%) participants attended seven sessions. No participants missed the EMDR G-TEP session. Using the CSQ-8 scale, participants indicated an elevated level of satisfaction with the LTP + EMDR G-TEP intervention ($M = 26.78$, $SD = 2.72$).

3.3 | Qualitative results

Ten participants agreed to take part in semi-structured interviews. We interviewed participants using online platforms, and each interview lasted approximately 30–50 min ($M = 42$). Four participants refused due to domestic duties ($n = 2$), busy schedules ($n = 1$) and illness ($n = 1$). The analysis of the data generated five themes (Table 2).

Participants were not questioned on their needs as a caregiver in the interviews, yet nearly all participants reflected on their experiences and expectations as a parent (theme 1).

TABLE 1 Participants' demographic characteristics ($N = 14$)

	n (%)
Residence status	
Refugee	5 (35.71)
Asylum seeker	9 (64.28)
Time in the UK (years)	
0–2	6 (42.86)
3–5	5 (35.71)
6–10	3 (21.43)
Gender	
Female	14 (100)
Male	–
Age (years)	
18–30	4 (28.58)
30–40	9 (64.28)
40–50	1 (7.14)
Marital status	
Married	7 (50)
Divorced	5 (35.71)
Widowed	2 (4.29)
Education	
No formal education	–
Primary school	5 (35.71)
High school	5 (35.71)
University	4 (28.58)
Employment status	
Employed	3 (21.43)
Unemployed	11 (78.57)
Number of children	
1	5 (35.71)
2	3 (21.43)
3	3 (21.43)
4+	3 (21.43)
Monthly household income (£)	
0–1,000	10 (71.42
1,000–2,000	4 (28.58)
Ethnicity	
Asian	3 (21.43)
Arab	3 (21.43)
Black, African, Caribbean	1 (7.14)
Mixed or multiple ethnic groups	7 (50)

> P2: Sometimes, because of our stress, we just forget to look after things, and we just treat them like disciplined mothers. But I want to raise my child in a way where she is not harmed, and I feel okay.

Moreover, the sense of readiness to be a good parent was highlighted by several participants throughout the interviews, with

TABLE 2 Themes and supporting quotes

Theme	Supporting quotes		
Seeing the need	P2: Sometimes, because of our stress, we just forget to look after things, and we just treat them like disciplined mothers. But I want to raise my child in a way where she is not harmed, and I feel okay.	P4: As a single parent, I struggle a lot, let alone I have been through trauma, so I need to understand how my daughter is doing and what she needs.	
Acceptability of the intervention	P7: The training was helpful, especially the worksheet session (G-TEP) was very helpful. I mean, we were thinking about our stress in a safe place. So, it felt safe and secure.	P1: The training was very informative on child behaviours. I was thinking that if I had had this training earlier, I would have been a much better parent. So, when we are dealing with children, we usually don't know how to deal with them. I liked the illustrations, they were very helpful.	P8: I think sessions are easy when you have the same therapist (facilitator) for all sessions. Because I had counselling sessions before and I was feeling much more stressed because the counsellor changed a lot. So, I just don't like it because when you start having a relationship with someone to talk about things, and then they change and then you have to start from the beginning.
The impact of the intervention	P3: Sometimes, you think maybe your child is not responding well. Now I know all those early developmental stages and I can understand that sometimes I have to give my child some time to develop. It wasn't a long time ago I was thinking that, oh, by this age, they're supposed to be doing this, they're supposed to be doing that. Meanwhile, it's not like that.	P4: The training reminded me of some of the things which I did it well, and it reminded me of some of which, like, I should have done well. So, I was just recalling things and it was like, if I would have done this the other way, because of his developmental stage or if I would have looked into this, I could have done it better. So yes, it has helped me.	P10: So, for example, my daughter says no a lot. So now I know that they learn from us, they see what we do or what we say. So now I am thinking maybe it's me or her dad saying no to my son, maybe she has learned this way.
Engagement and remote delivery	P5: I've been trying to get myself into EMDR to release my stress out. But I did not have enough courage to do it. But now we are used to having video sessions, I felt that it was quite comfortable in my own space. There were other people, it was a group session, but I was not with them. I was just concentrating on what you were talking about, I was not even looking at what others were doing. So, it was quite more comfortable to do it.	P2: You know some people love gossiping and they always judge others. They speak behind you and say bad things. This is why I don't want anyone to know about worries or stress. Online training helped me in this way, it gave me privacy and distance from others.	
Future suggestions and modifications	P9: The calendar was useful, but it could have had more pictures or videos to illustrate some points or more case examples with real stories of children, like how parents are doing as a response.	P6: ... In some places, maybe because the training was online, the wording of the worksheet (G-TEP) challenged me. The practice sessions were helpful, but language can be simpler in the future.	

participants reflecting on their mental health difficulties and whether they feel ready to raise a child. These parents reported that their mental health problems and marital status were challenging, so they needed support in parenting, mental health and child development.

> P4: As a single parent, I struggle a lot, let alone I have been through trauma, so I need to understand how my daughter is doing and what she needs.

Participants also reflected on their experiences of the LTP+ EMDR G-TEP intervention. This included a more in-depth understanding of changes in their parental behaviours, their relationship with facilitators and their experiences of the intervention content (theme 2).

> P7: The training was helpful, especially the worksheet session (G-TEP) was very helpful. I mean, we were thinking about our stress in a safe place. So, it felt safe and secure.

P1: The training was highly informative on child behaviours. I was thinking that if I had had this training earlier, I would have been a much better parent. So, when we are dealing with children, when we usually do not know how to deal with them. I liked the illustrations; they were very helpful.

The consistent relationship participants had with the facilitators had an important influence over their views of the intervention, in terms of both trust and safety.

P8: I think sessions are easy when you have the same therapist (facilitator) for all sessions. Because I had counselling sessions before and I was feeling much more stressed because the counsellor changed a lot. So, I just do not like it because when you start having a relationship with someone to talk about things, and then they change and then you have to start from the beginning.

The impact of the intervention was also discussed (theme 3). Many participants described how they internalised information from the sessions on early childhood development. Several participants reflected on the skills they gained through the intervention. One of the participants revealed how the intervention helped her to manage her unrealistic expectations. Many participants articulated how they put the training content into practice.

P3: Sometimes, you think maybe your child is not responding well. Now I know all those developmental stages and I can understand that sometimes I have to give my child some time to develop. It was not a long time ago I was thinking that, oh, by this age, they are supposed to be doing this, they are supposed to be doing that. Meanwhile, it is not like that.

Several participants repeatedly shared their regret throughout the interviews. These participants described how they felt sorry for not fulfilling their child's needs.

P4: The training reminded me of some of the things which I did it well, and it reminded me of some of which, like, I should have done well. So, I was just recalling things and it was like, if I would have done this the other way, because of his developmental stage or if I would have looked into this, I could have done it better. So yes, it has helped me.

Many participants reflected upon the changes in their behaviours and knowledge as a result of the intervention. In particular, one participant explained her increased awareness of the impact of caregivers' behaviours on children.

P10: So, for example, my daughter says no a lot. So now I know that they learn from us, they see what we do or what we say. So now I am thinking maybe it is me or her dad saying no to my son, maybe she has learned this way.

Despite all participants reporting that they benefited from the intervention, some also highlighted that the remote delivery further motivated them to attend. Overwhelmingly, participants described how the remote delivery protected them from their community and their fears (theme 4).

P5: I have been trying to get myself into EMDR to talk and release my stress out. But I did not have enough courage to do it. But now we are used to having video sessions, I felt that it was quite comfortable in my own space. There were other people, it was a group session, but I was not with them. I was just concentrating on what you were talking about, I was not even looking at what others were doing. So, it was quite more comfortable to do it. And the language content, it was understandable to me.

Several participants spoke greatly about the challenges in their community. One participant described how she was struggling with stigma and shame and how it affected her lifestyle and forced her to keep things as secret. Following this, many participants highlighted the online nature of the intervention, which led to greater feelings of privacy and confidentiality.

P2: You know some people love gossiping and they always judge others. They speak behind you and say terrible things. This is why I don't want anyone to know about my worries or stress. Online delivery helped me in this way, it gave me privacy and distance from others.

The final theme—future suggestions and modifications—highlighted important feedback for future trials (theme 5). For example, participants suggested that LTP could have more real-life examples.

P9: The calendar was useful, but it could have had more pictures or videos to illustrate some points or more case examples with real stories of children, like how parents are doing as a response.

Moreover, despite the practices of the G-TEP worksheet being cited by many parents as helpful, some participants also felt that simpler words could have been used when delivering the EMDR G-TEP worksheet.

P6: … In some places, maybe because the training was online, the wording of the worksheet (G-TEP)

challenged me. The practice sessions were helpful, but language can be simpler in the future.

3.4 | Quantitative results

Although this study did not aim to measure effectiveness, the results indicated potential benefits of the intervention on all outcome measures. The quantitative data were analysed using RCI and CSC analyses. Table 3 outlines the means for all outcome variables and documents whether the change is reliable and clinically significant.

As shown in Table 3, based on the pre- and post-intervention scores, eight (57%) showed a reliable improvement in self-esteem scores, as measured by PSOC; however, none of the participants' score met the criterion for CSC. Six participants (43%) showed no reliable change. Changes in symptoms of anxiety were measured using GAD-7 and, among the participants, 10 (71%) showed a reliable improvement in the GAD-7 scale, with all of these also meeting the criterion for CSC, whereas four (29%) showed no change. For the PHQ-9 scale, 10 (71%) showed a reliable improvement in scores at pre- and post-intervention, with nine of these also scoring below the clinical cut-off point, while four (29%) showed no change in their scores. Among the 14 participants, five (36%) showed a reliable improvement in PTSD symptoms, as measured by ITQ, with all of these also meeting CSC, whereas nine participants (64%) did not show any reliable change. Finally, nine participants (64%) showed a reliable improvement in DSO symptoms, as measured by ITQ, with eight of these scoring below the cut-off point. Five (36%) did not show any reliable change. For details, please see Appendix S3 (changes in quantitative outcomes—detailed figures).

4 | DISCUSSION

Over the past years, and exacerbated by the impact of the COVID-19 pandemic, the interest in online interventions has increased enormously (Fischer et al., 2020; Schleider et al., 2021; Shaygan et al., 2021). However, little attention has been paid to the use of online interventions with forcibly displaced people, despite the high number of refugees around the world and the urgent need to support their personal well-being and parental functioning. The current trial was the first to test the feasibility of an online parenting intervention for refugees and asylum seekers with young children. It also tested whether remote interventions are feasible and effective tools for engaging with displaced populations. The preliminary results indicated that the participants perceived the intervention as acceptable and feasible, as reflected in high attendance rates, satisfaction scores and qualitative findings. Considering the challenges in recruiting displaced populations (Robertshaw et al., 2017), the trial showed very rapid recruitment and a great response, with a recruitment rate of 87% and a retention rate of 100%. The acceptability was demonstrated through high attendance, with 78% of participants attending all sessions. Rates of satisfaction produced remarkable results, with an average score of 27 out of 32 on the CSQ-8 scale.

There may be several explanations for the high level of attendance and acceptability. First, our pretrial commitments may benefit the current trial (Kaptan et al., 2022). In the pretrial qualitative study, we investigated strategies to enhance recruitment, data collection and acceptability. The findings of this qualitative study offered several recommendations to improve the acceptability of the intervention. For example, participants suggested stigma among refugees is high and the mental health component may deter participants. Following this advice, we changed the order of the components (LTP and G-TEP) and started the intervention with the parenting component, which gave participants time to establish trust in the research team. Other factors, like a culturally aware research team and rapport with the group facilitators, also improved engagement and retention, as evident in qualitative interviews and previous literature (Robertshaw et al., 2017). Another important explanation for attendance may be the use of activity-based manuals in the trial, as the importance of activity-based implementations for keeping participants engaged with parenting interventions is well known (Moran et al., 2004). In this trial, the use of the pictorial elements of the LTP manual, which contains illustrations of play activities, and the G-TEP worksheet, seemed to be effective in keeping participants engaged during the sessions and helping them transfer these activities into their daily lives.

Although the study aimed to evaluate feasibility rather than effectiveness, preliminary findings suggested that participants

TABLE 3 Mean, *SD* and cut-off scores

	Parenting self-efficacy (PSOC)	Anxiety (GAD-7)	Depression (PHQ-9)	PTSD (ITQ)	CPTSD (ITQ)
Pre-treatment mean (*SD*)	56.66 (15.07)	13.36 (4.91)	15.47 (5.65)	14.19 (5.36)	13.56 (5.65)
Post-treatment mean (*SD*)	74.20 (19.80)	7.22 (3.30)	6.83 (3.40)	8.28 (3.44)	8.05 (3.86)
Standard error of measurement	7.07	1.63	1.87	2.40	1.38
RCI value	19.59	4.52	5.19	6.65	3.84
Number “no change”	6	4	4	9	5
Number “deteriorate”	0	0	0	0	0
Number “improved”	8	10	10	5	9
Number meeting CSC	0	10	9	5	8

demonstrated reliable improvements on all scales, as measured by the RCI. Over half of the participants (57%) showed reliable improvement on the PSOC, while 71% of participants showed reliable improvement on both the GAD-7 and PHQ-9 scales. Regarding traumatic symptoms, 36% of the participants demonstrated reliable improvement on the ITQ PTSD subscale, while 64% showed improvement on the ITQ DSO subscale. It is noteworthy that the positive improvement is relatively smaller in traumatic stress than in depression and anxiety. One possible explanation may be that participants did not use the EMDR component of the intervention to treat traumatic events that were salient to them (e.g., perhaps associated with their displacement history). Instead, participants chose to process recent COVID-related stress during the final session, which is important to consider.

The qualitative analysis also enabled us to explore further aspects of the trial regarding its content and delivery. Qualitative findings indicated that participants internalised the materials from the intervention, which promoted positive parenting behaviours, along with gaining knowledge about early childhood development. The issue of accessibility of services to refugees and asylum seekers has received considerable attention in the literature (Colucci et al., 2015; Robertshaw et al., 2017). The main innovative feature of the current trial was the remote delivery of the intervention. In line with this, participants valued the use of online delivery and acknowledged the usefulness of this type of delivery in improving their sense of safety, confidentiality and accessibility. In fact, many participants attributed the acceptance of the intervention to this method of delivery as it created a safe space to take part without any stigma or shame.

The presentation of asylum seekers who have unique risk factors for mental health (Ryan et al., 2009) in the current trial is noteworthy as asylum seekers are often underrepresented in interventions (Gillespie et al., 2022; van Es et al., 2021). However, in the current trial, over half of the sample consisted of asylum seekers (64%), which may be another indicator of improved accessibility.

The difficulty with medical terminology in host countries is a well-known challenge for displaced groups (DeSa et al., 2022). In line with previous literature, some of the participants in this trial highlighted several caveats, namely using simpler wording on the G-TEP worksheet. Some participants also struggled with completing the outcome tools and required one-to-one assistance, which implies that future studies should allow time for one-to-one consultations to facilitate recruitment and attendance.

In the current trial, the participants did not gather in one location to receive the intervention. Instead, the sessions were conducted in a setting of each participant's choice, usually their homes. This was challenging for some participants, especially those without childcare support, as domestic duties caused disruptions from time to time. Future researchers may consider identifying safe places with appropriate childcare services for smooth delivery, as such supports aid help-seeking behaviours (Gulliver et al., 2010).

Several limitations of this study must be acknowledged. First, as the study focused on the evaluation of the feasibility and acceptability to inform a larger trial, the sample size was small and there was no control group. Therefore, results should be interpreted with caution and further trials with larger sample sizes are needed to test the clinical and cost-effectiveness, as well as long-term outcomes. Second, due to time and budget constraints, a long-term follow-up assessment and child-related outcomes were not included, which means that results are tentative. Third, the study employed self-report tools only, which may produce a bias in results. Furthermore, recruiting participants with access to the internet or smart devices may lead to a biased sample and limit the generalisability of the results. Finally, there was no evaluation of the type or level of trauma that the participants experienced both before and after immigrating to the UK. Moreover, the participants' amount of time in the UK varied from less than 2 years up to 10 years, which would suggest another source of variation in their needs and expectations. The potential differences in traumatic experiences and the amount of time in the UK did not create any challenge or barrier to participation, but future studies may employ more pretrial work to explore such variables to create more targeted interventions.

It is also important to acknowledge that the qualitative interviews were conducted by the same facilitators who delivered the intervention, and one of the facilitators came from a similar cultural background. Therefore, we acknowledge that this might have shaped the qualitative findings. For instance, some of the authors' interest in scaling up interventions for refugees may have led to an increased focus on the advantages of remote delivery. To overcome such biases and maintain a balanced tone, the findings were returned to the participants and they were given a chance to offer feedback on the findings. However, none of the participants expressed any notable changes or disagreement with the findings.

To the best of our knowledge, the current trial is the first attempt to assess engagement with a remote parenting intervention targeting parent refugees and asylum seekers. The findings support the feasibility of the LTP + EMDR G-TEP intervention. Moreover, the findings suggest that remote interventions have the potential to be used with displaced families that have young children. The preliminary data suggest that the LTP + EMDR G-TEP intervention can also improve self-esteem and well-being.

The global burden of mental health difficulties is high and requires cost- and time-effective interventions which can be scaled up and adapted for displaced populations. Remote group applications are one of the most promising frontiers, with the capability of providing rapid and sustained relief. The current trial highlights that integrated interventions can be an important and accessible tool once they have been tested in a large and powered trial.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest with any aspects of this article.

DATA AVAILABILITY STATEMENT

The data of the current study are available from the corresponding author.

INFORMED CONSENT

Informed written consent was obtained from all subjects involved in the study.

ADVERSE EFFECT

No participants reported any adverse effects from the intervention.

ORCID

Safa Kemal Kaptan https://orcid.org/0000-0002-4709-6543
Filippo Varese https://orcid.org/0000-0001-7244-598X
Betul Yilmaz https://orcid.org/0000-0001-5981-2183
Panoraia Andriopoulou https://orcid.org/0000-0002-5745-6741
Nusrat Husain https://orcid.org/0000-0002-9493-0721

REFERENCES

Aghajafari, F., Pianorosa, E., Premji, Z., Souri, S., & Dewey, D. (2020). Academic achievement and psychosocial adjustment in child refugees: A systematic review. *Journal of Traumatic Stress*, *33*(6), 908–916. https://doi.org/10.1002/jts.22582

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, *17*(1), 240. https://doi.org/10.1186/s12884-017-1433-2

Back Nielsen, M., Carlsson, J., Køster Rimvall, M., Petersen, J. H., & Norredam, M. (2019). Risk of childhood psychiatric disorders in children of refugee parents with post-traumatic stress disorder: A nationwide, register-based, cohort study. *The Lancet Public Health*, *4*(7), e353–e359. https://doi.org/10.1016/S2468-2667(19)30077-5

Ballard, J., Wieling, E., & Forgatch, M. (2018). Feasibility of implementation of a parenting intervention with Karen refugees resettled from Burma. *Journal of Marital and Family Therapy*, *44*(2), 220–234. https://doi.org/10.1111/jmft.12286

Bernstein Carlson, E., & Putnam, F. W. (1993). An update on the dissociative experiences scale. *Dissociation*, *6*(1), 16–27.

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Bogic, M., Ajdukovic, D., Bremner, S., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., Lecic-Tosevski, D., Morina, N., Popovski, M., Schützwohl, M., Wang, D., & Priebe, S. (2012). Factors associated with mental disorders in long-settled war refugees: Refugees from the former Yugoslavia in Germany, Italy and the UK. *British Journal of Psychiatry*, *200*(3), 216–223. https://doi.org/10.1192/bjp.bp.110.084764

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review*, *14*(1), 44–56. https://doi.org/10.1007/s10567-010-0081-0

Bryant, R. A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K. L., Silove, D., Steel, Z., Nickerson, A., McFarlane, A. C., Van Hooff, M., & Hadzi-Pavlovic, D. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: A cohort study. *The Lancet Public Health*, *3*(5), e249–e258. https://doi.org/10.1016/S2468-2667(18)30051-3

Burchert, S., Alkneme, M. S., Bird, M., Carswell, K., Cuijpers, P., Hansen, P., Heim, E., Shehadeh, M. H., Sijbrandij, M., Van't Hof, E., & Knaevelsrud, C. (2019). User-centered app adaptation of a low-intensity e-mental health intervention for Syrian refugees. *Frontiers in Psychiatry*, *10*, 663. https://doi.org/10.3389/fpsyt.2018.00663

Calafat, A., García, F., Juan, M., Becoña, E., & Fernández-Hermida, J. R. (2014). Which parenting style is more protective against adolescent substance use? Evidence within the European context. *Drug and Alcohol Dependence*, *138*(1), 185–192. https://doi.org/10.1016/j.drugalcdep.2014.02.705

Caldwell, C. H., Rafferty, J., Reischl, T. M., De Loney, E. H., & Brooks, C. L. (2010). Enhancing parenting skills among nonresident African American fathers as a strategy for preventing youth risky behaviors. *American Journal of Community Psychology*, *45*(1–2), 17–35. https://doi.org/10.1007/s10464-009-9290-4

Christodoulou, J., Le Roux, K., Tomlinson, M., Le Roux, I. M., Katzen, L. S., & Rotheram-Borus, M. J. (2019). Perinatal maternal depression in rural South Africa: Child outcomes over the first two years. *Journal of Affective Disorders*, *247*, 168–174. https://doi.org/10.1016/j.jad.2019.01.019

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The international trauma questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, *138*(6), 536–546. https://doi.org/10.1111/acps.12956

Colucci, E., Minas, H., Szwarc, J., Guerra, C., & Paxton, G. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. *Transcultural Psychiatry*, *52*(6), 766–790. https://doi.org/10.1177/1363461515571624

de Anstiss, H., Ziaian, T., Procter, N., Warland, J., & Baghurst, P. (2009). Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry*, *46*(4), 584–607. https://doi.org/10.1177/1363461509351363

DeSa, S., Gebremeskel, A. T., Omonaiye, O., & Yaya, S. (2022). Barriers and facilitators to access mental health services among refugee women in high-income countries: A systematic review. *Systematic Reviews*, *11*(1), 62. https://doi.org/10.1186/s13643-022-01936-1

Eldridge, S. M., Chan, C. L., Campbell, M. J., Bond, C. M., Hopewell, S., Thabane, L., Lancaster, G. A., Altman, D., Bretz, F., Campbell, M., Cobo, E., Craig, P., Davidson, P., Groves, T., Gumedze, F., Hewison, J., Hirst, A., Hoddinott, P., Lamb, S. E., … Tugwell, P. (2016). CONSORT 2010 statement: Extension to randomised pilot and feasibility trials. *The BMJ*, *355*, i5239. https://doi.org/10.1136/bmj.i5239

Eldridge, S. M., Lancaster, G. A., Campbell, M. J., Thabane, L., Hopewell, S., Coleman, C. L., & Bond, C. M. (2016). Defining feasibility and pilot studies in preparation for randomised controlled trials: Development of a conceptual framework. *PLoS One*, *11*(3), e0150205. https://doi.org/10.1371/journal.pone.0150205

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *The Lancet*, *379*(9812), 266–282. https://doi.org/10.1016/S0140-6736(11)60051-2

Fischer, R., Bortolini, T., Karl, J. A., Zilberberg, M., Robinson, K., Rabelo, A., Gemal, L., Wegerhoff, D., Nguyễn, T. B. T., Irving, B., Chrystal, M., & Mattos, P. (2020). Rapid review and meta-meta-analysis of

self-guided interventions to address anxiety, depression, and stress during COVID-19 social distancing. *Frontiers in Psychology*, *11*, 2795. https://doi.org/10.3389/FPSYG.2020.563876/BIBTEX

Fuhr, D. C., Acarturk, C., McGrath, M., Ilkkursun, Z., Sondorp, E., Sijbrandij, M., Ventevogel, P., Cuijpers, P., McKee, M., & Roberts, B. (2019). Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: A cross-sectional survey. *Epidemiology and Psychiatric Sciences*, *29*, e70. https://doi.org/10.1017/S2045796019000660

Gillespie, S., Banegas, J., Maxwell, J., Chan, A. C. Y., Darawshy, N. A.-S., Wasil, A. R., Marsalis, S., & Gewirtz, A. (2022). Parenting interventions for refugees and forcibly displaced families: A systematic review. *Clinical Child and Family Psychology Review*, *25*, 1–18. https://doi.org/10.1007/s10567-021-00375-z

Guhn, M., Forer, B., & Zumbo, B. D. (2014). Reliable change index. In A. C. Michalos (Ed.), *Encyclopedia of quality of life and well-being research* (pp. 5459–5462). Springer Netherlands. https://doi.org/10.1007/978-94-007-0753-5_2465

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), 113. https://doi.org/10.1186/1471-244X-10-113

Hincks, C.-D. (2002). The learning through play calendar: Training manual.

Husain, N., Zulqernain, F., Carter, L. A., Chaudhry, I. B., Fatima, B., Kiran, T., Chaudhry, N., Naeem, S., Jafri, F., Lunat, F., Haq, S. U., Husain, M., Roberts, C., Naeem, F., & Rahman, A. (2017). Treatment of maternal depression in urban slums of Karachi, Pakistan: A randomized controlled trial (RCT) of an integrated maternal psychological and early child development intervention. *Asian Journal of Psychiatry*, *29*, 63–70. https://doi.org/10.1016/j.ajp.2017.03.010

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12–19. https://doi.org/10.1037/0022-006X.59.1.12

Jeong, J., Franchett, E. E., Ramos de Oliveira, C. V., Rehmani, K., & Yousafzai, A. K. (2021). Parenting interventions to promote early child development in the first three years of life: A global systematic review and meta-analysis. *PLoS Medicine*, *18*(5), e1003602. https://doi.org/10.1371/journal.pmed.1003602

Johnston, C., & Mash, E. J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology*, *18*(2), 167–175. https://doi.org/10.1207/s15374424jccp1802_8

Kamis, C. (2021). The long-term impact of parental mental health on Children's distress trajectories in adulthood. *Society and Mental Health*, *11*(1), 54–68. https://doi.org/10.1177/2156869320912520

Kaptan, S. K., Dursun, B. O., Knowles, M., Husain, N., & Varese, F. (2021). Group eye movement desensitization and reprocessing interventions in adults and children: A systematic review of randomized and nonrandomized trials. *Clinical Psychology & Psychotherapy*, *28*(4), 784–806. https://doi.org/10.1002/cpp.2549

Kaptan, S. K., Varese, F., Yilmaz, B., Andriopoulou, P., & Husain, N. (2021). Protocol of a feasibility trial for an online group parenting intervention with an integrated mental health component for parent refugees and asylum-seekers in the United Kingdom: (LTP + EMDR G-TEP). *SAGE Open Medicine*, *9*, 205031212110678. https://doi.org/10.1177/20503121211067861

Kaptan, S. K., Yilmaz, B., Varese, F., Andriopoulou, P., & Husain, N. (2022). What works? Lessons from a pretrial qualitative study to inform a multi-component intervention for refugees and asylum seekers: Learning through play and EMDR group traumatic episode protocol. *Journal of Community Psychology*, 1–21. https://doi.org/10.1002/jcop.22908

Karp, S. M., Lutenbacher, M., & Wallston, K. A. (2015). Evaluation of the parenting sense of competence scale in mothers of infants. *Journal of Child and Family Studies*, *24*(11), 3474–3481. https://doi.org/10.1007/s10826-015-0149-z

Kiselev, N., Pfaltz, M., Haas, F., Schick, M., Kappen, M., Sijbrandij, M., De Graaff, A. M., Bird, M., Hansen, P., Ventevogel, P., Fuhr, D. C., Schnyder, U., & Morina, N. (2020). Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland. *European Journal of Psychotraumatology*, *11*(1), 1717825. https://doi.org/10.1080/20008198.2020.1717825

Kizilhan, J. I., & Noll-Hussong, M. (2020). Psychological impact of COVID-19 in a refugee camp in Iraq. *Psychiatry and Clinical Neurosciences*, *74*(12), 659–660. https://doi.org/10.1111/pcn.13142

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lakkis, N. A., Osman, M. H., Aoude, L. C., Maalouf, C. J., Issa, H. G., & Issa, G. M. (2020). A pilot intervention to promote positive parenting in refugees from Syria in Lebanon and Jordan. *Frontiers in Psychiatry*, *11*, 257. https://doi.org/10.3389/fpsyt.2020.00257

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, *2*(3), 197–207. https://doi.org/10.1016/0149-7189(79)90094-6

Liem, A., Natari, R. B., Jimmy, & Hall, B. J. (2021). Digital health applications in mental health Care for Immigrants and Refugees: A rapid review. *Telemedicine Journal and E-health: The Official Journal of the American Telemedicine Association*, *27*(1), 3–16. https://doi.org/10.1089/tmj.2020.0012

Lindert, J., von Ehrenstein, O. S., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees – A systematic review and meta-analysis. *Social Science & Medicine*, *69*(2), 246–257. https://doi.org/10.1016/j.socscimed.2009.04.032

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the generalized anxiety disorder screener (GAD-7) in the general population. *Medical Care*, *46*(3), 266–274. https://doi.org/10.1097/MLR.0b013e318160d093

Manning, C., & Gregoire, A. (2009). Effects of parental mental illness on children. *Psychiatry*, *8*(1), 7–9. Elsevier. https://doi.org/10.1016/j.mppsy.2008.10.012

Maxfield, L. (2021). Low-intensity interventions and EMDR therapy. *Journal of EMDR Practice and Research*, *15*(2), 86–98. https://doi.org/10.1891/EMDR-D-21-00009

Miller, K. E., Arnous, M., Tossyeh, F., Chen, A., Bakolis, I., Koppenol-Gonzalez, G. V., Nahas, N., & Jordans, M. J. D. (2020). Protocol for a randomized control trial of the caregiver support intervention with Syrian refugees in Lebanon. *Trials*, *21*(1), 277. https://doi.org/10.1186/s13063-020-4175-9

Montgomery, C., Fisk, J. E., & Craig, L. (2008). The effects of perceived parenting style on the propensity for illicit drug use: The importance of parental warmth and control. *Drug and Alcohol Review*, *27*(6), 640–649. https://doi.org/10.1080/09595230802392790

Moran, P., Ghate, D., & Van Der Merwe, A. (2004). What works in parenting support? A review of the international evidence.

Morley, S., & Dowzer, C. N. (2014). *The Leeds reliable change indicator: Simple excel applications for the analysis of individual patient and group data*. University of Leeds. https://dclinpsych.leeds.ac.uk/wp-content/uploads/sites/26/2018/09/Manual-for-Leeds-RCI-CSC-calculators.pdf

Notiar, A., Jidong, D. E., Hawa, F., Lunat, F., Shah, S., Bassett, P., Edge, D., Naeem, F., & Husain, N. (2021). Treatment of maternal depression in low-income women: A feasibility study from Kilifi, Kenya. *International Journal of Clinical Practice*, *75*(12), e14862. https://doi.org/10.1111/ijcp.14862

Renzaho, A. M. N., & Vignjevic, S. (2011). The impact of a parenting intervention in Australia among migrants and refugees from Liberia, Sierra Leone, Congo, and Burundi: Results from the African migrant parenting program. *Journal of Family Studies*, *17*(1), 71–79. https://doi.org/10.5172/jfs.2011.17.1.71

Robertshaw, L., Dhesi, S., & Jones, L. L. (2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research. *BMJ Open*, *7*(8), e015981. https://doi.org/10.1136/bmjopen-2017-015981

Roncallo, C. P., Barreto, F. B., & de Miguel, M. S. (2018). Promotion of child development and health from the perinatal period: An approach from positive parenting. *Early Child Development and Care*, *188*(11), 1539–1551. https://doi.org/10.1080/03004430.2018.1495630

Ryan, D. A., Kelly, F. E., & Kelly, B. D. (2009). Mental health among persons awaiting an asylum outcome in western countries: A literature review. *International Journal of Mental Health*, *38*(3), 88–111. https://doi.org/10.2753/IMH0020-7411380306

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. https://doi.org/10.1111/inm.12512

Sanders, M. R., Divan, G., Singhal, M., Turner, K. M. T., Velleman, R., Michelson, D., & Patel, V. (2021). Scaling up parenting interventions is critical for attaining the sustainable development goals. *Child Psychiatry and Human Development*, 1–12. https://doi.org/10.1007/s10578-021-01171-0

Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, *123*(9), 851–863. https://doi.org/10.1016/j.healthpol.2019.02.007

Schleider, J. L., Mullarkey, M. C., Fox, K. R., Dobias, M. L., Shroff, A., Hart, E. A., & Roulston, C. A. (2021). A randomized trial of online single-session interventions for adolescent depression during COVID-19. *Nature Human Behaviour*, *6*(2), 258–268. https://doi.org/10.1038/s41562-021-01235-0

Shapiro, E. (2013). The group traumatic episode protocol (G-TEP) for early EMDR intervention (EEI), November 2013, Istanbul, Turkey.

Shapiro, E., & Moench, J. (2020). EMDR G-TEP Fidelity scale.

Shaygan, M., Yazdani, Z., & Valibeygi, A. (2021). The effect of online multimedia psychoeducational interventions on the resilience and perceived stress of hospitalized patients with COVID-19: A pilot cluster randomized parallel-controlled trial. *BMC Psychiatry*, *21*(1), 93. https://doi.org/10.1186/s12888-021-03085-6

Sim, A., Fazel, M., Bowes, L., & Gardner, F. (2018). Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon. *Social Science and Medicine*, *200*, 19–26. https://doi.org/10.1016/j.socscimed.2018.01.009

Song, S. J., Tol, W., & de Jong, J. (2014). Indero: Intergenerational trauma and resilience between burundian former child soldiers and their children. *Family Process*, *53*(2), 239–251. https://doi.org/10.1111/famp.12071

Stevenson, K., Alameddine, R., Rukbi, G., Chahrouri, M., Usta, J., Saab, B., Bennett, P., Glover, V., & Reynolds, R. M. (2019). High rates of maternal depression amongst Syrian refugees in Lebanon - a pilot study. *Scientific Reports*, *9*(1), 11849. https://doi.org/10.1038/s41598-019-48247-5

Swinson, R. P. (2006). The GAD-7 scale was accurate for diagnosing generalised anxiety disorder. *Evidence-Based Medicine*, *11*(6), 184. https://doi.org/10.1136/ebm.11.6.184

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: Umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems*, *11*(1), 1–14. https://doi.org/10.1186/s13033-017-0156-0

UNHCR (2021). Global trends: Forced displacement in 2020. UNHCR global trends. https://www.unhcr.org/60b638e37/unhcr-global-trends-2020

Vallières, F., Ceannt, R., Daccache, F., Abou Daher, R., Sleiman, J., Gilmore, B., Byrne, S., Shevlin, M., Murphy, J., & Hyland, P. (2018). ICD-11 PTSD and complex PTSD amongst Syrian refugees in Lebanon: The factor structure and the clinical utility of the international trauma questionnaire. *Acta Psychiatrica Scandinavica*, *138*(6), 547–557. https://doi.org/10.1111/acps.12973

van Ee, E., Kleber, R. J., Jongmans, M. J., Mooren, T. T. M., & Out, D. (2016). Parental PTSD, adverse parenting and child attachment in a refugee sample. *Attachment and Human Development*, *18*(3), 273–291. https://doi.org/10.1080/14616734.2016.1148748

van Es, C. M., Boelen, P. A., Zwaanswijk, M., te Brake, H., & Mooren, T. (2021). Family empowerment (FAME): A feasibility trial of preventive multifamily groups for asylum seeker families in The Netherlands. *Journal of Marital and Family Therapy*, *47*(4), 864–881. https://doi.org/10.1111/jmft.12539

Vostanis, P., Graves, A., Meltzer, H., Goodman, R., Jenkins, R., & Brugha, T. (2006). Relationship between parental psychopathology, parenting strategies and child mental health: Findings from the GB national study. *Social Psychiatry and Psychiatric Epidemiology*, *41*(7), 509–514. https://doi.org/10.1007/s00127-006-0061-3

WHO (2017). Scalable psychological interventions for people in communities affected by adversity A. Retrieved from https://www.who.int/publications-detail-redirect/WHO-MSD-MER-17.1

World Health Organization (2021). Mental Health Atlas 2020. Retrieved from https://www.who.int/publications/i/item/9789240036703

Zahra, D., & Hedge, C. (2010). The reliable change index: Why isn't it more popular in academic psychology. *Psychology Postgraduate Affairs Group Quarterly*, *76*(76), 14–19.

Zhang, L., Ssewanyana, D., Martin, M.-C., Lye, S., Moran, G., Abubakar, A., Marfo, K., Marangu, J., Proulx, K., & Malti, T. (2021). Supporting child development through parenting interventions in low- to middle-income countries: An updated systematic review. *Frontiers in Public Health*, *9*, 671988. https://doi.org/10.3389/fpubh.2021.671988

AUTHOR BIOGRAPHIES

Safa Kemal Kaptan is a researcher and teaching assistant at the University of Manchester where he investigates the effectiveness of culturally adapted interventions for minority groups. His primary research interests are in trauma, psychosis, mental health interventions and EMDR therapy.

Filippo Varese is a Clinical Senior Lecturer in Psychology and an NIHR Advanced Fellow at the University of Manchester. Since 2018, they have been the Director of the Complex Trauma and Resilience Research Unit (C-TRU). The unit is led by established clinical researchers in Manchester and actively works with NHS stakeholders and survivors of complex traumatic experiences in the design and delivery of impactful research.

Betul Yilmaz is investigating the association between migration experiences / trauma and psychotic-like experiences in Arabic speaking refugees, asylum seekers and migrants in the UK. Part of their PhD involves translating questionnaires into Arabic to accurately collect information about mental health and migration / trauma experiences in this population and to culturally adapt them.

Panoraia Andriopoulou is a HCPC registered Clinical & Counselling Psychologist and Senior Lecturer in Psychology at Hellenic Open University, Greece. She is fully trained in CBT, Schema Therapy, and Systemic Family Therapy and has worked as a practitioner psychologist for more than 15 years both in private practice and in the public sector, gaining extensive experience in the assessment and treatment of adolescents and adults with anxiety, depressive, and personality disorders. Her research interests lie within the areas of clinical/counselling psychology and psychotherapy, psychopathology, psychological well-being, and the therapeutic properties of close relationships with a special focus on attachment.

Nusrat Husain has had a keen interest in addressing the huge treatment gap in low- and middle-income countries (LAMIC). After initial training in psychiatry, Professor Husain was awarded the "WHO Prize for the Best Diplomat". He organizes the conference "Culture & International Mental Health" in Manchester, which is jointly sponsored by University of Toronto and University of Manchester. His latest awards includes: Clinical Research Role Model of the Year (2017) and Psychiatric Academic Researcher of the Year - Royal College of Psychiatrists (2016).

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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