JORDAN QUINN MSc BSc Hons

EXPLORING CULTURAL ADAPTATIONS AND THE CULTURAL FIT OF
TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY

Section A: How have trauma-focused cognitive behavioural interventions for
children and adolescents been culturally adapted, and how effective are they?
A narrative synthesis and critical review of the literature.
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Section B: An exploration of parents' understanding of therapeutic support
following the Grenfell Tower fire, including a consideration of cultural
adaptations made to the TF-CBT model that was employed.
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A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
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Acknowledgements

In memory of the lives lost due to the Grenfell Tower Fire on the 14th of June 2017.

Summaries

Section A: Literature review

The paper reviewed studies that developed cultural adaptations to trauma-focused cognitive behavioural (TF-CBT) interventions for children and young people. A systematic literature search was carried out which identified twelve eligible studies. The studies were evaluated for methodological quality, quality of the adaptation development process, and replicability of adaptations. The narrative synthesis and critique identified areas of strength and weakness in the literature. The review is supportive of the effectiveness of culturally adapted TF-CBT interventions for children and young people. Clinical and research implications are discussed.

Section B: Empirical paper

This study explored parent's views and understanding of the cultural dimensions of their child's TF-CBT assessment and intervention after the Grenfell Tower Fire. Six parents were recruited through database contact and clinician referral. Following completion of interviews, reflexive thematic analysis was used to develop three themes and eight subthemes. The three themes were: "Starting from a place of mistrust"; "The therapeutic benefits of a working parent-clinician alliance"; and "Trusting in the process of change". The study reports that parents experienced cultural fit of the support provided as a relation process underpinned by trust. Study strengths, limitations, and implications are discussed.

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Abstract

Background:

Trauma-focused cognitive behavioural therapy is an evidence-based and recommended intervention for children and young people who develop difficulties following exposure to traumatic events. Simultaneously, the cross-cultural relevance of this intervention is being challenged by clinicians and researchers. Therefore, this study reviewed studies that developed cultural adaptations to trauma-focused cognitive behavioural (TF-CBT) interventions for children and young people. The aim of the study was to identify what adaptations were made, how they were made, and if the consequent interventions were effective.

Methodology:

A systematic literature search was carried out which identified twelve eligible studies. The studies were evaluated for methodological quality, quality of the adaptation development process, and replicability of adaptations. Studies were synthesized using narrative synthesis.

Results:

All twelve studies reported that their respective culturally adapted interventions were effective in reducing distress. Four studies were identified as providing methodologically robust findings in support of the intervention. Only two of these provided enough detail describing the adaptations and the development process used for quality and replicability to be assessed.

Conclusions:

TF-CBT seems amenable to cultural adaptation whilst retaining effectiveness, although this finding is limited by the small number of good-quality studies that support this. Clinical and research implications are discussed.

Keywords: trauma-focused cognitive behavioural therapy, culture, review, children and young people, effectiveness

Introduction

Children and Trauma

The psychological impact of human exposure to threatening situations such as war, disasters, accidents, and abuse has long been of interest to psychologists. The distress that has been observed and experienced in people exposed to such events has been referred to differently over time, for example as: "shellshock" or "war neurosis" as applied to soldiers during World War I; "Soldier's Heart" as applied to soldiers during the American Civil War; and, more recently, post-traumatic stress disorder (American Psychiatric Association, 1980). The word 'trauma' to describe a psychic rather than physical wound first began being used in this context in the 19th century and is now commonly used to describe psychic pain following negative events (Figley et al., 2017). In modern day, a common conceptualization for difficulties in response to traumatic events is Post Traumatic Stress Disorder (PTSD) which is characterized by symptoms such as avoidance of event reminders, intrusive thoughts and images relating to the event, and hypervigilance (Dyregov & Yule, 2006). However, this conceptualisation does not necessarily fit with understandings of reactions to traumatic events in cultures that emphasise generating meaning from symptoms of distress through the lens of religion, spirituality, or local idioms of distress (Theisen-Womerlsey, 2021).

Although the origins of the study of trauma reactions largely began in the context of war, we now know that such experiences can impact anyone exposed to life-threatening situations, including children (Kaminer et al., 2005).

In a cohort study carried out in England and Wales, Lewis et al. (2019) estimated that 31% of children were exposed to at least one traumatic event by the time they reached eighteen years of age. A meta-analysis of eighteen studies, primarily based on English language publications, suggested that 21.5% of children under six years of age were

diagnosed with PTSD following exposure to a traumatic event (Woolgar et al., 2021).

Similarly, rates of PTSD prevalence following trauma exposure are estimated in one third of

children in lower- and middle- income countries (Stupar et al., 2021).

The literature presents a wide range of traumatic event types which have been shown to

negatively impact children's' wellbeing. A review of a series of meta-analyses carried out by

Stoltenborgh et al. (2015) described that many children experienced abuse across sexual,

physical, and emotional dimensions, ranging from between 3 to 363 per 1000 affected

children depending on abuse and research study type. Indeed, the authors estimated that

millions of children are affected by such abuses, although it is important to note that the

authors highlighted the research eligible for review was primarily carried out in North

America and Europe. According to UNICEF, "266000 grave violations were verified against

children" in conflicts between 2005 and 2020, with grave violations being defined at

experiences of being "enslaved, trafficked, abused and exploited" (UNICEF, 2021).

Children can experience a wide range of difficulties because of exposure to difficult

events. Such difficulties include stress reactions (Hitchcock et al., 2021; Lewis et al., 2019),

anxiety symptoms (Groome & Soureti, 2010), low mood (Heptinstall et al., 2004), separation

anxiety (Hoven et al., 2004), aggressive behaviour (Schiff et al., 2012), and poor quality of

sleep (Giannakopoulos & Kolaitis, 2021). Indeed, such is the impact of exposure to difficult

events that McLaughlin et al. (2020) claimed it increases the risk of developing "virtually all

commonly occurring forms of psychopathology".

Exposure to traumatising events is also associated with a number of neuropsychological

developmental challenges in childhood, which include poorer executive functioning

(DePrince et al., 2009) inclusive of attention (Bücker et al., 2012 ; DePrince et al., 2007) and

working memory (Mirabolfathi et al., 2020), increased difficulty in emotion recognition

(Pollak et al., 2000), and decreased visuospatial and linguistic functioning (Pears & Fisher, 2005).

Untreated, the psychological difficulties associated with trauma exposure in childhood can be later observed in adults across psychological, neurological, and physiological domains (Dye, 2018). Indeed, associated difficulties are suggested to affect the development of the immune system (Danese & Lewis, 2017), increase the likelihood of developing "fearful, preoccupied, and dismissive attachment styles" (Erozkan, 2016), and increase the likelihood of substance dependency in adulthood (Banducci et al., 2014). Suicidal ideation in adulthood has been specifically associated with sexual abuse in childhood (Bahk et al., 2017). Research by Brown et al. (2009) also suggested that exposure to six or more "adverse childhood events" was associated with increased likelihood of premature death. Therefore, the possible ongoing negative impacts of trauma exposure in childhood through to adulthood cannot be underestimated.

To support children experiencing difficulties associated with trauma exposure, a number of psychological interventions have been developed to alleviate distress, which includes (but are not limited to): eye movement desensitization therapy, reprocessing therapy (Shapiro, 1993; Tinker & Wilson, 1999), art therapy (Cohen-Yatziv & Regev, 2019; van Westrhenen et al., 2019), tree of life methodology (Ncube, 2006), and trauma-focused cognitive behavioural therapy- which is the focus for this review.

What is trauma-focused cognitive behavioural therapy?

In the United Kingdom, trauma-focused cognitive behavioural therapy (TF-CBT) intervention is the first recommended treatment for children and adults experiencing difficulties conceptualized as post-traumatic stress disorder (NICE, 2018). TF-CBT addresses difficulties such as an involuntary re-experiencing of a traumatic memory, hypervigilance,

avoidance of traumatic memory reminders, and ongoing dysfunctional appraisals of the traumatic event (Cohen & Mannarino, 2015; Ehlers & Clarke, 2008). Unless otherwise indicated, TF-CBT is a time-limited intervention of at least twelve weekly 60–90-minute sessions. Although the specific labels for the different phases of trauma-focused therapies may differ, they generally include psychoeducation, the development of grounding and stabilization strategies, an active phase of cognitive restructuring and/or exposure to traumatic memories, and an ending phase of therapy consolidation.

It is important to note that TF-CBT can be understood as an umbrella term for a larger family of CBT-based trauma interventions, with the majority using a combination of exposure and cognitive techniques (Mavranezouli et al., 2019). Indeed, cognitive processing therapy (Resicke, 1992; Resicke & Schnicke, 1993), cognitive therapy for PTSD (Clarke & Ehlers, 2000), narrative exposure therapy (Schauer et al, 2005) and prolonged exposure therapy (Foa et al, 2007) can all be understood as trauma-focused CBT interventions, and are recognized as such by the National Institute of Clinical Excellence (NICE, 2018). Within this family of CBT interventions, treatment approaches have been adapted and developed for children and young people. Specific models include: Cohen, Mannarino & Deblinger (2006; 2015); Dalgleish et al.'s (2015) Trauma-Focused Cognitive Behavioural Therapy for Younger Children (TF-CBT-YC) for children ages 3-8; Smith et al.'s (2010) Cognitive Therapy for PTSD; Narrative Exposure for Children, also known as "KidNET" (Schauer et al., 2017); and Child Accelerated Trauma Treatment (Raby & Plant, 2021).

Review of the evidence base for TF-CBT interventions for children exposed to trauma

For the purposes of reviewing the evidence base, unless otherwise indicated, the acronym TF-CBT will be used to refer to the wider family of cognitive behavioural therapy approaches described above that address traumatic events and experiences, as defined by

Morina et al. (2016) and Silverman et al. (2008). In a meta-analysis of 41 randomised controlled trials of child-focused treatment interventions for post-traumatic stress, Morina et al. (2016) suggest that Trauma-Focused CBT is the most researched approach in this area.

A network meta-analysis carried out by Mavranezouli et al. (2020) reviewed seventeen intervention types across thirty-two randomised control trials. The outcome of this analysis suggested that individual trauma-focused cognitive behavioural therapies yielded greater effect size changes in reducing symptoms of post-traumatic stress and rate of continued remission at follow up within four months of treatment end, compared to other interventions such as EMDR or child-parent psychotherapy, although the latter also seem helpful in supporting children and young people experiencing post-traumatic stress. This study also reported that within TF-CBT approaches, the greatest effect size changes were identified in "Cognitive Therapy for PTSD […followed by] combined TF-CBT and parent training, […] narrative exposure, exposure/prolonged exposure, […] Cohen's TF-CBT, […and] group TF-CBT". This meta-analysis further posits that Cohen et al.'s model and TF-CBT groups have the largest evidence base within the TF-CBT family of interventions. It is nonetheless important to note that this meta-analysis makes no mention of cultural characteristics of study participants or the country the original studies originate from, which may suggest that the efficacy detected may not be generalizable across cultures and health services.

Rationale for adaptations of TF-CBT to enhance cultural relevance

The theory of cultural scripts for traumatic stress (Chentsova-Dutton & Maercker, 2019) argues that individuals develop their understandings of trauma exposure and consequent interventions to alleviate distress in part by both the culturally-bound schemas they hold relating to traumatic stress and their attitude to said schemas. Therefore, this

implies that trauma models that are developed from Global North[1] cultural scripts may not converge comfortably, if at all, with scripts from diverse cultures, therefore reducing its acceptability and accessibility. Rathod (2019) argued that cultural limitations of CBT include narrowness of valuing beliefs and idioms about distress, not accounting for systemic sources of support, and not attending to issues of mistrust in engaging with services. This concern of cultural fit underpins a view that the only way for CBT to be appropriate for minoritized communities is by adapting the intervention.

The effectiveness of TF-CBT has been extensively studied, but the findings are mainly drawn from participant samples of ethnically White and European or American individuals (Horrell, 2009), which may limit the generalizability of treatment effectiveness to individuals not identifying as ethnically white European or White American. In addition, research carried out by Lester et al. (2010) in the United States suggested that individuals from ethnic minorities may end cognitive processing treatment sooner than White American counterparts. This converges with Rathod et al.'s (2005) argument that persisting with culturally unadapted CBT interventions can cause poor therapeutic outcomes. At present, there are mixed findings in relation to the cross-cultural effectiveness of standard TF-CBT interventions. Some emerging data does provide support for the effectiveness and acceptability of culturally unadapted TF-CBT interventions for children in different regions across the world, including Japan (Kameoka et al., 2020), South-East Asia (Mattheß et al., 2020), Palestine (Barron et al., 2013), and Tanzania (O'Donnell et al., 2014), but the number of effectiveness studies in the global North far exceeds studies in the Global south.

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[1] In keeping with Wallerstein (1992) this thesis will refer to countries previously referred to as 'Western' or 'Developed' as Global North which is more geographically accurate. Countries previously referred to as 'Developing or Undeveloped will be referred to as the Global South.

Despite a lack of consistent terms for defining cultural adaptation, researchers have nonetheless highlighted this area as being of clinical importance. Rathod et al. (2015) created an evidenced-based framework for making cultural adaptations to CBT that can be understood across four dimensions, which include: "philosophical orientation, practical considerations of societal and health system-related factors, technical adjustments of methods and skills, and theoretical adaptations of concepts". In practice, this means that clinicians are encouraged to adapt the intervention to be responsive and congruent with client's cultural beliefs, experiences, and practices. Such adaptations can range from the modification of eurocentric metaphors, examples, and imagery to the inclusion of cultural practices within the intervention.

A meta-analysis of 78 studies describing all types of culturally adapted psychological interventions across child and adult populations carried out by Hall et al. (2016) indicated that participants accessing culturally adapted therapies reported greater reductions in psychological distress compared to accessing an unadapted intervention or no intervention. Within this meta-analysis, the authors described that CBT was used in approximately 30% of studies analysed. The findings of this research suggested that delivering culturally adapted interventions can enhance treatment outcomes compared to unadapted psychological interventions, although the latter can be effective also. The spirit of these findings is reflected in the United Kingdom's NICE recommendations (2018) for post-traumatic stress. These recommendations include the need for cultural awareness in clinicians and cultural appropriateness in use of assessment measures to support the identification of, and intervention with, difficulties related to trauma exposure. Therefore, the perspectives of clinicians, researchers, and health policy makers suggest that cultural adaptations to TF-CBT for children are recommended to maximise opportunities for good treatment outcomes and equity in access for a range of communities.

Systematic reviews in this area

There are a number of relevant systematic reviews examining the benefits of TF-CBT for children. Chipalo's (2021) review of four studies of TF-CBT treatment for child refugees provided support for the effectiveness of the model for this clinical population, although the small number of studies eligible for review limits the findings. McGuire et al's (2021) review of 11 TF-CBT intervention studies for children aged 3 to 6 tentatively suggested that TF-CBT is "probably efficacious" for this age group, and that establishing effectiveness is limited due to a small number of studies and variations in TF-CBT protocols used. This review also did not provide an account of cultural factors. Of more relevance, Thomas et al. (2020) carried out a review of 11 studies describing "culturally considered" TF-CBT interventions for children and young people in low and middle-income countries and suggested that this intervention type appears to significantly reduce distress as conceptualized by a range of outcome measures. However, this review did not provide an appraisal of the quality of the studies included for review, nor did it analyse the process by which cultural adaptations were developed. A systematic review carried out by Ennis et al (2019) reviewed seventeen studies describing culturally adapted TF-CBT interventions across child and adult populations, generally finding that TF-CBT interventions seemed effective but highlighting the inconsistent approaches adopted in developing the cultural adaptations. This review did not provide an analysis of the quality rating developed for the studies selected, did not make distinctions between child- and adult- focused studies in the discussion, nor did it provide an appraisal of the quality of the cultural adaptations.

Rationale and scope for this review

This review will address identified gaps in the literature by reviewing studies which specifically use culturally adapted TF-CBT for children, and it will evaluate the quality of the

research, the quality of the process of developing cultural adaptations, and the replicability of adaptations made, for each of the reviewed studies. In comparison to the studies selected for this review and those reviews discussed above, there is no overlap of studies with McGuire et al. (2021), seven studies overlap with Thomas et al. (2019), and six studies overlap with Ennis et al. (2019). Where there is overlap, the studies have still been included in the present review as the research questions were new and would offer different insight.

Research questions

1: What is the overall quality of the evidence supporting the reported effectiveness of culturally adapted TF-CBT?

2: What TF-CBT models have been used?

3: In what ways have TF-CBT interventions for children been culturally adapted?

4: How were cultural adaptations to TF-CBT developed?

5: How are these adaptations experienced by clients and their families?

6: What are the reported clinical outcomes following adapted TF-CBT completion?

Methodology

Three databases were used to identifying possible eligible studies: Pubmed, PsycInfo, ASSIA. PsychInfo and ASSIA were used as they are suitably specific databases for the area of interest (developed for psychology-focused and and child-focused research respectively) Pubmed was used as a suitably scientifically-focused inter-disciplinary database that would capture any studies not identified by PsycInfo or ASSIA. The following search terms were used for appearance in abstracts:

cultur* OR refugee OR American Indian or Indigenous OR Africa or India or Sub-continent OR Global South or Developing Countr* or Third World OR Non-white OR non-European

AND cognitive behavio* therap* OR cognitive OR behavio* OR cognitive-behavio* OR CBT OR TF-CBT OR TF CBT AND trauma* OR PTSD OR traumatic stress

AND child* OR adolesc* OR youth OR young* OR teen* OR minor OR infant OR toddler.

AND adapt*.

Inclusion Criteria

The following inclusion criteria were applied to establish eligibility for review.

- Studies published either in English, (or translated into English).
- Studies that have been published in a peer-reviewed journal.
- Studies which explicitly describe an adaptation of a TF-CBT intervention to enhance cultural relevance or sensitivity. As there are no systematic or consistent definitions of cultural adaptations as applied to therapy, studies can only be included in this review if the adaptation they propose has been explicitly named as a cultural adaptation. This means that studies describing an adaptation of an intervention through translation only do not meet inclusion criteria.

- Studies which explicitly describe an intervention offered only to children and young people (aged under 18 years old) following exposure to at least one potentially traumatising event (includes but is not limited to individuals described as having PTSD).

- Studies which have applied and evaluated the adaptation in clinical practice or as part of a research trial.

- Any methodology including qualitative and single case research.

- Studies or reports which provide an analysis and discussion of the effects of the adapted intervention for the participants (inclusive of clinical outcomes).

- Studies must have been published no earlier than 1964, which is the earliest year credited with the beginnings of Cognitive Behavioural practice (Beck, 1964).

- Interventions could be carried out in either individual or group formats.

Exclusion criteria.

The following criteria were established to exclude inappropriate research from the review.

- Studies where the description of study methodology is absent (in relation to study design and data analysis).

Figure 1 below provides a description of the search process using a PRISMA (2009) diagram.

Figure 1.

Prisma Diagram
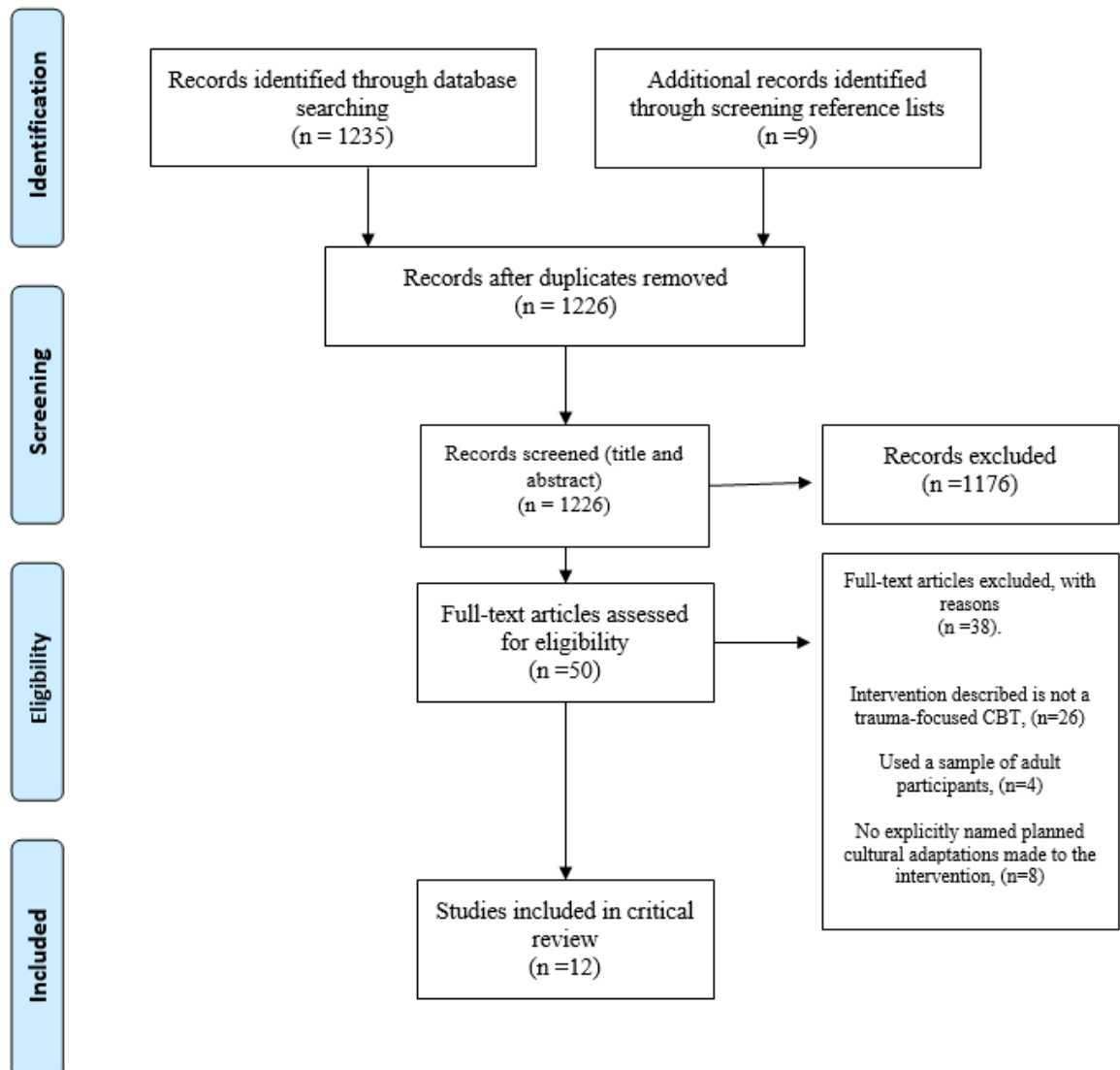
Review

A total of twelve studies were identified and evaluated. Studies examined the effectiveness of a culturally adapted TF-CBT intervention for a specific community of interest. Studies were carried out between 2008 and 2021. Four studies used a randomised controlled trial design, three used mixed methods, three used a quasi-experimental design, and two used case studies. Models of TF-CBT that were adapted included Cohen & Marino (2006) (seven studies), Jaycox (2004) (three studies), and Walker et al. (2014) (one study). Intervention formats were described as group in eight studies and individual therapy in four studies. Adaptations described were made for communities that were either from Global South countries or who are minoritized within the United States of America. Three studies offered adapted interventions to members of Native Indian communities in the USA, and one study for members of the African American communities in the USA. The remaining studies were carried out in Zambia (two studies), Democratic Republic of Congo (two studies), Kenya (one study), Tanzania (one study), Jordan (one study), and Haiti (one study). Collectively, 1184 participants were recruited to studies reviewed. Summarising information for each study is described in Table 1.

Table 1.

Summary of selected studies

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children	BigFoot & Schmidt (2010). United States of America.	Case Study	1 American Indian adolescent who experienced sexual abuse.	Honoring Children, Mending the Circle (HC-MC). No further details are provided.	Cohen, Mannarino, & Deblinger, 2006).	The authors describe: -expanding the concept of the "cognitive triangle" to include spiritual, relational, emotional, mental and physical aspects. -inclusion of tribal rituals and practices in treatment process. -inclusion of healing ceremonies in graded exposure. -use of tribal imagery in relaxation activities -using a tool to explore cultural affiliation and need for incorporation HC-MC methods.	A descriptive account of the participant's experience of HC-MC is provided.	Not described.	The authors claim that the HC-MC tools support young people and families establish individual need for use of HC-MC within a TF-CBT intervention. Attrition rate: none.	The study was evaluated as being of poor methodological quality. The process for developing adaptations was in keeping with quality criteria. The adaptations described were replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Trauma-focused cognitive behavioral therapy: Cultural adaptations for application in Jordanian culture.	Damra, Nassar, & Ghabri (2014). Jordan.	Mixed-methods.	18 male children (aged 10-12) presenting with symptoms of PTSD associated with physical abuse from a parent.	A weekly group TF-CBT intervention over a period of two weeks.	Not described.	For child-parent dyad components to intervention, gender should be matched in accordance with Jordanian culture.	Childhood PTSD symptoms Scale (Foa, Treadwell, Johnson, & Feeny, 2001); Child's Depression Inventory (Kovacs, 2003); The Childhood PTSD; The Childhood Depression Inventory. The measures were completed prior to the group, two weeks after completion, and four months after completion. Participants were also interviewed after intervention.	Quantitative data is reported to have been analysed using inferential statistics, one-way ANOVA and repeated measures ANOVA. Qualitative data is reported to be analysed using Thematic Content Analysis.	The study reports that participant who access the intervention reported reduced distress as measured on the post-traumatic stress and depression measure, with gains sustained at 4 months. Attrition from TF-CBT was (n=9) 33.3%. Participants provide positive feedback about the intervention. No effect size reported.	The study was evaluated as being of poor methodological quality. The process for developing adaptations was in keeping with quality criteria. The single adaptation described is replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Effectiveness of task-shifted trauma-focused cognitive behavioral therapy for children who experienced parental death and posttraumatic stress in Kenya and Tanzania: A randomized clinical trial	Dorsey, Lucid, Martin, King, O'Donnell, Murray, Wasonga, Itemba, Cohen, Manongi & Whetten (2020). Kenya & Tanzania.	Randomised controlled trial.	640 orphan children from Tanzania and Kenya presenting with post-traumatic stress and / or prolonged grief difficulties, aged 7-13.	Group TF-CBT. "12 group sessions and 3 to 4 individual sessions for 12 consecutive weeks[…]Child groups and guardian groups met concurrently, with joint child guardian activities in the final 5 sessions"	Cohen, Mannarino, & Deblinger (2006) model of TF-CBT.	"modifications included group (vs individual) modality; the use of local metaphors to explain concepts; simplified, step-by-step guides for sessions; and language (delivering TF-CBT in Kiswahili, referring to the sessions as "class" vs therapy, and no psychological labels)."	Outcome measures were recorded before intervention, after intervention, and at 3-, 6-, and 12-month follow up. Child PTSD symptom scale (Foa et al, 2001) Inventory of complicate grief (Melhem et al, 2013) Youth self-report (Achenbach, 1991) Parent perspective: Child Behavior Checklist (Achenbach, 1992) Child-parent relationship scale (Pianta, 1992).	ANOVA.	TF-CBT was significantly more beneficial than support as usual in reducing symptoms of post-traumatic stress, prolonged grief, depressive and internalising symptoms (as measured by YSR and CBC). Maintained at follow ups. Kenyan children and caregivers accessing TF-CBT reported enhance levels of closeness. Power calculations referenced, but no report of required number of participants need to detect effect. Attrition from TF-CBT: 15 of 314 participants did not complete the treatment, which equates to 4.77%. Effect sizes (Cohen's d) ranges for intervention effectiveness were: for Kenya (urban and rural: .56 (medium) & 1.04 (large) after intervention and .99 (large) and 0.86 (large) at 12 month. For Tanzania (urban and rural): -0.12 (no effect) & 0.45 (small effect) after intervention and .11 (no effect) & 0.09 (no effect) at 12 months.	Methodological quality was evaluated as good. The quality of the process for developing adaptations, and the replicability of the adaptations, could not be established.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Primary Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth.	Goodkind, Lanoue, & Milford (2010). United States of America.	Mixed methods.	23 American Indian adolescents aged between 12 to 15, from three different American Indian / American Native communities in New Mexico, USA.	Group CBITS intervention, delivered once-weekly over ten weeks at school during school hours. In addition, study clinicians met individually with participants twice, twice with parents, and once with teachers.	Cognitive Behavioral Intervention for Trauma in Schools, Jaycox (2004).	The authors describe making "surface level" adaptations. Removal of "Eurocentric examples of cognitive restructuring" Use of culturally-bound stories, examples, and practices where appropriate/required. Addressing different cultural beliefs about psychological phenomena.	Outcome data was collected before the intervention, at the end of the internvention, and at 3 and 6 months follow up. Focus groups were carried out to discuss participant experience of the intervention. Childhood PTSD symptoms Scale (Foa, Treadwell, Johnson, & Feeny, 2001); Child's Depression Inventory (Kovacs, 1992); MASC (March & Parker, 1999); Children's Coping Strategies Checklist, 1996).	Outcome data was analysed using hierarchical linear modelling. No named analytic method for qualitative data.	Quantative fndings indicate that participants maintained reductions in post-traumatic stress, anxiety, and avoidant coping strategy, and low mood scores at 3 month follow up. However, PTSD and avoidant coping strategy scores were similar to baseline at the 6 month follow up point. Qualitative findings suggest that participant experience the intervention as enjoyable, helpful, and would take part in a similar intervention in the future. Power calculations not done. Attrition from TF-CBT: not reported. Effect sizes (Percentage of variance explained) reported were: 0.1 (medium) for post-traumatic stress and .08 (small) for anxiety.	Methodologically poor. The process of developing adaptations was partially in keeping with quality criteria. The adaptations described were replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Primary Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DR Congo: a randomised controlled trial	McMullen, O'Callaghan, Shannon, Black, & Eakin (2013). Democratic Republic of the Congo.	Randomised controlled trial	50 Congolese male children aged 13-17, who are either former child soldiers or otherwise war-affected, presenting with psychological distress.	15 session group TF-CBT intervention, with the addition of three parent sessions.	Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen, Mannarino, & Deblinger, 2006	"culturally applicable analogies and exemplars throughout." The cultural adaptations mainly involved the use of familiar games and songs to help the children relax, learn social skills and participate in group activities. Culturally appropriate stories and metaphors were employed throughout to explain certain points and provide relevant examples. Examples include: the script for progressive muscle relaxation which employed imagery of local animals and food; role-playing fear of local animals (e.g. mouse, cat, snake, etc.) to demonstrate the levels of intensity of feelings; considering the belief in one's neighbour is a witch as a thought that can affect feelings and behaviour"	Outcome measures were completed at before the intervention, after the intervention, and at 3 month follow up. UCLA-PTSD Reaction Index (Revised; Pynoos & Steinberg, 2002) African Youth Psychosocial Assessment (Betancourt et al., 2009)	ANCOVA	The authors report TF-CBT led to statistically significant reductions in post-traumatic stress, depression/anxiety symptoms; conduct problems, and increase in pro-social behaviour. At 3 month follow up, gains were maintained in all dimensions except for conduct problems. No power calculations made. Attrition from TF-CBT: 1 of 24, 4.16%. Effect sizes (Cohen's d) were reported as: .665 (medium) for post traumatic stress symptoms, .567 (medium) for anxiety and depression symptoms, .288 (small) for conduct problems, and .432 (small) for increased prosocial behaviour. At three months, effect sizes were: 2.17 for trauma symptoms, 2.64 for depression and anxiety symptoms, 1.07 for prosocial behaviour, and 0.11 for conduct problems.	Methodological quality was assessed as good. The quality of the process for developing adaptations could not be established. The adaptations were assessed as partially replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Cognitive behavioral intervention for trauma in schools (CBITS): School-based treatment on a rural american indian reservation.	Morsette, Swaney, Stolle, Schuldberg ,van den Pol, & Young (2008). United States of America.	Quasi-experimental design	4 children, aged 11-12 years old. It is assumed that the children who participated are American Indian, however this is not clarified (in the context of "another unspecified ethnicity" being reported when reporting results from the screen.	Group CBITS intervention, delivered once-weekly over ten weeks at school during school hours. In addition, study clinicians met individually with participants upto three times, twice with parents, and once with teachers.	Cognitive Behavioral Intervention for Trauma in Schools, Jaycox (2004).	The authors describe adapting: adding "linguistic concepts, adding" local history", adding "local allegories", modifying examples of cognitive distortions; adapting manual interpretation of what constitutes irrational belief; clinician sensitivity to fit between CBT causal assumptions and cultural epistemology; labelling feelings;	Child PTSD symptom scale, (Foa et al, 2001); Children's Depression Inventory (Kovacs, 2003). Measures were completed three times: at the initial screening appointment, before beginning the treatment, after the treatment. However, the authors do not state how long after the intervention's ended the post-treatment measure was taken.	Descriptive statistics the authors call "visual analysis".	For three of four participants, there is a reduction in scores reported in the CDI and fall below the clinical cut-off. Only one participant scored below the threshold at post-test, where the pre-test score was above the threshold. The authors claim that the data suggests their adapted CBITS s an effective method of treating PTSD and depression symptoms for American Indian children. This is not supported due to the poor quality of the study and data analysis. There is substantial discrepancy between this claim and the data presented. Attrition from TF-CBT: 3 of 7 dropped out. 42.85%	Methodological quality was evaluated as poor. The process for developing cultural adaptations was in keeping with quality criteria. The adaptations were partially replicable.
Cognitive behavioral treatment for trauma symptoms in American Indian youth: preliminary findings and issues in evidence-based practice and reservation culture	Morsette, van den Pol , Schuldberg , Swaney & Stolle (2012). United States of America	Quasi-experimental design	57 american Indian students, aged 10-15, presenting with symptos of traumtic stress and reporting exposure to violence.	A 10- session group TF-CBT intervention for children, with the inclusion of individual meetings with children, as well as meetings with parents and teachers.	Cognitive Behavioral Intervention for Trauma in Schools, Jaycox (2004).	Inclusion of tribal elders to provide cultural perspective on "trauma and healing" in initial session and "o conduct ceremonies that were based on traditional culture and healing practices for their respective tribes (as needed and at graduation)".	Outcome measures were collected at screening, pre-intervetnion, and post-intervention.	Childhood PTSD symptoms Scale (Foa, Treadwell, Johnson, & Feeny, 2001); Child's Depression Inventory (Kovacs, 2003).	The authors report significant improvements in post-traumatic stress and depression scores following group intervention. No power calculations. Attrition from TF-CBT: 14 of 57 (25%). Effect sizes (partial eta squared) were reported as .285 (large) for post-traumatic stress symptoms, and .121 (medium) for symptoms of depression.	Methodological quality was assessed as poor. The quality of the process for developing adaptations was assessed as partially in keeping with quality criteria. Adaptations were somewhat replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Identification, modification, and implementation of an evidence-based psychotherapy for children in a low-income country: the use of TF-CBT in Zambia	Murray, Dorsey, Skavenski, Kasoma, Imasiku, Bolton, Bass, & Cohen (2013). Zambia.	Mixed methods	21 children and adolescent exposed to sexual violence.	Individual TF-CBT adapted for the local culture, delivered on a weekly basis, with sessions lasting between 30 minutes to 2 hours dependent on participant context and need.	Cohen, Mannarino, & Deblinger (2006) model of TF-CBT.	Contextualising difference between local understanding of "counselling" and the provision of TF-CBT. More gradual discussion of sexual abuse Introduction of praise within parenting skill Adaptation of analogies, practices and activities relating to relaxation Identifying feelings through language and music Discussing cultural implications of expressing emotions to caregivers "inclusion and reference to religion" and other culturally-relevant analogies in cognitive restructuring Analogies for the rationale of a trauma narrative Ongoing risk assessment and management to ensure child safety. Provision of additional psychoeducation and information relating to HIV.	The outcome measure used was the PTSD-RI, completed before and after intervention completion. Counsellors provided qualitative feedback.	Paired samples t-test for quantitative data. No analytic method described for qualitative data.	The authors report a significant reduction in scores on the PTSD-RI following participants accessing the intervention. Counsellors reported several adaptations made throughout the study. Attrition rate from TF-CBT not reported. Effect size not reported.	Outcome of evaluative suggests this study is of poor methodological quality. Cultural adaptations development process appears in keeping with quality criteria, and replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description (name of intervention, format, mode of delivery, frequency, duration, location).	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Effectiveness of trauma-focused cognitive behavioral therapy among trauma-affected children in Lusaka, Zambia: A randomized clinical trial.	Murray, Skavensku, Kane, Mayeya, Dorset, Cohen, Michalopouos, Imasiku, & Bolton (2015). United States of America & Zambia.	Randomised controlled trial.	257 Zambian children aged 5-18 presenting with symptoms of post-traumatic stress took part in the study. Participants were randomised into treatment (n=106) and treatment as usual (n=104) conditions	Weekly individual TF-CBT, with sessions lasting 60-90minutes.	Cohen, Mannarino, & Deblinger (2006) model of TF-CBT.	Contextualising difference between local understanding of "counselling" and the provision of TF-CBT. More gradual discussion of sexual abuse Introduction of praise within parenting skill Adaptation of anologies, practices and activities relating to relaxation Identifying feelings through language and music Discussing cultural implications of expressing emotions to caregivers "inclusion and reference to religion" and other culturally-relevant analogies in cognitive restructuring Analogies for the rationale of a trauma narrative Ongoing risk assessment and management to ensure child safety. Provision of additional psychoeducation and information relating to HIV.	Measures completed before treatment and at one month post completion. PTSD-RI (Steinberg et al, 2013). Steinberg AM, Brymer MJ, Kim S, et al. Psychometric properties of the UCLA PTSD reaction index: part I.J Trauma Stress. 2013;26(1):1-9. Functional impairment was measured using locally developed tool. HIV risk behavior (Sikkema et al, 2005) World Aids Foundation Measure. Alcohol, Smoking, and Substance Involvement Screening Test (Humeniuk et al, 2010). Caregivers completed the Child Behavior Checklist (Achenbach, 1992)	Mixed-effects regression modelling.	Participants in the treatment group reported reduced distress in post-traumatic stress measures an functional impairment, with an affect size for the PTSD between groups difference much larger than treatment as usual. Caregiver reported not analysed. Power calculations suggest that n=100 in each condition needed. This was achieved. Attrition from TF-CBT: 12 of 131, 9.16% Effect size (Cohen's d) reported as 2.39 (large) for trauma symptoms, and .26 (small) for functional impairment.	Methodological quality assessed as good. Cultural adaptations development process appears in keeping with quality criteria, and replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description (name of intervention, format, mode of delivery, frequency, duration, location).	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioral Therapy for Sexually Exploited, War-Affected Congolese Girls	O'Callaghan, McMullen, Shannon, Rafferty, & Black (2013). Democratic Republic of Congo.	Randomised Controlled Trial.	52 female children aged 12 to 17 years old exposed to rape and inappropriate sexual touch. Randomised to treatment (n=24) and wait list control (n=28).	A 15 session group TF-CBT intervention, with the addition of three sessions for caregivers only.	Treating Trauma and Traumatic Grief (Cohen, Mannarino, & Deblinger, 2006.	"Cultural adaptations included having a female facilitator talk about ways to reduce the risk of sexual violence in the future (e.g., fetching firewood with a friend, not working in a brothel, etc.); the use of culturally familiar games, songs, and examples (e.g., belief that a neighbour is a witch); and social workers visiting the girl's guardians to try to re-establish contact, reduce stigmatization, and foster family acceptance".	Outcome measures were collected at screening, at postintervention, and at 3 months follow up. Included: UCLA PTSD Reaction Index (Steinberg et al, 2004). African Youth Psychosocial Assessment (Betancourt et al., 2009)	ANCOVA	Completion of TF-CBT was associated with significant symptomatic improvements in post-traumatic stress, depression and anxiety, conduct problems, and pro-social behaviour, with gains maintained at 3months follow up. Power calculations suggested n=20 in each condition. Achieved recruitment to target. Attrition rate from TF-CBT was four of twenty-four participants (16.6%), although this was because they moved away. Effect size (partial eta squared) was reported as: .518 (large) for trauma symptoms, .517 (large) for depression and anxiety symptoms, .259 (large) for conduct problems, .099 (medium) for prosocial behaviour. Effect sizes (Cohen's d) at three months were: 2.04 (large) for trauma symptoms, 2.45 (large) for anxiety and depression symptoms, 0.95 for conduct problems.	Methodological quality was assessed as good. The process for developing adaptations was partially in keeping with quality criteria. Adaptations were replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description (name of intervention, format, mode of delivery, frequency, duration, location).	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Leveraging Technology and Cultural Adaptations to Increase Access and Engagement Among Trauma-Exposed African American Youth: Exploratory Study of School-Based Telehealth Delivery of Trauma-Focused Cognitive Behavioral Therapy	Stewart, Orengo-Aguayo, Wallace, Metzger, & Rheingold (2021). USA.	Case study	3 African-American children exposed to trauma.	Culturally-tailored weekly individual trauma-focused CBT, delivered by videoconferencing technology.	Cohen, Mannarino, & Deblinger, 2006).	Cultural adaptations were made on case-by-case basis. Adaptation types included: inclusion of racial achievement messages; inclusion of gospel songs as relaxation activities; matching of therapy resources (pictures, videos) with client's experience and ethnic background; inclusion of racial pride messages in psychoeducation component.	UCLA PTSD-RI (Steinberg et al., 2004); Short mood feeling questionnaire (Angold et al., 1995); Telehealth satisfaction questionnaire (Stewart et al., 2018).	Descriptive statistics.	Overall symptom reduction as measured by PTSD-RI was 63% before and after intervention. No drop out from intervention reported.	The methodological quality was assessed as poor. The process for developing cultural adaptions was not in keeping with quality criteria. The adaptations were replicable.

Study Title	Study Authors (Year). Location.	Study Design	Study Sample	Intervention Description (name of intervention, format, mode of delivery, frequency, duration, location).	TF-CBT Intervention Model used	Summary of adaptations made as described by authors	Outcome data and measures	Data Analysis methods	Primary Findings	Critical Appraisal of quality Outcome
Culturally adapted spiritually oriented trauma-focused cognitive-behavioral therapy for child survivors of restavek.	Wang, Aten, Boan, Jean-Charles, Griff, Valcin, Davis, Hook, Davis, Van Tongeren, Abouezzed ine, Sklar, & Wang, (2016). Haiti.	Quasi-experimental	58 children living in Haiti who have experienced domestic enslavement.	CA-SO-TF-CBT is a twelve week group intervention, delivered by either undergraduate students, lay counsellors, or NGO staff.	Intervention is based on the protocol developed by Walker, Courtois, & Aten (2014).	No description of adaptations is provided.	The outcome measures used were the Child PTSD symptom scale (Foa et al., 2001) and the BRIEF RCOPE (Pargament et al., 2011). Measures were completed before and after the intervention.	Analysis of Variance was used to analyse data.	Participants in the treatment groups reported lower scores on both outcome measures, suggesting clinical improvements. Participants reported significantly lower BRIEF RCOPE scores in the NGO staff-facilitated group, compared to the student facilitate group. Attrition rate from TF-CBT was 20 of 58 participants, although this was not attributed to the treatment. Effect size (partial eta squared) was: .10 (medium) for trauma symptoms, .15 (large) for spiritual struggles.	The methodological quality was assessed as fair. The process for developing adaptations was partially in keeping with quality criteria. The adaptations were not replicable as they were not described.

Three tools were used to evaluate the quality of the studies methodology and the development of cultural adaptations.

Although critical appraisal skills programme (CASP) tools are commonly used and endorsed by Cochrane (Noyes et al., 2018), they were not selected as tools for this review. CASP tools are generally described as being unvalidated by the developers themselves (CASP, 2012). Different CASP tools would also only have been useful for two of the four research design types that are represented in the studies selected for review. Given this diversity in research designs, two different tools were used to evaluate the quality of study methodology for papers selected for review.

The Downs and Black (1998) checklist (Appendix 1) was used to evaluate the quality of the presented evidence in randomised controlled clinical trials and quasi-experimental studies. The checklist has been evaluated as having high internal consistency, external validity, test-retest reliability, and inter-rated reliability (Downs & Black, 1998). This tool was developed to generate total quality scores which can be used to compare studies, which is particularly helpful for the purpose of this review. The tool can yield scores ranging from 0 to 28, with score ranges categorized as "excellent (25-28), good (20-25), fair (15-19), poor (less than 14)". This measure was also used in a systematic review of a similar topic and was therefore used for evaluation (Ennis et al., 2019). Mixed-method studies and case studies were reviewed using the Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong et al., 2018) (Appendix 2). This tool is commonly used in the field of human and social science and has been evaluated as a helpful and ecologically valid method of evaluating the quality of studies (Hong et al., 2018). The authors provided a categorization of quality according to the following: less than three quality criteria achieved is considered low quality, between three to four quality criteria considered moderate quality, and all five criteria achieved is considered high quality. This meant that MMAT could be used to order the quality of the studies.

As a means of evaluating the quality of the process for developing cultural adaptations and the replicability of adaptations, a brief 7-item checklist was developed. This checklist (referred to hereafter as the "cultural adaptation checklist") (Appendix 3) was developed from the key dimensions outlined by Rathod et al's (2021) framework for culturally adapting cognitive behaviour therapy. As far as the authors are aware, there is no established framework for appraising cultural adaptations. The cultural adaptation checklist aimed to establish the quality of the process of adaptation and the replicability of the content of the adaptations. The following descriptions were used for each dimension of evaluation: If all quality criteria were achieved, this equated to "Satisfactory Adherence"; if some quality criteria were achieved, this equated to "partial adherence"; if no quality criteria were achieved, this equated to "No Adherence".

Synthesis and critique of study results

Research Question 1: What is the quality of the evidence supporting the reported effectiveness of culturally adapted TF-CBT?

The Downs & Black checklist was used to evaluate the methodological quality of seven studies. Murray et al. (2015), Dorsey et al. (2020), McMullen et al. (2013) and O'Callaghan (2013) were rated as "good", Wang et al. (2016) was rated as "fair", Morsette et al (2008) and Morsette et al. (2012) were rated as "poor". The MMAT was used to evaluate the methodological quality of five studies. Goodkind et al. (2019), Damra et al. (2014), Murray et al. (2013), Stewart et al. (2021), and Bigfoot and Schmidt (2010) were rated as "low quality". A summary of the findings from the quality appraisal is available in Table 2.

Table 2.

Summary findings of study quality appraisals for methodology, cultural adaptation development, and

replicability of adaptations.

Study	Outcome of Quality Appraisal Tool (Name of Tool used)	Adherence to quality criteria for developing cultural adaptations	Replicability of cultural adaptations	Comments
BigFoot & Schimdt (2010)	Low quality (MMAT)	Satisfactory adherence	Replicable	
Damra et al., (2014)	Low quality (MMAT)	Satisfactory adherence	Replicable	Only one adaptation was described.
Dorsey et al., (2020)	Good (Downs & Black)	Unable to assess.	Unable to assess.	
Goodkind et al., 2019.	Low quality (MMAT)	Partial adherence	Replicable	
Morsette et al., (2008)	Poor (Downs & Black)	Satisfactory adherence	Partially replicable	
Morsette et al., (2012)	Poor (Downs & Black)	Partial adherence	Partially replicable	
McMullen et al., (2013)	Good (Downs & Black)	Unable to assess.	Partially replicable.	
Murray et al., (2013)	Low quality (MMAT)	Satisfactory adherence	Replicable	
Murray et al., (2015)	Good (Downs & Black)	Satisfactory adherence	Replicable	
O'Callaghan et al., (2013)	Good (Downs & Black)	Partial adherence	Replicable	
Stewart et al.,(2021)	Low quality (MMAT)	No adherence.	Replicable	
Wang et al., (2016)	Fair (Downs & Black)	Partial adherence	Not replicable	The adaptations were not described.

Research methodologies

Mixed methods. A mixed methods design was used for Goodkind et al. (2019), Damra et al. (2014), and Murray et al. (2013). Generally, these studies applied this method poorly. Goodkind et al. (2019) and Damra et al. (2014) did not provide an explicit rationale for using this method. Murray et al. (2013) referenced the DIME methodology as informing their study design. DIME is a systematic process for designing, implementing, monitoring and evaluating mental healthcare interventions (Applied Mental Health Research Group, 2000). None of these studies provided a framework for integrating quantitative and qualitative outputs and findings. Goodkind et al. (2019) did not include the qualitative aspect of the study within its expressed research questions. Given a lack of methodological integration, there is no documented reflection on convergences and divergences across outputs in either study.

In the application of qualitative methodologies within mixed-methods, Goodkind et al. (2019) and Murray et al. (2013) did not name the qualitative approach used. The authors of Goodkind et al. (2019) described the use of focus groups which seemed appropriate. The authors reported that the participants experienced the intervention as enjoyable and helpful, but no qualitative evidence is included to demonstrate this. Damra et al. (2014) stated that thematic content analysis is used however there is no justification or analytic procedure described, therefore this does not appear to be a robust method of establishing cultural appropriateness. Overall, the studies did not provide sufficiently detailed accounts of the analytic methodology or process.

In the application of quantitative methodology within mixed-methods, all studies used appropriate measures in keeping with their research questions. Goodkind et al. (2019) justified and appropriately used their statistical methods of analysis, however consequent

findings in relation to symptom improvement across key variables was limited by an absence of a control group.

Randomised Controlled Trials (RCT). Studies by Murray et al. (2015), Dorsey et al., McMullen et al., and O'Callaghan et al. used a RCT design to evaluate the effectiveness of their respective culturally adapted interventions. Generally, all RCT studies were designed and delivered in keeping with the quality criteria for this method. Appropriate randomization procedures using computer software were described by Murray et al. (2015), McMullen et al. (2013) and O'Callaghan et al. (2013), whereas Dorsey et al. (2020) did not describe randomisation. All studies presented groups which were comparable at baseline. All studies reported outcome assessors being blinded to condition assignment. Two of the four studies reported completed data, whereas Murray et al. (2015) suffered from a poor response rate for secondary outcome data which were consequently un-analysed. Across RCT studies, there is no report that participants did not adhere to the requirements and interventions of their assigned treatment group. All three studies reported making power calculations, although Dorsey et al. (2020) did not disclose the sample size required to achieve it. Murray et al. (2015) and Dorsey et al. (2020) developed control groups from support as usual provided from community centres participants were recruited from, whereas O'Callaghan (2013) use a wait-list control. These represented suitable and ethical use of control groups given the context in which they were carried out.

Quasi-experimental design. Morsette et al. (2008), Morsette et al. (2012) and Wang et al. (2016) used a quasi-experimental design. These studies selected outcome measures appropriate for its research questions, with outcome data which appears complete and with no significant deviations reported in adherence to assigned study conditions. In Morsette et al. (2008), the report did not provide detailed characteristics regarding the four participants that took part, therefore sample representativeness could not be established. The use of descriptive

methods to present outcome data did not sufficiently support researcher's claims that CBITS is "an effective method of treatment for American Indian children suffering from symptoms of PTSD and depression". In Morsette et al. (2012) it was not possible to establish if confounders were considered in the design or analysis as they were not reported. Absence of a control group in Morsette et al. (2008) and Murray et al. (2013) meant that it was not possible to reliably attribute symptom improvements to TF-CBT. Although Morsette et al. (2012) did use a control group, the small number of participants in each group (n=9) meant that the parametric inferential analyses used were probably inappropriate, given that there was unlikely to be a normal distribution of scores.

Case studies. Stewart et al. (2021) and Bigfoot & Schmidt (2010) used a case study research design. Stewart et al. (2021) proposed an appropriate sampling strategy and used appropriate outcome measures to answer the research questions for their three respective participants. The risk on non-response bias was low as measures were completed within interviews pre- and post- treatment. Bigfoot & Schmidt (2010) claims of intervention effectiveness were not supported by data or analyses as they provided a descriptive account of participant's experience instead.

Samples. The studies reviewed reported a wide range of participant numbers, ranging from 4 (Morsette et al., 2008) to 640 (Dorsey et al, 2020). Seven studies reported sample sizes of less than 38, three studies recruited between 50 to 57 participants, and Murray et al. (2015) and Dorsey et al. (2020) recruited 257 and 640 participants respectively. It is clear that the generally small sample sizes is limiting of the generalizability of findings.

With regards to age, nine studies recruited participants in the 10 to 15 years age range, whereas only three studies recruited participants either in 5 to 9 years or over sixteen years, and none recruited participants under the age of 5. This represents a significant gap of

research attending to the possible developmentally bound effects of trauma exposure for children who are pre-adolescent or in later stages of adolescence.

One important issue is that of gender representation. Morsette et al. (2012) included a participation exclusion criterion of sexual assault as the primary index trauma, so as not to compound participant vulnerability in the context of a therapy. Damra et al. (2014) reported that the sample included only male children with no further explanation.

Consent procedures

It is important to highlight that three studies reviewed did not report consent procedures. Although there is limited research in this area, reviews indicated that the frequency and quality of reporting consent procedures in publications are frequently found lacking in child research (Sifers et al., 2002). Given the potent issues of trust and collaboration in the adaptation of a Eurocentric model of therapeutic intervention across cultures, it is essential that future research ensures that all relevant consent and procedures are reported. Modeling ethical practice in research documentation is especially important in building an evidence base for supporting trauma-exposed youth to trust and engage with interventions such as TF-CBT.

Impact of accessing a culturally adapted TF-CBT

Clinical outcomes. Generally, the studies reviewed selected outcome measures appropriate to the clinical implications of trauma exposure. Importantly, all studies reported that accessing their respective culturally adapted TF-CBT interventions reduced psychological distress. Post-traumatic stress was the psychological difficulty that was most studied, treated and improved across studies. However, there are significant limitations to claims made across the studies. One limitation includes the lack of follow-up. Only five studies carried out follow-up assessments, all of which were under twelve months from

intervention completion, and most within three months. This means that findings cannot be generalizable in terms of long-term therapeutic gains. In addition, no studies described "caseness" following intervention, therefore it was not possible to establish how helpful interventions were in reducing distress to a point of non-clinical significance. In addition, studies reviewed over-relied on child-reported measures- only studies by Murray et al. (2015) and Dorsey et al. (2020) used caregiver measures to corroborate their respective primary outcome measures. This represents a missed opportunity for most studies to enhance the reliability and validity of their reported findings. Furthermore, most studies except for Murray et al. (2015), Stewart et al. (2021), and Bigfoot & Schmidt (2010) investigated the effectiveness of group formats of TF-CBT. The implications of this are not clear for the wider generalizability of findings relating to the model as there does not appear to be any research comparing effectiveness of group against individual formats of the model.

Participant experience. No studies effectively reported the qualitative experience of engaging with a culturally adapted TF-CBT intervention. Only one study (Goodkind et al., 2019) attempted to collect children's views of the intervention. The lack of findings in relation to participant experience of the intervention (beyond clinical outcome measures) is a highly significant gap in the literature. Without such evidence, it is unclear how researchers will incorporate the views of people who access support in the ongoing development and improvement of culturally adapted TF-CBT.

Research Question 2: What TF-CBT models have the studies used?

All studies selected for review named a specific TF-CBT model that they made cultural adaptations to. Goodkind et al. (2019), Morsette et al. (2008), and Morsette et al. (2012) reported using Cognitive Behavioral Intervention for Trauma in Schools (Jaycox, 2004). Murray et al. (2013), Murray et al. (2015), Dorsey et al. (2020), McMullen et al.

(2013), O'Callaghan et al. (2013), Stewart et al. (2021), and Bigfoot & Schmidt (2010) named Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen, Mannarino, & Deblinger, 2006) as their model of choice. Wang et al. (2016) named their model as Spiritually Oriented Trauma-Focused Cognitive-Behavioral Therapy. Damra et al. (2014) named three adaptation manuals of interest (Camino, 2000; Deblinger & Heflin, 1996; NCTSN, 2008), however it was not clear which model was consequently used to inform the intervention presented in their paper.

Research Question 3: In what ways have TF-CBT interventions for children been culturally adapted?

The level of detail provided by authors in describing the process of justifying, developing, and implementing cultural adaptations made to their respective TF-CBT interventions varied greatly between studies. Generally, the validity, reliability, and replicability of the adaptations developed across most studies reviewed could not be assured. Only four studies (Goodkind et al., 2019; Murray et al., 2013; Murray et al, 2015, Wang et al., 2016) reported using a framework, theory, or model to guide the process of developing cultural adaptations, which included the DIME methodology. Using the cultural adaptation checklist developed from the work of Rathod et al. (2019), it was established that seven studies provided enough information for the content of adaptations to be fully replicated. Four studies provided limited information that meant that adaptations were only partially replicable, and three studies did not provide enough information to replicate the content of their adaptations.

What adaptations were made?

The studies selected for review described a diversity of adaptations made to their respective TF-CBT interventions.

The most common adaption across studies was the use and inclusion of culturally relevant stories, allegories, metaphors and examples to illustrate or provide rationale for intervention strategies and techniques, which was described in all studies (except Goodkind et al., 2019; Morsette et al., 2008; Murray et al, 2015; Wang et al., 2016) as either removing or modifying examples of cognitive restructuring or distortions specifically. Other adaptations to enhance the relevance of CBT content and principles included: addressing different cultural beliefs about psychological phenomena (Bigfoot & Schmidt, 2010; Goodkind et al., 2019); adapting interpretation of irrational belief (Morsette et al., 2012); further developing the explanation and practice for "labelling feelings" (Morsette et al.,2008; Murray et al., 2015); enhancing clinician sensitivity regarding fit between "CBT causal explanations and local cultural epistemology" (Morsette et al., 2008; Wang et al., 2016).

Additions to enhancing cultural fit were also described in the studies reviewed. Such additions included: use of familiar games and songs (McMullen et al, 2013; O'Callaghan et al., 2013); use and inclusion of cultural practices (Bigfoot & Schmidt, 2010; Goodkind et al., 2019; Morsette et al., 2012) inclusion of tribal elders in intervention (Morsette et al., 2012); provision of target population's own cultural perspective on "trauma and healing" within intervention (Morsette et al.,2012); discussing cultural implications of expressing emotions to caregivers, (Murray et al., 2015); no discrediting of spiritual experiences (Morsette et al.,2012); adding linguistic concepts (Morsette et al., 2008; Murray et al, 2013); removal of psychological labels (Dorsey et al., 2020); naming intervention as a "class" (Dorsey et al., 2020); explaining the difference between local understanding of "counselling" and the

intervention proposed (Murray et al.,2015); gradual introduction of discussions relating to sexual abuse (Murray et al.,2015); inclusion of racial pride and achievement within psychoeducation (Stewart et al., 2021).

In relation to caregiver components to intervention, the following adaptations were described: gender matching child-parent dyads, where parent-child components are indicated by intervention (Damra et al, 2014); further development of the rationale for praise in parenting skill (Murray et al., 2015); group facilitator engagement with caregivers to promote familial acceptance of child and reduce stigmatization in the context of sexual assault (O'Callaghan et al., 2013).

An enhanced risk assessment and management procedure to ensure child safety was described in three studies, specific to cultural contexts and to index trauma events (Murray et al., 2013; Murray et al., 2015; O'Callaghan, 2013).

RQ4: How were cultural adaptations to TF-CBT developed?

The quality of the process described for developing cultural adaptations was reviewed using a purpose-made checklist derived from the framework developed by Rathod et al. (2019). The findings of the checklist suggest that five studies were fully in keeping with quality criteria, four were partially in keeping with criteria, and three studies did not provide enough information to evaluate this dimension.

The studies reviewed shared different methods of initially developing the adaptations required for their context. Most studies described formal meetings between the research teams and important cultural stakeholders (such as elders, teachers, local mental health professionals), described as consultation (Damra et al., 2014; Goodkind et al., 2019; Morsette et al, 2008; Murray et al., 2015), working partnership (Bigfoot & Schmidt, 2010), focus group (Dorsey et al. 2020) or field interviews (Murray et al., 2013; Wang et al., 2016).

Stewart et al. (2021) developed adaptations idiosyncratically with clients. O'Callaghan et al. (2013) described some of the adaptations being developed during supervisory meetings between research team and lay counsellors. McMullen et al. (2013) and Morsette (2012) did not describe their development process. Stewart et al. (2021) did not provide enough information in this domain for evaluation.

What frameworks, theories or models informed the development of adaptations?

Most studies did not report using a specific framework, theory or model to inform this process the process of developing cultural adaptations. Murray et al. (2015) and Murray et al. (2013) describes using the Apprenticeship Training Model (Murray et al, 2011) and DIME methodology, the latter also being used by Wang et al. (2016).

What were the reported justifications for developing adaptations?

A range of justifications were provided for culturally adapting TF-CBT interventions. All studies referred to the prevalence of trauma in the target population. Other rationales for adaptation included: meeting an identified gap in the literature for TF-CBT effectiveness for the target population (Goodkind et al., 2019; McMullen et al., 2013; Morsette et al, 2012; O'Callaghan et al., 2013); meeting an expressed need or wish from the target population, as documented in a published work (Goodkind et al., 2019; Morsette et al., 2008; Wang et al., 2016); acting on organizational recommendations to promote TF-CBT for trauma (Dorsey et al., 2020; Morsette et al., 2012); acting on a statement that the target population's practices have been ignored in previous efficacy research (Morsette et al., 2012); and that previous studies appear to support its effectiveness (Murray et al., 2013); and reducing barriers to accessing intervention (Stewart et al., 2021).

Research Question 5: How are these adapted interventions experienced by children, young people and their families?

Most studies selected for review did not include a design component to explore participant, caregiver or familial experience of the adapted intervention. The researchers from Goodkind et al. (2019) reported using a focus group to establish the acceptability of the intervention to the young people who completed it. They reported that child attendees experienced the intervention as enjoyable, helpful, and that they would re-access a similar intervention in the future. Unfortunately, the validity and reliability of these findings could not be established as there was no qualitative methodology and associated analysis or control group provided in the paper to support these assertions. Stewart et al. (2021) collected participant and caregiver experiences of the intervention with consequent findings suggesting intervention acceptability, however these were limited by no reports of method of data collection or means of analysis.

Research Question 6: What are the reported clinical outcomes following adapted TF-CBT completion?

Eight clinical outcomes of interest were reported across the studies selected for review. Post-traumatic stress was the most commonly featured clinical outcome measured, followed by depression and anxiety. Table 3 provides summarising information for what measures were used and what outcomes were reported.

Table 3.

Summary of outcome measures.

Variable of interest	Reported clinical outcomes
Post-traumatic stress	All studies, except Bigfoot & Schmidt (2010) (who used no outcomes at all), used an outcome measure for post-traumatic stress symptoms. Measures used included: Childhood PTSD Ssymptoms Scale (Foa, Treadwell, Johnson, & Feeny, 2001; UCLA-PTSD Reaction Index (Revised; Pynoos & Steinberg, 2002) and PTSD-RI (Steinberg et al, 2013). Compared to baseline measures, completing the TF-CBT intervention was associated with reduced distress as conceptualized and measured as post-traumatic stress, when measured shortly after intervention completion, across all studies. Where follow-up outcome measures were completed, reductions in post-traumatic stress symptoms were maintained at one month (Murray et al., 2015), three months (Dorsey et al., 2020; Goodkind et al., 2019), McMullen et al., 2013; O'Callaghan et al., 2013), 4 months (Murray et al.,2015), and six and twelve months (Dorsey et al, 2020). Therapeutic gains were not maintained at the six month follow up in Goodkind et al. (2019) . Improvements reported in Dorsey et al. (2020) were corroborated by guardian-provided feedback as measured in the Child PTSD symptoms scale.
Depression	Seven studies used an outcome measure for symptoms of child depression. Measures used were: Child's Depression Inventory (Kovacs, 1992); Short Mood and Feeling Questionnaire (Angold et al, 1995); and the Child Behavior Checklist (Achenbach, 1992), which is a caregiver measure. Child-reported improvements on measures of depression following TF-CBT were reported by Damra e al. (2014), Goodkind et al. (2019), Morsette et al. (2008), Morsette et al. (2012),Murray et al. (2015), and Stewart et al. (2019). Gains were reportedly maintained at three months follow up (Dorsey et al., 2020; Goodkind et al., 2019) and four months follow up (Damra et al., 2014), and six and twelve months follow up (Dorsey et al., 2020).
	Caregiver-reported improvements in this dimension post-intervention and at three, six, and twelve month follow up were reported in Dorsey et al. (2020) Although Murray et al. (2015) used the Child Behavior Checklist, a "very low" response rate meant that this data was not analysed.
Anxiety	Goodkind et al. (2019), McMullen et al. (2013), and O'Callaghan et al. (2013) attended to anxiety symptoms as an outcome of interest. This was measured by the Multidimension Anxiety Scale for Children (MASC; March &

	Parker, 1999) in Goodkind et al. (2019)., whereas studies McMullen et al. (2013) and O'Callaghan et al. (2013) used subscale items of the African Youth Psychosocial Assessment (AYPA; Betancourt et al., 2009). Improvements in self-reported anxiety post-intervention and at three month follow up were documented in all three studies.
Conduct	McMullen et al. (2013) and O'Callaghan et al. (2013) explored the impact of TF-CBT on conduct problems, as measured by the externalizing subscale of the AYPA (Betancourt et al., 2009). Improvements in conduct problems were reported in both studies following TF-CBT. However, at the three month follow up carried out by both studies, therapeutic gains were only maintained for O'Callaghan et al. (2013).
Complicated Grief	Dorsey et al. (2020) examined the effects of TF-CBT for children experienced prolonged grief. Measured using the Inventory of complicated grief (Melhem et al., 2013), TF-CBT was associated with improvements in experiencing of complicated grief, maintained at three, six, and twelve-month follow up points.
Psychosocial Functioning	McMullen et al. (2013) and O'Callaghan et al. (2013) explored psychosocial functioning as a variable of interest, as measured by the AYPA (Betancourt et al., 2009). Prosocial behaviour was found to increase following completion of TF-CBT and at three-month follow up for both studies.
Parent-Child Relationship	Dorsey et al. (2020) explored the impact of their TF-CBT intervention on the relationship between the participating child and their primary caregiver, measured using the Child-Parent relationship scale (Pianta, 1992). Findings suggest that Kenyan children and their caregivers reported enhanced levels of closeness as a result of the intervention.
Spiritual Struggles	Wang et al. (2016) use of the RCOPE measure to assess participant's reports of spiritual struggles suggest that TF-CBT reduced distress in this area.

Discussion

Outcome of appraisal

Although all the selected studies presented interesting insights in the area of culturally adapted TF-CBT interventions for children, a number of developmental, methodological and analytic problems compromise the methodological quality of the research, the quality of the process for developing cultural adaptations, and the replicability of the adaptations created.

The studies assessed as demonstrating the strongest quality in each of these dimensions simultaneously were Murray et al. (2015) and O'Callaghan et al. (2013). Both studies demonstrated effectiveness of locally adapted TF-CBT interventions reviewed for children living in Zambia and in the Democratic Republic of Congo. Adaptations were characterized by modifications of content to enhance cultural relevance; inclusion of culturally relevant and known games and songs; provision of risk reduction strategies to promote child safety in context of local risks. Both of these studies were randomised controlled trials with relatively large sample sizes providing credible findings, supported by methodologically driven cultural adaptations that are described in enough detail for replication. Therefore, this review suggests that these two studies currently represent the best examples of research into culturally adapted TF-CBT interventions. The total number of participants represented by these studies is 309. Due to the heterogeneity in cultural adaptations and development processes, findings of these two studies cannot be collated within a meta-analysis at this point. A further two studies were promising. Dorsey et al. (2020) and McMullen et al. (2013) were of good methodological quality. The intervention described in Dorsey et al. (2020) was significantly associated with reductions in distressing symptoms, however the limited description of adaptations and development process meant it was not possible to establish quality in development of adaptations, nor where they

replicable. McMullen et al. (2013) provided more detail in providing examples of adaptations which meant that they were partially replicable, although the process for adapting these could not be evaluated. These studies provided further support for the cross-cultural effectiveness of TF-CBT on measures of psychological distress (specific to post-traumatic stress, low mood, and anxiety). Across Dorsey et al. (2020), McMullen et al. (2013), Murray et al. (2015), and O'Callaghan et al. (2013), effect sizes in support of effectiveness were reported as medium to large following intervention, and then large effects at one, three, and twelve month follow ups.   Although no specific reference was made in these studies as to the contribution of a trusting relationship to intervention effectiveness, it is likely that the therapeutic relationship did so. It is known that therapeutic relationships are essential in promoting positive change across evidence-based psychological therapies (Ardito & Rabellino, 2011).

Damra et al. (2014) and Murray et al. (2013) provided good examples of describing the adaptations made and how these were developed, however these studies were conversely limited by methodologies assessed as being of low quality. Nonetheless, these studies provided important insight into adaptation development processes which seemed collaborative and attuned to the communities they aimed to support and were in keeping with Rathod et al.'s (2019) evidence-based framework.

The findings from this review indicates that culturally adapted TF-CBT was experienced as helpful. This further suggests that adapting TF-CBT can be coherent with the theory of cultural scripts of traumatic stress (Chentsova-Dutton & Maercker, 2019). It may also suggested that TF-CBT has incorporated universal knowledges about managing reactions to difficult events- such as confronting one's fears to overcome them, which would be known as exposure work in CBT terms. Studies described adaptations as a means of increasing the cultural fit of the intervention, and this was done by modifying aspects of TF-CBT such as

metaphors, linguistic terms, and practices. This means that the interventions offered fit with participant's understandings of trauma exposure and how to intervene with the difficulties that arise from it. This is supported by the relatively low attrition rates from methodologically-sound interventions: 9.16% reported by Murray et al. (2015); 16.6% O'Callaghan et al. (2013); 4.77% Dorsey et al. (2020); 4.16% by McMullen et al. (2013). Two of these studies attributed intervention drop as unrelated to experience of intervention.

It is noted that most of the studies reviewed used quantitative designs in evaluating the effectiveness of TF-CBT. This emphasis on positivist approaches to developing knowledge may only shed light on some aspects of investigating the helpfulness and experience of a culturally adapted intervention. Other philosophical perspectives could be helpful in enriching the understanding of important cultural dimensions in the application of TF-CBT. Social constructivism could offer an interesting perspective in exploring how individuals create knowledge and resolve dissonances related to TF-CBT in the context of culture, and specific to cultural scripts of traumatic stress. In practice, this would mean the use of qualitative research designs to explore this area of enquiry.

None of the studies that met criteria for review were based in the United Kingdom. According to Lewis et al. (2019), approximately 31% of children in England and Wales are exposed to at least one traumatic event by the time they reach eighteen years of age. A review of qualitative research by Coelho et al. (2022), inclusive of three studies related to post-traumatic stress, explored minoritized children's and parent's experiences of accessing child mental health services in the UK. This review suggested that ethnic inequities in access was influenced by "a lack of understanding of mental health problems, lack of information about services, lack of trust in care professionals, social stigma and cultural expectations about mental resilience" (Coelho et al., 2022). Overall, this suggests that there is an unmet need for culturally coherent TF-CBT interventions for young people in England and Wales. This is

especially important given that TF-CBT seems to retain effectiveness with adaptations. This need can be met by both clinicians and researchers.

Implications for clinical practice

The following recommendations are made for clinicians who deliver TF-CBT interventions.

- TF-CBT can be helpfully culturally adapted and remain effective. Adaptations aimed at children can include modifying analogies, games, practices and activities to enhance cultural relevance, using music to label emotions, incorporation of religious themes in cognitive restructuring, incorporation of risk mitigating strategies to reduce vulnerability, and more gradual introduction of conversations related to sexual abuse. Adaptations aimed at parents can include fostering familial acceptance and contact, reducing stigmatization of the nature traumatic event, and promoting praise as a skill within parenting.
- Both individual and group TF-CBT interventions seem amenable to being culturally adapted.
- Culturally adapted TF-CBT can be helpful to young people who present with symptoms of post-traumatic stress and concurrent low mood and anxiety.

Implications for research

There is an urgent need for more and better-quality research in this area. Several theoretical, conceptual, methodological, and analytic flaws means that the findings reported by the studies selected for review are very limited in their quality and generalisability.

Based upon the findings from this review, the following recommendations are made for future research efforts in this area:

- Future research should ensure that all relevant information relating to participant characteristics be appropriately reported in the publication. Several studies reviewed did not provide such information, which meant it was not possible to ascertain sample representativeness. This is a key problem to overcome, as without such information others cannot establish who the findings are relevant and applicable for.

- Future research should clearly identify and describe the model or approach to TF-CBT that was studied. This means that studies have the capacity to be replicated in research and in clinical practice.

- Future research should provide sufficient detail for adaptations and the process for developing them can be replicated.

- Studies should aim to recruit greater sample sizes as the majority of studies reviewed reported small samples.

- Studies should explore the effectiveness and experience of TF-CBT for people who identify as culturally different to the Global North areas they live in.

- Future research should seek to obtain data from parents, where appropriate and feasible, to further corroborate reported improvements following completion of a culturally adapted TF-CBT intervention.

- Research should carefully consider inclusion and exclusion criteria for study participation. For example: as sexual assault predominantly affects females, to use this as an exclusion criterion runs the risk of privileging the study of trauma types that most commonly affect males, which compounds gender inequities in accessing evidence-based treatment. Therefore, researchers should ensure participation criteria do not inadvertently perpetuate health inequities in relation to participant characteristics.

- It is possible that an over-reliance on quantitative methodologies in this area of study means that intervention-specific mechanisms, processes, or components that attenuate or inhibit participant improvement are obscured from the data. This also means that child, caregiver, and family experiences of the intervention are not captured, which presents highly significant limitations in establishing whether cultural adaptations and the consequent intervention provided are acceptable and relevant to the target populations researchers are attempting to help. Therefore, future research should make effective use of qualitative methods to address this problem.

- Future research should seek to investigate whether culturally adapted forms of TF-CBT yield superior clinical outcomes compared to non-adapted TF-CBT. This could take the form of meta-analytic research once enough studies have been carried out in this field.

- Future studies should ensure that the process of developing cultural adaptations is suitably grounded in psychological theory and the evidence base where this is available. One such framework that can be used is Rathod et al.'s (2019) "Evidence based framework to culturally adapt cognitive behaviour therapy".

Conclusion

This critical review identified ~~four~~ two studies of acceptable quality and replicability that suggest that culturally-adapted trauma-focused cognitive behavioural therapy can be effective in treating a range of psychological difficulties associated with exposure to traumatic events. Two further studies present promising findings that provide additional support for the effectiveness of culturally adapted TF-CBT, although their respective adaptations and development processes could not be assessed for quality or replicated. A number of cultural adaptations are identified as being supported by the available, albeit limited, evidence. Further rigorous research using both quantitative and qualitative methodologies is required to expand and provide further detail on the effectiveness and experience of accessing culturally adapted TF-CBT.

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JORDAN QUINN MSc BSc Hons

EXPLORING CULTURAL ADAPTATIONS AND THE CULTURAL FIT OF TRAUMA-FOCUSED COGNITVE BEHAVIOURAL THERAPY

Section B: An exploration of parents' understanding of therapeutic support following the Grenfell Tower fire, including a consideration of cultural adaptations made to the TF-CBT model that was employed.
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Abstract:

Aims:

Trauma-focused cognitive behavioural therapy (TF-CBT) is a recommended intervention for difficulties arising from exposure to traumatic events. This study explored parent's views about the cultural dimensions of their children's psychological assessment and TF-CBT intervention with the NHS Grenfell Health and Wellbeing Service following the Grenfell Tower Fire.

Methodology:

Six parents took part in research interviews. The data was analysed using reflexive thematic analysis.

Results: A total of three themes were developed from the data, which were: starting from a place of mistrust; the therapeutic benefits of a working parent-clinician alliance; and trusting in the process of change. Together, the themes meant that cultural fit was experienced as a relational process underpinned by trust. Participants generally reported that the assessment and intervention as being of good cultural fit. Participants shared aspects of the intervention that were particularly valued (relationship with clinician) and that would benefit from further development (incorporation of pro-social values; temporary nature of some strategies).

Conclusions:

Findings suggest that clinicians should actively discuss issues relating to culture and trust with the families they support in the delivery of TF-CBT. This study also emphasizes that parent experience of cultural fit is at least partially a relational process underpinned by trust.

Introduction

On the 14th of June 2017, a fire broke out in a block of flats called Grenfell Tower. This fire claimed the lives of 72 people and resulted in the displacement of over two hundred families who lived in the tower and its immediate surroundings (Full Fact, 2018). This constituted the worst domestic fire since the Second World War (Royal Borough of Kensington and Chelsea, 2019). According to the Guardian newspaper, 85% of individuals who died in the fire were from ethnic minorities (The Guardian, 2020), giving credence to the Equality and Human Rights Commission's view that members of Black and Minority Ethnic groups were disproportionately affected by the fire (2019).

The clinical context: The Grenfell Health and Wellbeing Service

The initial clinical response from public services was provided by local authority and existing health services, inclusive of Kensington & Chelsea and Westminster CAMHS teams. The NHS estimated at the time that at least 11000 people were likely to develop significant mental health difficulties because of the Grenfell Tower Fire (Donelly, 2017). This precipitated the creation of the NHS Grenfell Health and Wellbeing Service (GHWS), which was initially tasked to screen and treat trauma-related difficulties in the communities living near the tower. Within this service, the children and young person's team (CYP) offered trauma-focused cognitive behavioural therapy (TF-CBT) as one proposed treatment for children who experienced psychological difficulties following the Grenfell tower fire. The TF-CBT intervention umbrella included specific interventions such as Cohen and Mannarino's model of TF-CBT (2015), the Children and War Foundation's Teaching Recovery Techniques protocol (Smith, Dyregrov, & Yule, 2002), Narrative Exposure Therapy adapted for children (Schauer, Neuner, & Elbert, 2017), and Child Accelerated Trauma Treatment (Raby & Plant, 2021). Whilst the offering of TF-CBT is in line with National Institute of Clinical Excellence recommendations for children exposed to traumatic

events (NICE, 2018), it also presented a dilemma in the application of theory to practice: can

a theory that is centralized on Global North[2] philosophy, and tested for efficacy on a majority

eurocentric sample (Stamm & Friedman, 2000), be a culturally sound trauma intervention for

the multiple ethnic minoritised communities affected by the fire?

Research in the GHWS as an opportunity to engage with different views about TF-CBT

The Race Equality Foundation (2022) stated that "black and minority ethnic

communities have significantly poorer mental health outcomes and poorer experience of

services" and are also less likely to access mental health services (Murray, 2020). Minoritised

communities access to traumatic stress services in the UK appears unreported, and did not

feature in the NHS Race & Health Observatory report attending to "ethnic inequalities in

healthcare" (2022). Data shared by the GHWS indicated that by January 2020, nine thousand

residents living in the North Kensington area had been seen by their service (NHS West

London Clinical Commissioning Group, 2020), including 744 children who had accessed

trauma-related treatment (ITV news, 2020). From a research lens, this unique service firmly

embedded in the community offered an opportunity to explore cultural aspects of trauma for

children from a multi-ethnic viewpoint.

Culture and Trauma

Heine (2011) defines cultural psychology as the study of the relationship and

influence between a culture and the psychological processes of the members of a culture. A

general critique levelled at Global North psychology is the lack of replication of its findings

across places and cultures (Shweder, 1991). In Global North communities, difficulties

associated with exposure to traumatic events are often conceptualized as post-traumatic

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[2] In keeping with Wallerstein (1992) this thesis will refer to countries previously referred to as 'Western' or 'Developed' as Global North which is more geographically accurate. Countries previously referred to as 'Developing or Undeveloped will be referred to as the Global South.

stress. In children, this is identified by the presence of intrusive thoughts or memories of the trauma, avoidance of reminders of the trauma, and hypervigilance (Dyregov & Yule, 2006), although observed symptoms may present differently in very young children (Scheeringa et al, 2003). There remains ongoing debate about post-traumatic stress (PTS) in the context of culture. Foa et al (2009) argue that PTS is universally experienced across culture, which is contrast to Patel & Hall's (2021) view that its utility is limited due to origins in Global North psychiatry.

Beyond the Global North understanding of trauma, many culturally salient experiences are reported to be essential in responses to trauma. Examples include the role of religion in meaning-making after a disaster (Park, 2016), heightened stress responses in Aboriginal families with a history of intergenerational trauma in Canada (Bombay et al, 2013), "ataque de nervios" in Hispanic culture (Schechter et al, 2000), the manifestation of "bad karma" in Nepalese families following the Maoist civil war (Kohrt & Hruschka, 2010), and inter-community mistrust following the Rwandan genocide of 1994 (Rieder & Elbert, 2013). It has been argued that screening measures and interventions informed by individualistic cultures are inappropriate for assessing and intervening with the psychological impact of trauma in children in collectivistic societies (McKay & Wessells, 2004). This has led to calls for a trans-cultural approach to being curious about different understandings of trauma (Wylie et al, 2018); this may be answered by contextual and non-diagnostic conceptualisations of difficulties typically offered in systemic and holistic psychology approaches.

Theory of Cultural Scripts

Chentsova-Dutton & Maercker's (2019) theory of cultural scripts for traumatic stress emphasises the necessity for clinicians to attend to cultural dimensions of help-seekers relationship to distress to better offer support. Cultural scripts for traumatic stress are

described as a means for individuals to understand distress, as well as for setting a norm for members of a community or culture to adhere to in terms of consequent actions that require taking. This theory is positioned alongside cultural models of trauma and schema theory within cognitive psychology, whilst also bearing resemblance to Byng-Hall's theory of family scripts (1985). Scripts are described as subjective, intersubjective, and as cultural concepts and behaviours related to understanding and responding to mental health difficulties. Scripts are likely to affect a person's wellbeing, regardless of that person's attitudes to them. Rechsteiner et al (2019) described remaining silent following sexual assault as an example of a cultural script in an indigenous Indian community. The authors suggest that cultures may also hold multiple scripts about the changes that occur in individuals after exposure to trauma, with the nature, availability, and detail of these differing across cultures.

Due to limited research, it is unclear if children from cultures and heritages that are not Global North have poorer outcomes compared to those who do when accessing TF-CBT. Systematic reviews by Chipalo (2021) and Genç (2022) argue there is preliminary evidence for the effectiveness of TF-CBT for child refugees but that it is limited. While some studies claim that TF-CBT can be cross-culturally effective (Woods-Jaeger et al, 2016), to the author's best knowledge there are no studies exploring the views of the families accessing the intervention in relation to their experience of the cultural fit. It follows that negative outcomes from TF-CBT could be related to a lack of convergence between the cultural scripts about traumatic stress espoused by TF-CBT and those held by families, some of which may not be available to the child. In this study, discussions about TF-CBT and cultural fit would be aimed at establishing the views of families within the specific cultural context of North Kensington residents accessing an NHS-provided TF-CBT intervention. It is hoped that the range of cultural communities in North Kensington may generate findings that may be relevant to a range of UK communities accessing the NHS in the future.

The importance of parents in supporting a child's recovery from exposure to traumatic events

Bowlby's attachment theory (1958) puts the relationship with a parental figure in the forefront of a child's healthy social and emotional development. One of the many functions a parent holds for a child is in supporting them to explore and make sense of their environment and the world. Therefore, the role of the parent in supporting a child to recover from exposure to a traumatic event is likely to be highly important. Indeed, parental decision making has been associated with increase or decreases in likelihood of post-traumatic stress symptoms (Scheering and Zeanah, 2001), opportunities to be supported with coping strategies at home (Cobham et al, 2016), and access to specialist treatment for PTSD (Williamson et al, 2019). Therefore, parental views about a therapy intervention are likely to influence child access to it. However, parental views about their children's therapy generally seems to be an under-researched gap in the literature requiring further enquiry. This study aims to specifically attend to parental views in relation to TF-CBT for their children in the context of culture.

Rationale

The proposed research aims to explore parents' views of the cultural fit and possible limitations of using trauma-focused cognitive behavioural therapy for supporting their child with difficulties associated with exposure to a traumatic event.

This study seeks to contribute to a small but growing area of research exploring the cultural relevance of trauma-focused cognitive behavioural therapy by identifying areas for consolidation and further development. In recognising and working with unique cultural scripts, clinical practice may be improved, and as a result there may be an enhancement of engagement and outcomes for a more diverse group of children and their families.

Therefore, the research questions posed by this study were:

1. How do parents understand the clinician's explanation of their child(ren)'s reaction(s) to the Grenfell Tower Fire; how did this fit (or not) with their own family and cultural understandings?

2. How do parents understand and experience the clinician's recommendation that their child(ren) should access trauma-focused cognitive behavioural therapy; how did this fit (or not) with their own family and cultural understandings of how to help children?

3. How do parents report how any similarities and/or differences in understanding affected how they supported their child(ren) during the time they received therapy?

Methodology

Design and epistemological position

The study interviewed parents of children affected by the Grenfell tower fire who had begun or finished trauma-focused cognitive behavioural therapy using a semi-structured interview schedule. The study used a reflexive thematic analysis method (Braun & Clarke, 2019) to explore and conceptualise the accounts of parents. This methodology was selected for a number of reasons. This method's constructivist approach fitted well with considering how parents of children constructed and learnt new knowledge about exposure to, and recovery from, traumatic events in the context of cultural scripts. The methodology values and acknowledges researcher subjective experience (Gough & Madill, 2012) which is in keeping with the researcher's own values and prior clinical experience related to the Grenfell Tower fire. Reflexive thematic analysis has been used effectively in attending to questions of culture (Campbell et al, 2021; Rangiwai et al, 2021) with a view of organising findings around central organising concepts developed across accounts (Braun & Clarke, 2019).

The application of reflexive thematic analysis is coherent with a constructivist epistemology (Arksey & O'Malley, 2003), which is the position adopted in this study. The premise of this research is that interpreting health and mental health are heavily influenced by cultural understandings. The researcher begins from a premise that there are no universal psychological truths about how persons or communities deals with difficult situations such as traumatic events, and that such responses are developed through an active process of learning and constructing knowledge from experience. The research takes a critical orientation by starting from the premise that language can be an important pathway by which our social realities are created (Terry et al, 2017).

Researcher position in relation to the research

Given the constructivist epistemology of this research, it is presumed that findings from this study will be in turn constructed through the lens of a researcher who holds their own constructs of traumatic stress from their own cultural background and experiences. Dimensions of identity and experience which inform the researcher's understanding of traumatic stress and Grenfell include identifying as: Male, White Irish and British, middle-class, and Francophile. The researcher trained as clinical psychologist in the UK, preceded by working for 20 months in the Grenfell Health and Wellbeing Service. Reflections on the ongoing positioning of the researcher are included in the reflective log (Appendix 4) and bracketing interview (Appendix 5) which have informed reflections shared in this study.

Participants

Criteria for participation.

Purposive sampling was used to recruit participant to the study due to the specific nature of the experience being explored. The inclusion criteria for participation are described in Table 1. Ethnicity was not used as either an inclusion or exclusion criterion as this study adopted a conceptualisation of culture as a "shared set of values, ideas, concepts, and rules of behaviour that allow a social group to function" (Hudelson, 2004), meaning that identification with a specific culture does not equate to membership of a specific ethnic group. This fits well with the multi-cultural and multi-ethnic make up of the population in North Kensington.

Table 1.

Inclusion criteria.

Inclusion criteria relating to the child	Inclusion criteria relating to the parent
The parent/carer's child was:	The parent:
- under eighteen years of age at time of fire (14/06/2017). - living in the North Kensington area at the time of the fire. -had begun or completed individual or group Trauma-Focused Cognitive Behavioural Therapy for Grenfell-related psychological difficulties with the GHWS. Therapy models include standard TF-CBT (Ehlers and Clark), Narrative Exposure Therapy, Child Accelerated Trauma Treatment, and Teaching Recovery Techniques protocol.	- was able to communicate in a level of English that allows them to express their feelings and experiences, - was willing to be interviewed with an interpreter. - attended all or part of the assessment appointment with GHWS.

Establishing sample size

The project reviewed a number of previous papers within a similar topic area to establish appropriate participant numbers. Williamson et al (2017) interviewed six parents of children accessing psychological intervention for exposure to a traumatic event, and Thoresen

et al. (2022) interviewed eight adults about their experience of trauma treatment. The

information power model (Malterud et al, 2016) was also used to estimate an appropriate

sample size. The information power model proposed by Malterud et al (2016) is a qualitative

research framework used to estimate the number of participants that are likely to be needed to

obtain data of sufficient richness and depth., This method is suggested as an alternative to the

concept of saturation and is proposed by Braun & Clarke (2019) as a recommended

framework for considering sample size in reflexive thematic analysis studies.

This model states that the higher the information power, the fewer interviews are

needed to obtain sufficiently rich data. Information power was gauged by considering five

domains of study design which include breadth of research aims, specificity in participant

characteristics, degree to which the study is grounded in existing theory, quality of dialogue

in the interview, and use of either case or cross-case analysis. Against these dimensions, this

study was gaged as requiring a relatively small sample size (see Table 2).

Table 2.

Assessment of study information power

Dimension of Information Power Model	Author's assessment in relation to dimension	Outcome of author's assessment in relation to dimension
Breadth of research aims	The aims of the study are narrow, insofar as they are interested in the views of parents and guardians of children who have had children access a specific trauma-focused therapy, namely trauma-focused cognitive behavioural therapy. In addition, the study is particularly interested in their views in relation to their experience of the cultural fit of the therapy.	Indicative of higher information power
Specificity in participant characteristics	The specificity of the sample is considered "dense". The sample is made of parents of children who accessed-trauma focused cognitive behavioural therapy. All participants were recruited from the Grenfell Health and Wellbeing Service. All participants either lived or went to school in the North	Indicative of higher information power

	Kensington Area that was affected by the Grenfell tower fire. This means that there is a commonality of experience in relation to: exposure to similar traumatic events, being a parent of a child exposed to traumatic events, and their children accessing a Trauma-Focused cognitive behavioural therapy.	
Degree to which the study is grounded in existing theory	There is substantial theoretical grounding to this study. A review of the literature (see Part A) found several studies that highlight the experience of a trauma-focused therapy in the context of cultural norms, values, and understandings. Theories supporting study include the cognitive model for post-traumatic stress, and cultural scripts for traumatic stress.	Indicative of higher information power
Quality of dialogue in the interview	This study is considered as having strong dialogue. The interviewer spent twenty months working in the Grenfell Health and Wellbeing Service as an Assistant Psychologist prior to this research study, which meant that they were very familiar with the local area, the impact of the Grenfell tower fire, and the associated narratives and contexts related to it. The researcher had good clinical experience and knowledge in relation to exposure to trauma, which meant that conversations around these topics were familiar. The researcher identifies as a White British / Irish male, commited to anti-discriminatory practice and had an explicit stance with participants that he was interested in hearing a range of views about trauma-focused therapy, framed as wanting to know about areas to consolidate and further develop.	Indicative of higher information power
Case or cross-case analysis	The proposed analysis is cross-case.	Indicative of lower information power

Taking into account previous research and recommendations from the Information Power model, a small sample size was gaged as sufficient to develop rich enough data to meet the aims of the project.

Recruitment method

All participants who were eligible for the study and were still open to the service were approached by the clinician they were most familiar and offered the participant information sheet (Appendix 6). Interested parents agreed to have basic contact information shared with

the principal researcher for follow up discussion about the study. Parents who had recorded consent to be contacted by the service received an initial SMS message with a brief message explaining the opportunity to take part (see Appendix 7). Follow up calls were made at least one week after SMS were sent to establish if parents were interested in taking part.

Procedure

Ethics approvals and guidelines

Ethical approval was provided by the Stanmore NHS Research Ethics Committee. The researcher adhered to the British Psychological Society (BPS) code of ethics (BPS, 2021).

Study procedures

Parents and caregivers who wished to take part were offered either a face-to-face or a videocall interview according to their preference. Participants completed consent forms (Appendix 8) in person or digitally. All participants were offered a copy of the interview schedule (Appendix 9) ahead of the interview.

Participant consent was re-established at the beginning of the interview. The interview schedule was followed flexibly and was recorded using an encrypted audio device. In keeping with the epistemological position and being mindful of possible inhibiting power dynamics in the context of perceived difference, the researcher made explicit at the beginning of the interview that there was a valuing in hearing a range of views, which was re-stated reflexively at times during the interview when interviewees seemed hesitant or withholding. Participants were debriefed and provided with a debriefing form (Appendix 10). Participants were asked for their consent to share their email address to receive a £10 "thank you" voucher for their time.

Data Analysis

The six phases of Braun and Clarke method (2019) ("familiarisation with data; coding; generating themes; developing and reviewing themes; refining, defining and naming themes; and writing up") were used for analysing data with the principal researcher moving between phases as necessary. Analysis was primarily inductive to promote openness and valuing of participant views, although deductive analysis was deployed where the researcher perceived views being clearly linked to awareness or comments of aspects of TF-CBT. Latent and semantic coding were both used according to whichever coding type seemed to respond best to the research questions.

The researcher initially familiarised himself with, and coded, the transcripts as and when these were available (as recruitment was conducted over a number of months). Initial codes were identified and recorded as single units of meaning, which led to early iterations of themes and thematic maps which were then re-developed and reviewed upon familiarisation and coding of new transcripts. All transcripts were then re-coded to explore fit of themes, subthemes, and codes to the original data. Further review meant that promoting and demoting of sub-themes to codes, and vice-versa. Provisional themes, subthemes, and codes were then discussed in a supervisory context to support the researcher to reflect on their understanding of these and interpretation of the original data. This led to researcher to seek further conceptual depth in re-organising codes and sub-themes to generate, redefine, and name coherent themes around central organising concepts. Further reflecting on the data led to a realisation that much of participants communications were implicitly discussing relational processes with their child's clinician, which was then reflected in codes, sub-themes, and themes.

Quality Assurance

Quality assurance was ensured by reflexive adherence to Yardley's principles

of "sensitivity to context, commitment and rigour, transparency and coherence, impact and

importance" (2007) through regular use of bracketing interviews (Tufford &

Newman, 2010) and a reflexive research diary throughout the research (see extract in

Appendix 4). The researcher noticed their understanding of post-traumatic stress shift from a

positivist to a social constructivist epistemology as the study developed. This meant that he

could better interrogate his own white European understanding of what traumatic stress may

present as and better attune to the participants they met with. This promoted more explicit

discussion and acknowledgement of cultural differences in experience and scripts meaning

that greater rapport could be developed. Consultation with the service community lead (who

was from a minoritised community), and the service research panel offered additional

perspectives, for example, suggestions to ensure that the language used was non-diagnostic

and that participants were offered a copy of the interview schedule ahead of time to allow

them time to reflect on their relationship to culture.

Results

Six people were recruited to study. Four parents initially consented to the study but withdrew prior to the interview. A further 10 parents expressed initial interest in participation but then declined participation or were lost to follow up upon receipt of the PIS.

Given the sensitive nature of the study, the relatively limited amount of people affected by the Grenfell Tower fire, and the specificity of recruiting participants from the Grenfell Health and Wellbeing Service only, the presentation of demographic data provides as much information as is possible to demonstrate diversity in sample characteristics, without de-anonymising participants. Brief summaries of participant's context are provided (Table 4). Ethnic similarities or differences between clinicians and families were established during interviews. Table 3 illustrates the recruitment processes.

Table 3.

Recruitment processes.

Stage of Recruitment	Recruitment Method		Participation declined / withdrawn
	Direct contact from researcher	Clinician referral	
Screening & Approach	Clinical notes were screened. All eligible clients were contacted by SMS.	All clinicians in the service discussed study with clients who were eligible and open to service.	• Not applicable.
Expressions of interest	No responses to SMS. With follow up calls, 10 parents requested PIS.	Clinicians referred 10 parents who wished to receive PIS.	• 10 parents explicitly declined offer of PIS in follow up call. • Remaining eligible cohort either requested call backs and were lost to further follow up; were not contactable with the information available; or declined PIS when approached by clinical staff.
Recruitment to Study	(N=4)	(N=4)	• 12 parents who received PIS declined participation.
Completion of Interview	(N=2)	(N=4)	• 2 parents did not attend interview and were lost to follow up.

Table 4.

Summaries of participant's socio-demographic context and exposure to the Grenfell tower fire.

Participant	Participant socio-demographic context	Participant exposure to the Grenfell Tower Fire	Dimensions of similarity and difference in ethnicity between young person and clinician
Participant 1	Participant 1 was a White British mother who is born and raised in the North Kensington area, and continues to live there.	They lived close enough to the tower that they could see the fire from their home's windows.	Their children accessed TF-CBT with two clinicians. One has a similar ethnicity and the other a different ethnicity.
Participant 2	Participant 2 was a White Western-European mother who moved to the area approximately thirty years ago.	She could see the fire from their home, and her children attended schools that were significantly impacted in the immediacy of the fire.	Her child had a therapist of similar European ethnicity.

Participant 3	Participant 3 was a woman who was was raised in a country in the Middle-East, who decided to move to the area in the early 2010s.	She could see the fire from her home	Her child had a therapist of a different ethnicity to their own.
Participant 4	Participant 4 was a Black British woman of Caribbean descent, who was born and raised in the area, and continued to live there	She lived in an estate close to the tower and were evacuated on the night of the fire. A close relative died in the fire.	Her child had a therapist of a different ethnicity to their own.
Participant 5	Participant 5 was an East African woman who has not lived in the area for an extended period of time.	She and her children saw the tower on fire the following morning from outside their home, once they were alerted to what had happened.	Her child had a therapist of a different ethnicity to their own.
Participant 6	Participant 6 was a Black British woman of Caribbean descent	She and her family were evacuated on the night of the fire. She and her child lost friends in the fire.	Her child had a therapist of a different ethnicity to their own.

who has lived in the area for

many years.

Thematic Analysis

A total of three themes were developed from the data, which were titled: 'Starting from a place of mistrust'; 'The therapeutic benefits of a working parent-clinician alliance'; and 'Trusting in the process of change'. Each theme is supported by sub-themes, with some subthemes being relevant across more than one main theme. The three themes are conceptually related to one another, which is illustrated in the thematic map (Figure 1). Together, the themes support an overarching concept: that cultural fit in this study was a relational process underpinned by trust.

Figure 1.

Thematic Map.
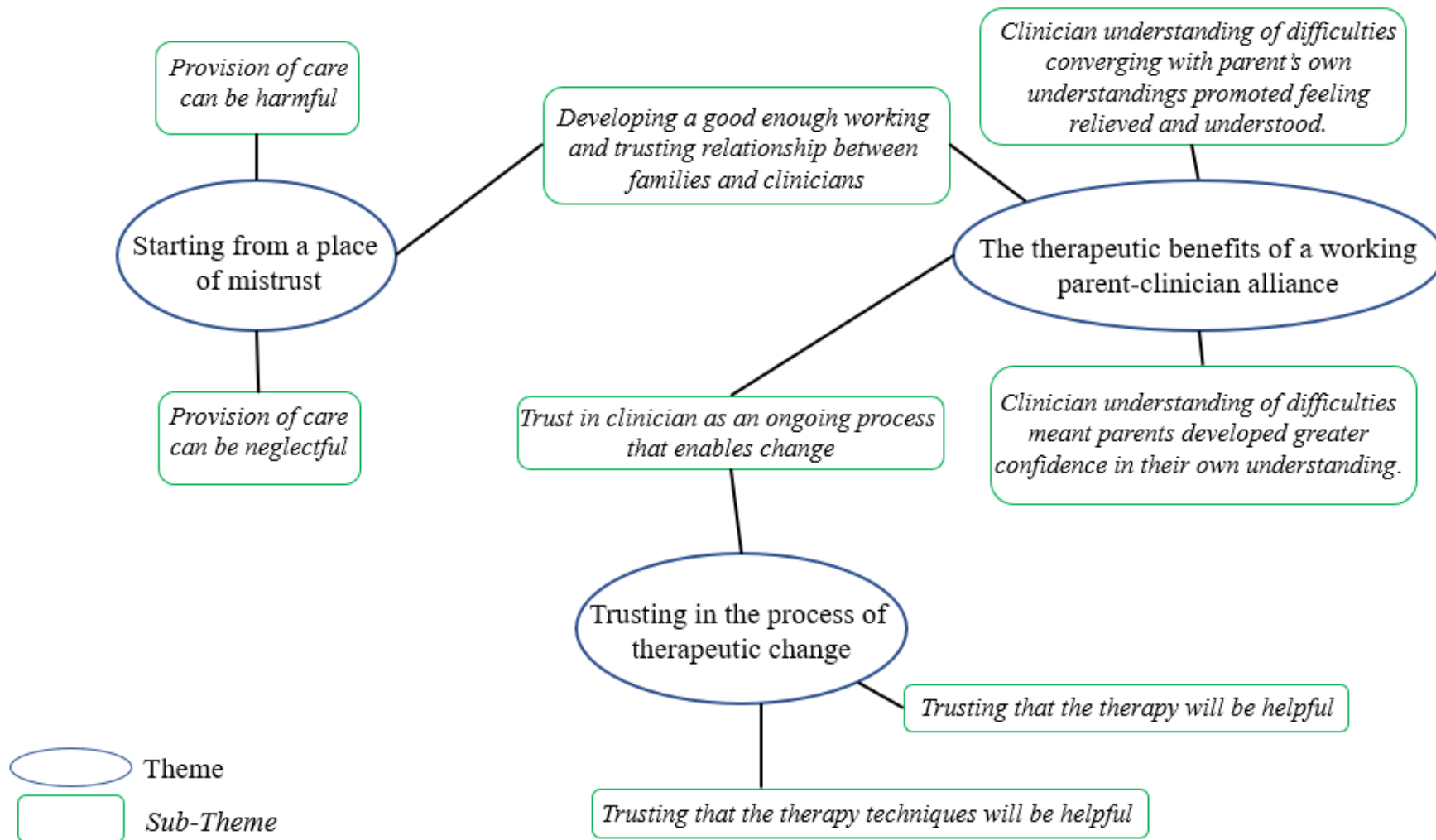
Theme 1: Starting from a place of mistrust.

Participants often referenced narratives of neglect and harm in their experience of the Grenfell Tower Fire and consequent help-seeking on behalf of their children. Parents from minoritized ethnic groups more often shared understandings of neglect and harm as a product of racism, whereas those from European or White British cultures of origin referenced these narratives in more generic ways. These were important reflections of the dynamic nature of navigating and believing that supportive services were trustworthy.

Sub-Theme: Provision of care can be neglectful. Parents reported having very little faith in the quality of the provision of care from generic NHS services. Many reported being worried about the timeliness and availability of support. Many parents referred to the "massive waiting lists" (Participant 1) of generic CAMHS services, which they believed meant that there would be a long wait for help. Participant 1 for example expressed her belief that a long wait may have meant that her son would have taken his own life. Participant 6 shared her experience of accessing a previous service:

> "I just felt like it was a tick box exercise […] First of all there was no waiting room. The day I took my little one was packed like sardines. […] the lady observed you but it was like you was just like she'd seen about ten people before you. And you just felt like [sigh], it just wasn't the right thing for us. "– Participant 6

Therefore, parents communicated a lack of trust of services insofar as they had experienced provision to date as being neglectful. This was also in the context of experiences of wider neglect in the context of Grenfell:

> "I have to live there every day when I open my door, my kitchen and my bathroom to this house. So in other countries, they might have like cordoned that area off and said it's not, you know, humane go to back but we all went back" – Participant 6

Participant 3 shared further insight into children's understandings that neglect was driven by racism:

> "First was the shock. Then an anger because the majority of the residents of the building were from ethnic minorities."

Sub-Theme: Provision of care can be harmful. Parents shared stories of experiencing harm from services that were meant to support them, which they linked with a consequent mistrust of these same services. Participant 1 shared that a traumatic experience with the Police affected their children's view that "people of authority are there to help you. […] but the way they were treated […] gave them a very different outlook." This sense of mistrust was also shared by Participant 4 in her experience of racial aggression from representatives of supportive services: " I know what I'm talking about because I'm not Caucasian […] sometimes you speak to people, and straight away they give you this aura as if they're speaking to you as though you have absolutely no intelligence whatsoever." The worry about possible racist harm was further discussed by Participant 6, in her reflections about their culture of origin's expectations of local help-seeking from services:

> " [The worry is] British, but it's also culturally descended from West Indian or African descent […] You should be scared to speak because you don't know where they document it […] Or don't say too much because they might have control over you."

Sub-theme: Developing a good enough working and trusting relationship between families and clinicians. This theme attends to parents weighing up whether to trust the clinicians they met with in the GHWS, and how this was influenced by the parent's initial experience of the clinicians and the service. This sub-theme is also conceptualised as a

channel between the themes of "Starting from a place of mistrust" to "The therapeutic benefits of a working parent-clinician alliance" in order to reflect the changing relational dynamics between help-seekers and help-providers.

It was clear that parents' accounts of their experiences of neglect and harm meant that they were approaching the help offered by the Grenfell Health and Wellbeing Service (GHWS) from a position of mistrust, rather than trust.

> "I've got to admit I went in with mistrusting as well, you know, because I walked in, saw two white ladies for want of a better words, and I thought now you tell me what do you understand about my struggle or our struggle? […] have got your pre-existing biases?" – Participant 4.

Parents within this theme expressed a sense of initial and ongoing relief that their experience of GHWS was contrary to their initial worries in relation to quality of care and possibility of further harm. An experience of feeling understood appeared to be associated with not feeling judged ("don't feel like you've done anything wrong" – Participant 1), being respected ("the service makes you feel like you are not begging"- Participant 6) and attentive to family needs. Parents also experienced the service's responsiveness to needs as an indication that they were a safe provider of care.

Therefore, parents reported a qualitatively different experience to what they worried they would experience prior to accessing the service. Participant 4 also shared that they valued that "there isn't a cultural divider. It's nice here because you see different therapists of different races", suggesting that the service communicated racial safety.

Overall, these efforts seem to have been responded well to. Participant 4 shared that their experience of clinicians meant that they would take a positive risk in engaging with them.

"there was just something about the two of them, you know, that was slightly different to some of the team, […] they just showed enough empathy to gain my trust. 'Cos I went in there mistrusting […] and they were able to show just enough empathy to make me feel […] that just maybe they understand" – Participant 4

Therefore, it appeared that the services and its clinicians were able to promote themselves as trustworthy enough, to allow parents to trust them enough to invite clinicians into offering an understanding of their child's distress.

Theme 2: The therapeutic benefits of a working parent-clinician alliance.

This theme attends to parent's experiences of their clinician in terms of their understanding of their child's difficulties and the implications of this for parents.

Sub-theme: Clinician understanding of difficulties converging with parent's own understandings promoted feeling relieved and understood. In the meeting of families and clinicians, parents had already developed their own understandings of what was happening to their children, insofar as difficulties were reflective of their being exposed to traumatic events, that these were distressing experiences to their children, and that their children needed an intervention to alleviate the distress.

Parents simultaneously expressed confusion about their child's difficulties, as well as showing understanding that it was reflective of their child's mental health. Participant 1 shared that "[their child] was definitely traumatised […] the behaviours that were coming out were because of that" but hadn't been sure if "it was an attention thing at first". This was similar to Participant 2's wondering that her daughter's fear of her mother dying was associated with her not wanting to separate from her.

Parents expressed relief that the clinician offered a formulation which meant that the young person's difficulties were understandable ("it was a relief." – Participant 3), and that it fit

with what they also thought- "obviously it's not just me that thinks it's a trauma" (Participant 1).

Sub-theme: Clinician understanding of difficulties meant parents developed greater confidence in their own understanding. Parents described how interactions with the clinician supported their confidence in their expanding understanding of what was happening to their children.

"Then when I did my reading, I understood that it made sense to me why my daughter

was doing what she was doing […] so it all made sense to me". – Participant 3

Parents appeared to particularly value ongoing advice and psychoeducation from clinicians, and this seemed to promote parents' own ability to cope with their children's distress. Participant 1 shared that advice helped parents navigate their own conversations with the children about "how much should you tell a child, how little should you tell a child, or do you not tell them anything." The value of clinician's promoting parent ability to cope through anticipating children's needs was shared by Participant 6's experiencing the ongoing advice as a learning experience.

Theme 3: Trusting in the process of therapeutic change.

Parents described three dimensions of trust with the intervention their child received. This was trust in the clinician, trust in the therapy, and trust in the techniques of the therapy.

Sub-theme: Trust in clinician as an ongoing process that enables change. Parents explored aspects of their relationship with their child's clinician that promoted the development and maintenance of trust, and how parents understood this relationship as enabling change. This sub-theme provides a coherent channel between the themes of "the benefits of a working parent-clinician relationship" and "Trusting in the process of therapeutic change", as trust in the relationship with the clinician channels consequent trust in the techniques and ideas proposed by the clinician.

Parents valued that clinicians worked with them to be flexible with the location for therapy sessions, which were described as often being held at school during school hours. Parents linked this willingness to meet outside of the therapy clinic as making the service more accessible to them and their professional situations. Parents further highlighted the collaborative nature of their relationship with their clinician in their valuing of receiving session feedback. This sense of collaboration was experienced as helping "our [parent-clinician] relationship grew as well" (Participant 3). Parents also shared that they experienced clinicians as being responsive in a crisis, available, and offering emotional containment. Participant 6 described how their clinician embodied many of these qualities in advocating for their child's needs.

> "With his after-school tutor, when he breaks down, she's been able to write emails
> […] She's been able to integrate him into secondary school […] She has been to
> meetings with me with meetings to explain his behaviour to the school. So when I
> say she's literally holding our hand through this journey, she literally has."

Parents from minoritized communities shared that they valued how clinicians sensitively navigated differences across dimensions of identity, inclusive of race, culture, and age. Parents shared that what was important to them was that the navigating of difference meant that the clinician was "speaking the same language" (Participant 4) as their young person and enhanced similarity and consequently trust with the family:

> "I don't think [clinician] makes you feel any different than anybody else. She just
> sees you as a person, which is more important to me. – Participant 6

> "I also wanted somebody that wasn't textbook orientated, and if it didn't fit in with
> whatever they learnt at university, then it couldn't be part of your – you know, the
> child's issue. And I never, ever picked that up from [clinician]" – Participant 4

Observations were made by parents that informed their understanding that the child's experience of the clinician was therapeutic, which further bolstered their sense of trust in the clinician. In relation to initial concerns that children were struggling to communicate their distress, parents valued that children seemed able to express themselves with their clinician and were keen to attend sessions.

> "It got to the point where he was actually asking if he can go back and speak to her. I'm like, wow" – Participant 5.

Parents also understood their child's engagement with their clinician as evidence of trust and of clinician's growing understanding of the young person.

> "She always sort of, you know, she was really good with [YP] and got on really well with her. […] Over time she obviously really got to know [clinician] and liked her, was quite trusting [of clinician]." – Participant 3.

It is clear that parent experience of trust in their clinician was an ongoing process maintained by clinicians developing their own therapeutic relationship with parents, with a view of applying this trust to enable change. This is reflected in parents' expansiveness and positivity in describing clinicians as a "godsend" (participant 1), "amazing" (participant 2) and "absolutely outstanding" (participant 4).

Sub-theme: Trusting that the therapy will be helpful. Parents reflected broadly similar views in trusting core ideas underpinning the practice of TF-CBT. Indeed, parents expressed understanding and endorsement of the idea that an intervention to alleviate distress related to exposure to traumatic events must focus on the "trauma", which seemed to be used by parents as a catch-all term encompassing the traumatic events themselves as well as

children's reactions to it. Participant 4 described the positive change they noticed in their young person which alluded to the clinician's application of the therapy model.

> "There was a time when YP couldn't even call her [relative's] name without getting really over emotional. And [clinician] brought her to a point where she, um, was able to rationalise some of it, I wouldn't say all of it but a great majority of it. Some of the irrational guilt that she was feeling" – Participant 4

For participant 6, trusting in the clinician's application of the model of TF-CBT and accessing trauma therapy meant navigating their own relationship to what would be considered acceptable in their culture of origin:

> "If I want to take my son to therapy then I'm going to do it. I know what's best for my child." – Participant 6.

Participant 3 expressed that although they had no significant concerns about the cultural fit of the model, she believes that it (and psychology more generally) could be more helpful by expanding the scope of the model to include pro-social values, spritiruality, and holisticism.

> "So if you look at we always teach our children that don't go for power, don't go for wealth, go for serving the humanity, go for excellency […] don't think that you have to be powerful to be a good." – Participant 3.

Sub-theme: Trusting that the therapy techniques will be helpful. Parents described varying degrees of awareness of therapy practices deployed to intervene with distress. Parents made reference to children writing about their thoughts and feelings, developing narratives about their experiences, and learning techniques to manage emotions. Similar to the relationship to the helpfulness of using labels, some parents shared that they "didn't know a lot about" (participant 4) the therapy itself, however, were happy as long as it

helped. Awareness of techniques did not seem to be particularly related to degree of trust in the intervention. Parent's positive reports in the techniques as enablers of change ranged from the generic:

> "[clinician] was an exceptionally good fit because like I said, I don't know what her technique was, I didn't see it, so I can't say what it was" – Participant 4

To the specific:

> "I was really amazed because I'd never thought about it and it made sense that if it's a colour and bright, it's like […] like not forgetting it but it's, you know, it's like more in your past […] So it seems like it worked with her […] she was happy to do safe place." – Participant 2.

Where parents reported that their children did not seem to benefit in hoped-for ways from the intervention, this seemed to be attributed to limitations in the techniques of the intervention, Participant 3 shared that although their young person's wellbeing deteriorated over time, she could "underst[and] herself very well. She could understand what was happening with her" which was experienced as helpful. This sense of limited helpfulness is also shared by Participant 4's description of model techniques as "temporary tools because I can tell you now was back to – I wouldn't say square one, but she's back to not a good place".

Discussion

This study set out to explore parent's views about the cultural fit of their child's assessment of difficulties and intervention from a TF-CBT perspective. The findings from this study suggest that cultural fit is a relational process underpinned by trust.

Findings in relation Questions 1 and 2

In contrast to initial fears, parents raised no significant concerns about the cultural fit or relevance of either the clinician's explanation for their children's difficulties or the recommendation that they should have a TF-CBT intervention. Parent and clinician views seemed to converge in their understandings that difficulties were related to exposure to traumatic events and the child had difficulty in making sense of them. This is in keeping with Meyer et al's (2022) findings that lay causal beliefs across five different geographic regions in the world all included an understanding that difficulties descriptive of post-traumatic stress can be caused by exposure to traumatic events. Parents also shared how hearing clinicians' explanations of difficulties meant that they themselves could better make sense of the difficulties and understand the rationale for intervening with a TF-CBT intervention. This helpfulness is characterized by parent's reports of the clinician's understanding as making sense of difficulty, establishing causal links, and identifying a means of intervention, which are hallmarks of good quality psychological formulation (Johnstone & Dallos, 2006). This study supports the view that TF-CBT conceptualisations of distress can support parents to understand their child's difficulties and that this understanding could be true across cultures.

This study further suggests that although this approach to conceptualizing distress and its associated intervention can be coherent cross-culturally, it is likely to be dependent on parents' perception of the trustworthiness of the clinician who offers this conceptualisation and that this trustworthiness does include cross cultural considerations. This has not previously been identified in the literature for cultural scripts of traumatic stress. For

example, Chentsova-Dutton & Maercker's (2019) theory of cultural scripts of traumatic stress emphasises that people's understanding of traumatic stress, and what sequence of actions they chose to take, is influenced by the cultural scripts they are aware of from their cultures of origin, as well as their relationship and adherence to these same scripts. These scripts may also include decisions to trust people perceived as being "out-group" members. The authors recommend that clinicians should explicitly explore individual's "opinions, beliefs and knowledge [about trauma], as well as those reflecting perspectives of their community members" as a means of improving care provision by understanding the scripts that help-seekers bring with them. In this study, parents described significant and understandable concerns about the possibility of experiencing neglect and harm from supportive services, driven by prior experience, prior trauma, and their experience of the Grenfell Tower Fire itself. These concerns were reportedly alleviated to some degree by the trust they had in the relationship with their clinician, which meant that reaching shared and acceptable understandings of their children's distress and plan for intervention was then possible, which then meant that further trust-building was possible. It is not surprising that issues of trust have been central in the experiences of parents. One traumatising feature of this disaster was the damaging rupture in trust between governing authorities and those they were tasked with supporting. It follows that alleviation of distress can be achieved through the development of trust with a helpful other, which explains parents' broadly positive experience of their child's clinician. This is in keeping with the promotion of relational trauma-informed care as improving service user experience (Sweeney et al., 2018).

Therefore, this study adds the following to the theory of cultural scripts of traumatic stress:

- help-seekers scripts about the trustworthiness of helpers are an important feature of a wider exploration of scripts of therapeutic 'fit', given that many traumatic experiences, including experiences of racism, are associated with interpersonal ruptures of trust in the context of cultural and ethnic difference.

- When there is already convergence in scripts between help-seekers and helpers about causality in trauma then trust is likely to be greater.

- Where trust has been built up between help-seekers and helpers then help-seekers are more likely to accept non-convergent scripts in understandings of traumatic stress offered by the helpers.

Findings in relation to Question 3

Parents interviewed broadly reported more similarities, rather than differences in their understanding of their child's difficulties, which meant that they made use of the support offered by the clinician to inform how they supported their child during therapy. Parents described three dimensions of trust in relation to TF-CBT as enabling change, which was in the clinician, in the ideas of the model, and in the techniques of the model. Parents seemed to speak most positively and expansively of their trust in the clinician as being an enabler of change, whereas views were more mixed in relation to the model's ideas and techniques as enabling of change. This may be reflective of the fact that what is most amenable to ongoing dynamic development of trust is the relationship with the clinician, rather than with the model's ideas and its techniques, which were less clear to parents. It may also be reflective of the possibility that parents made indirect therapeutic gains in respect to their own experience of traumatisation through their child's therapy. This finding may also

suggest that access to the clinician was particularly helpful. Parents described often making use of their clinician to get advice on an ad-hoc basis or in crisis; to ask for them to advocate on their behalf; and to seek emotional containment. This may indicate that the trust in the clinician scaffolded trust in the model and techniques. In the context of cultural scripts of traumatic stress, this emphasises the potential for a trusting relationship to support parents to accept holding different scripts about support in tension with one another. An example of such tensions included simultaneously believing that the clinician and intervention was an appropriate cultural fit, but that psychology in general (and inclusive of the intervention model) would benefit from incorporating diverse socio-politico-cultural understandings about humanity and distress, or that the techniques of the TF-CBT model provide only temporary relief.

Implications of the study for understanding the parent-clinician relationship in the delivery of TF-CBT for children

This study's findings extend the concept of a therapeutic and trusting relationship as a vehicle for change (Zetzel, 1956; Horvath, 2001) in the context of parent-clinician relationships and child's individual therapy. To date this relationship has received little attention in research, although this is beginning to be attended to. Psychotherapy research by Núñez et al. (2022) identified this relationship as being experienced as a facilitator of change in a young person's treatment by enhancing family motivation to engage, which converges with the finding of this study. This converges with systemic therapy research by Gilson & Abela (2021) emphasising the importance of parent-clinician collaboration to better support children to recover from relational trauma. Given the infancy of the research on parent-clinician trust, further research is warranted to deepen the understanding of its relevance in TF-CBT. Future iterations of TF-CBT should attend to the parent-clinician

relationship as an active component of intervention. This is of special importance in the knowledge that this relationship may enhance the cultural fit of this model for marginalised families who may otherwise choose not to engage with TF-CBT.

This study supports the notion that trusting relationships as agents of therapeutic change is a cross-culturally coherent concept. Indeed, there is growing literature exploring the development of therapeutic relationships in the context of cultural difference in therapy (Asnaani & Hofmann, 2012) and the need for culturally competent therapists (Sue et al, 2009). Across many cultures, a common cultural script for relieving psychological distress is to consult and talk with a trusted other. In proposing TF-CBT as an effective intervention for trauma, emphasising the trusting relationship it involves may be more cross-culturally accessible compared to other rationales for intervention (such as importance of stabilisation, psychoeducation, and cognitive processing).

Strengths, limitations, and future directions

The study is strengthened by the successful recruitment of parents from marginalized communities, and their openness to provide critique of the TF-CBT intervention their child accessed. The study is limited by a smaller than anticipated sample size, meaning only a partial capture of views was possible. Recruitment difficulties were at odds with the predictions of the research team who were familiar with supporting families affected by the Grenfell Tower Fire and the wider literature relating to exposure to traumatic events. There were relatively few families expressing interest in taking part, and relatively many withdrawing from participation after consenting to taking part. There is little literature specifically attending to issues of participant recruitment in trauma research. A randomised-controlled trial carried out by Vogel et al (2020) shared barriers to participation included the possibility of distress by discussing trauma. Given the impact of Grenfell on individuals,

families, and communities, it is possible that participants who were eligible for the study but declined to take part understandably continue to make use of avoidance as a psychological strategy. Engagement with research may also have been affected by mistrust of authorities such as the council or the NHS. This is understandable in the context of the Grenfell disaster, where to date there have been no prosecutions or accountability established. Canadian-based social justice researchers Ellard-Gray et al. (2015) suggest that vulnerable groups or communities may be less likely to participate in research due to a "mistrust […] [that] stems from historical violations by researchers". Similar concerns also include that findings would not be helpful to their communities (Jacklin & Kinoshameg, 2008). It is therefore possible that there are cultural scripts at play in relation to participation in research. Therefore, typical research methodologies and recruitment methods may be limited in engaging individuals from minoritised communities who have been distressed by exposure to traumatic events. This study highlights the need for further research to develop new ways of ensuring equitable access to research that is of cross-cultural benefit. This is in keeping with both growing calls for the use of culturally fitting research methods to better engage participants (Pelzang et al, 2018; Woodland et al, 2021) and the NHS England position paper on "Increasing Diversity in Research Participation" (2023). This may promote research take up for groups of individuals that have not engaged with this study, such as parents who are males, and/or who were not satisfied with the TF-CBT intervention.

The length of time between parents initially accessing the GHWS and the interviews for this study may have reduced participation as some parents may be less likely to recall the detail of the assessment and intervention. This emphasises the importance of carrying out research relating to trauma in a timely manner.

Although the research methodology used values researcher subjectivity as an asset in the analysis of data, it is nonetheless important to consider that the principal researcher was

not himself from a Grenfell-affected community and that institutional racism can still inadvertently influence how information is received and understood, even by well-intentioned people. Participatory action research approaches (Baum et al., 2006) could provide an alternative research methodology that could be of greater service to meeting the research needs communities deem important to explore.

Clinical implications

The following clinical recommendations are made based on the findings of this study:

- In keeping with recommendations made by Chentsova-Dutton & Maercker (2019), clinicians should explicitly discuss the cultural scripts that clients hold about distress, and their attitudes to them, to better provide culturally fitting support. Client's belief and perceptions of service and clinician trustworthiness should also be discussed to enable rapport building.

- Where possible, clinicians offering TF-CBT interventions to children should consider how to develop trusting relationships with parents to enhance support for the therapeutic work.

- Given that the cultural fit of TF-CBT is at least partially experienced as a relational process underpinned by trust, clinicians should attend to cultivating cultural awareness of the self and others (Christopher et al., 2015) and cultural competence (Sue et al., 2009) in their clinical practice. This would promote trust in the parent-clinician relationship, which is likely to promote further conversation to better enhance cultural fit.

- Clinical services that provide mental health support to multi-cultural populations should actively consider culturally fitting methods (inclusive of relational) for developing trust with individuals who would benefit from support but who mistrust the clinical service.

Conclusion

This study explored parents' views of the cultural fit of their children's TF-CBT assessment and treatment for difficulties related to exposure to traumatic events. Parents described mistrusting services due to previous experiences of neglect and harm. Parents who sought help from the GHWS developed trusting relationships with their child's clinician. This relationship meant that parents understandings of their child's difficulties were validated and expanded. Parents experienced trust in their clinician as a process that was enabling of change, meaning that the relationship was a channel for trust in the wider intervention. This meant that cultural fit was experienced as a relational process underpinned by trust and suggests that TF-CBT was a suitable cultural fit. Findings indicate that clinicians should actively discuss issues relating to culture and trust with the families they support in the delivery of TF-CBT, and emphasise developing a trusting relationship with parents. Future research should consider how to increase research participation for members of communities who may not typically engage in research and are affected by exposure to traumatic events.

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Section C: Appendices of supporting material

Appendix 1. Copy of Downs & Black checklist

Study reviewed:		
Reporting	**Responses**	**Score**
1. Is the hypothesis/aim/objective of the study clearly described?	Yes= 1 No= 0	
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.	Yes= 1 No= 0	
3. Are the characteristics of the patients included in the study clearly described ? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.	Yes= 1 No= 0	
4. Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described.	Yes= 1 No= 0	
5. Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided.	Yes=2 Partially=1 No=0	
6. Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).	Yes= 1 No= 0	
7. Does the study provide estimates of the random variability in the data for the main outcomes? In non normally distributed data the	Yes= 1 No= 0	

inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes		
8. Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).	Yes= 1 No= 0	
9. Have the characteristics of patients lost to follow-up been described? This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.	Yes= 1 No= 0	
10. Have actual probability values been reported(e.g. 0.035 rather than	Yes= 1 No= 0	
External Validity All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived.		
11. Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study	Yes=1 Unable to determine=0 No=0	

must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.		
12. Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.	Yes=1 Unable to determine=0 No=0	
13. Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.	Yes=1 Unable to determine=0 No=0	
Internal Validity - bias		

14. Was an attempt made to blind study subjects to the intervention they have received ? For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.	Yes=1 Unable to determine=0 No=0	
15. Was an attempt made to blind those measuring the main outcomes of the intervention?	Yes=1 Unable to determine=0 No=0	
16. If any of the results of the study were based on "data dredging", was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.	Yes=1 Unable to determine=0 No=0	
17. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls ? Where follow-up was the same for all study patients the answer should yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.	Yes=1 Unable to determine=0 No=0	
18. Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. For example nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the	Yes=1 Unable to determine=0 No=0	

question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.		
19. Was compliance with the intervention/s reliable? Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.	Yes=1 Unable to determine=0 No=0	
20. Were the main outcome measures used accurate (valid and reliable)? For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.	Yes=1 Unable to determine=0 No=0	
Internal Validity – confounding (selection bias)		
21. Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case control studies where there is no information concerning the source of patients included in the study.	Yes=1 Unable to determine=0 No=0	

22. Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time? For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.	Yes=1 Unable to determine=0 No=0	
23. Were study subjects randomised to intervention groups? Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable.	Yes=1 Unable to determine=0 No=0	
24. Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.	Yes=1 Unable to determine=0 No=0	
25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account	Yes=1 Unable to determine=0 No=0	

in the analyses. In nonrandomised studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.		
26. Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.	Yes=1 Unable to determine=0 No=0	
Power		
27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%? Sample sizes have been calculated to detect a difference of x% and y%.	A <n1 = 0 B n1–n2 = 1 C n3–n4 = 2 D n5–n6 = 3 E n7–n8 =4 F n8+ =5	
Total:		

Total score categories: Excellent (26-28); Good (20-25); Fair (15-19); and Poor (≤14).

Appendix 2. Copy of Mixed Methods Appraisal Tool (MMAT) version 2018

These are direct copies of the tool which are "free for use in education and research".

http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018

_criteria-manual_2018-08-01_ENG.pdf .

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

1. Qualitative studies	Methodological quality criteria
"Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2013b, p. 3).	1.1. Is the qualitative approach appropriate to answer the research question?
	Explanations
Common qualitative research approaches include (this list if not exhaustive):	The qualitative approach used in a study (see non-exhaustive list on the left side of this table) should be appropriate for the research question and problem. For example, the use of a grounded theory approach should address the development of a theory and ethnography should study human cultures and societies.
Ethnography	This criterion was considered important to add in the MMAT since there is only one category of criteria for qualitative studies (compared to three for quantitative studies).
The aim of the study is to describe and interpret the shared cultural behaviour of a group of individuals.	1.2. Are the qualitative data collection methods adequate to address the research question?
Phenomenology	Explanations
The study focuses on the subjective experiences and interpretations of a phenomenon encountered by individuals.	This criterion is related to data collection method, including data sources (e.g., archives, documents), used to address the research question. To judge this criterion, consider whether the method of data collection (e.g., in depth interviews and/or group interviews, and/or observations) and the form of the data (e.g., tape recording, video material, diary, photo, and/or field notes) are adequate. Also, clear justifications are needed when data collection methods are modified during the study.
Narrative research	
The study analyzes life experiences of an individual or a group.	1.3. Are the findings adequately derived from the data?
Grounded theory	Explanations
Generation of theory from data in the process of conducting research (data collection occurs first).	This criterion is related to the data analysis used. Several data analysis methods have been developed and their use depends on the research question and qualitative approach. For example, open, axial and selective coding is often associated with grounded theory, and within- and cross-case analysis is often seen in case study.
Case study	1.4. Is the interpretation of results sufficiently substantiated by data?
In-depth exploration and/or explanation of issues intrinsic to a particular case. A case can be anything from a decision-making process, to a person, an organization, or a country.	Explanations
	The interpretation of results should be supported by the data collected. For example, the quotes provided to justify the themes should be adequate.
Qualitative description	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
There is no specific methodology, but a qualitative data collection and analysis, e.g., in-depth interviews or focus groups, and hybrid thematic analysis (inductive and deductive).	Explanations
	There should be clear links between data sources, collection, analysis and interpretation.
Key references: Creswell (2013a); Sandelowski (2010); Schwandt (2015)	

4. Quantitative descriptive studies	Methodological quality criteria
Quantitative descriptive studies are "concerned with and designed only to describe the existing distribution of variables without much regard to causal relationships or other hypotheses" (Porta et al., 2014, p. 72). They are used to monitoring the population, planning, and generating hypothesis (Grimes and Schulz, 2002).	**4.1. Is the sampling strategy relevant to address the research question?** Explanations Sampling strategy refers to the way the sample was selected. There are two main categories of sampling strategies: probability sampling (involve random selection) and non-probability sampling. Depending on the research question, probability sampling might be preferable. Non-probability sampling does not provide equal chance of being selected. To judge this criterion, consider whether the source of sample is relevant to the target population; a clear justification of the sample frame used is provided; or the sampling procedure is adequate.
Common designs include the following single-group studies (this list if not exhaustive):	**4.2. Is the sample representative of the target population?** Explanations There should be a match between respondents and the target population. Indicators of representativeness include: clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.
Incidence or prevalence study without comparison group In a defined population at one particular time, what is happening in a population, e.g., frequencies of factors (importance of problems), is described (portrayed).	**4.3. Are the measurements appropriate?** Explanations Indicators of appropriate measurements include: the variables are clearly defined and accurately measured, the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the outcome of interest are used, variables are measured using 'gold standard', or questionnaires are pre-tested prior to data collection.
Survey "Research method by which information is gathered by asking people questions on a specific topic and the data collection procedure is standardized and well defined." (Bennett et al., 2011, p. 3).	**4.4. Is the risk of nonresponse bias low?** Explanations Nonresponse bias consists of "an error of nonobservation reflecting an unsuccessful attempt to obtain the desired information from an eligible unit." (Federal Committee on Statistical Methodology, 2001, p. 6). To judge this criterion, consider whether the respondents and non-respondents are different on the variable of interest. This information might not always be reported in a paper. Some indicators of low nonresponse bias can be considered such as a low nonresponse rate, reasons for nonresponse (e.g., noncontacts vs. refusals), and statistical compensation for nonresponse (e.g., imputation).
Case series A collection of individuals with similar characteristics are used to describe an outcome. **Case report** An individual or a group with a unique/unusual outcome is described in detail.	The nonresponse bias is might not be pertinent for case series and case report. This criterion could be adapted. For instance, complete data on the cases might be important to consider in these designs.
Key references: Critical Appraisal Skills Programme (2017); Draugalis et al. (2008)	**4.5. Is the statistical analysis appropriate to answer the research question?** Explanations The statistical analyses used should be clearly stated and justified in order to judge if they are appropriate for the design and research question, and if any problems with data analysis limited the interpretation of the results.

5. Mixed methods studies	Methodological quality criteria
Mixed methods (MM) research involves combining qualitative (QUAL) and quantitative (QUAN) methods. In this tool, to be considered MM, studies have to meet the following criteria (Creswell and Plano Clark, 2017): (a) at least one QUAL method and one QUAN method are combined; (b) each method is used rigorously in accordance to the generally accepted criteria in the area (or tradition) of research invoked; and (c) the combination of the methods is carried out at the minimum through a MM design (defined *a priori*, or emerging) and the integration of the QUAL and QUAN phases, results, and data.	**5.1. Is there an adequate rationale for using a mixed methods design to address the research question?** Explanations The reasons for conducting a mixed methods study should be clearly explained. Several reasons can be invoked such as to enhance or build upon qualitative findings with quantitative results and vice versa; to provide a comprehensive and complete understanding of a phenomenon or to develop and test instruments (Bryman, 2006).
Common designs include (this list if not exhaustive):	**5.2. Are the different components of the study effectively integrated to answer the research question?** Explanations Integration is a core component of mixed methods research and is defined as the "explicit interrelating of the quantitative and qualitative component in a mixed methods study" (Plano Clark and Ivankova, 2015, p. 40). Look for information on how qualitative and quantitative phases, results, and data were integrated (Pluye et al., 2018). For instance, how data gathered by both research methods was brought together to form a complete picture (e.g., joint displays) and when integration occurred (e.g., during the data collection-analysis or/and during the interpretation of qualitative and quantitative results).
Convergent design The QUAL and QUAN components are usually (but not necessarily) concomitant. The purpose is to examine the same phenomenon by interpreting QUAL and QUAN results (bringing data analysis together at the interpretation stage), or by integrating QUAL and QUAN datasets (e.g., data on same cases), or by transforming data (e.g., quantization of qualitative data).	**5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?** Explanations This criterion is related to meta-inference, which is defined as the overall interpretations derived from integrating qualitative and quantitative findings (Teddlie and Tashakkori, 2009). Meta-inference occurs during the interpretation of the findings from the integration of the qualitative and quantitative components, and shows the added value of conducting a mixed methods study rather than having two separate studies.
Sequential explanatory design Results of the phase 1 - QUAN component inform the phase 2 - QUAL component. The purpose is to explain QUAN results using QUAL findings. E.g., the QUAN results guide the selection of QUAL data sources and data collection, and the QUAL findings contribute to the interpretation of QUAN results.	**5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?** Explanations When integrating the findings from the qualitative and quantitative components, divergences and inconsistencies (also called conflicts, contradictions, discordances, discrepancies, and dissonances) can be found. It is not sufficient to only report the divergences; they need to be explained. Different strategies to address the divergences have been suggested such as reconciliation, initiation, bracketing and exclusion (Pluye et al., 2009b). Rate this criterion 'Yes' if there is no divergence.
Sequential exploratory design Results of the phase 1 - QUAL component inform the phase 2 - QUAN component. The purpose is to explore, develop and test an instrument (or taxonomy), or a conceptual framework (or theoretical model). E.g., the QUAL findings inform the QUAN data collection, and the QUAN results allow a statistical generalization of the QUAL findings.	**5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?** Explanations The quality of the qualitative and quantitative components should be individually appraised to ensure that no important threats to trustworthiness are present. To appraise 5.5, use criteria for the qualitative component (1.1 to 1.5), and the appropriate criteria for the quantitative component (2.1 to 2.5, or 3.1 to 3.5, or 4.1 to 4.5). The quality of both components should be high for the mixed methods study to be considered of good quality. The premise is that the overall quality of a mixed methods study cannot exceed the quality of its weakest component. For example, if the quantitative component is rated high quality and the qualitative component is rated low quality, the overall rating for this criterion will be of low quality.
Key references: Creswell et al. (2011); Creswell and Plano Clark (2017); O'Cathain (2010)	

Appendix 3. Copy of Cultural Adaptation Checklist.

Based on Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist, 12*, E10. doi:10.1017/S1754470X18000247

Study evaluated: ………………………………………………………………………………………………………

Process of adaptation	Yes / No / Partially	Comments
1 Does the study describe either of the following items to establish guidance on cultural adaptation? • a review of previous literature • consultation with field experts • consultation with key stakeholder		
2 Does the study describe the guidance generated from the review of the literature and consultations with field experts and stakeholders?		
3 Does the study clearly describe a rationale for developing and implementing cultural adaptations? (*Does the study make reference to: acculturation, beliefs and attributions to illness, help-seeking behaviours, cultural orientation towards psychotherapy?*).		
4 Does the study clearly describe a framework, theory or model that has informed the development of adaptations?		
Evaluation of quality for process of developing cultural adaptations.		
Replicability of adaptation	**Yes / No / Partially**	**Comments**
5 Does the study account for societal or health		

system-related practical considerations in accessing and engaging with the intervention?		
6 Does the study describe the technical adjustments made to the intervention? (*Does the study make reference to modifications to the methods of the therapy across: setting and environment of therapy, therapeutic relationship, therapeutic style, family structures and goals, the role of religion?*)		
7 Does the study describe the theoretical adaptations of concepts? (*Examples may include references to: body and mind, self and ego boundaries, individuality and collectiveness,*		
How replicable are the adaptations? (*Is the study conceptually and practically replicable?*).		

Scoring System: If all quality criteria are achieved, this equates to "Satisfactory Adherence"; If some quality criteria are achieved, this equates to "partial adherence"; If no quality criteria are achieved, this equates to "No Adherence".

Appendix 4. Extracts from reflective log.

January 2021

In lectures and research supervision I have begun getting my head around different philophical perspectives and how they related to understandings of traumatic stress. I have noticed that my previously held ideas have been very positivistic. Ideas about reactions to trauma being socially constructed is liberating and confusing, and seems to raise more questions than it answers. I am also finding it challenging to think about how to define my own position in the research proposals.

October 2022

I am noticing that participants do not seem to be explicitly volunteering information directly related to culture. I have decided to be more explicit in the conversation prior to the active questions in the interview schedule in reminding clients I am interested in hearing a range of views, which includes what work and what needs more development. I have reflected on this and it seems in keeping with the methodology. It makes sense to be reflexive in modelling openness to hearing about a variety of views by taking a lead in communicating openness to hearing them.

December 2022

Recruitment figures are much lower than expected. I am wondering if this is suggesting something about avoidance as a reaction to exposure to traumatic events, as well as relationship to help. This is leading me to think about the orthodoxy of research design and methodology- perhaps these in themselves are not a good cultural fit. This may warrant discussion in the write up or an amendment in design if recruitment stagnates.

January 2023

A participant asked me explicitly why I was personally interested in taking part in the research. I shared that I was doing the research because I cared about what happened and that I thought it was important that therapies are as helpful as possible for all. She seemed to respond well to this. It made me revisit thoughts about research orthodoxy, and that PIS may be enhanced through considered and thoughtful self-disclosure to promote trust.

March 2023

Thinking about how to respectfully balance latent and semantic coding and interpretation- I don't want to move too far away from what is being shared, as this is a repetition of people's experiences of not being listened to. Although I have come to realise that being too deductive was making the analysis a bit thin and not capturing important implicit communications- such as questions of culture being answered with discussions about trust.

Appendix 5. Extracts of bracketing interview.

What is likely to influence how I analyse the data and make meaning from it? What is likely to influence how I relate to the material that participants are sharing?

- Broadly speaking, I do subscribe to the helpfulness of cognitive models of traumatic stress. I need to be mindful that I remain open to being curious and valuing difficulties that would not typically be conceptualized as post-traumatic stress.

- Having worked in the service for 20 months as an Assistant Psychologist, I cut my metaphorical teeth there. I experienced the service as helpful and motivating, so I will be mindful of my reactions in the moment of interviews and analysis if views shared are "negative".

- I need to be clear in my mind that there will be differences in how the communities affected by Grenfell will have experienced it. There will be similarities and differences to experiences of traumatic events in my own culture of origin in northern Ireland, so it is important not to over-identify with particular types of experiences or opinions.

- As a white British/Irish male who grew up in western Europe, I am likely to understand participant experiences through this lens (amongst others). This may also influence what people choose to share with me. I subscribe and work towards being anti-racist and anti-discriminatory in my practice, and equally I need to be mindful to not be overly-directive in pushing cultural implications or views if the link is tenuous or non-existent. I am keen to empower the voices of participants, but equally want to develop my own position to own as a thoughtful advocate.

Appendix 6. Participant information sheet.

Participant Information Sheet

Study Title: An exploration of the cultural dimensions of parents' understanding of their children's psychological assessment and trauma-focused cognitive behavioural therapy following the Grenfell tower fire.

What is this sheet about?
Thank you for reading this information. My name is Jordan Quinn, I am a trainee clinical psychologist.

This information is to help you understand about my research project and what will happen if you decide to take part. This research project is for my university assignment as part of my training as a psychologist. This project is supervised by qualified psychologists, who are Dr Trish Joscelyne (Christ Church Canterbury University) and Dr Sara Northey (NHS Grenfell Health and Wellbeing Service). This project has been given a favourable opinion by the London-Stanmore Research Ethics Committee.

What is the purpose of the research?
I am interested in talking to clinicians who were involved in the assessment of children affected by the Grenfell Tower Fire, and who also provided Trauma-Focused Cognitive Behavioural Therapy.
- what parents thought of the therapist's understanding of their children's reactions to the Grenfell Tower fire;
- what they thought of the suggestion of trauma-focused cognitive behavioural therapy;
- and how the child's therapy was experienced by the parents.

Why have I been approached?
We are getting in touch with you as you are a parent or carer of a child (defined as a young person who is younger than eighteen years of age) who has begun or finished trauma-focused cognitive behavioural therapy with the NHS Grenfell Health and Wellbeing Service following the Grenfell Tower fire.

You could participate if all of the following statements apply to you:

- You and your child(ren) lived in the North Kensington area at the time of the Grenfell tower fire.
- Your child(ren) are/ were under eighteen years of age at the time of the fire.
- You and your child(ren) had an assessment meeting with a therapist from the NHS Grenfell Health and Wellbeing Service.
- During or after this meeting, the therapist you met recommended and offered for your child(ren) to have trauma-focused cognitive behavioural therapy.
- Your child(ren) has/have begun or finished having trauma-focused cognitive behavioural therapy.
- You have reasonable fluency in speaking English, or you would agree to having an interpreter (that I would provide) translate the conversation on your behalf.

Do I have to take part?
No. You do not need to take part in this project. It is totally your choice and any help that you or your child are currently receiving will carry on whether or not you take part in the research.

What would taking part involve?
If you would like to take part in this research, then we would meet for an interview for about an hour (or more if we agree this would be helpful or if we need the help of an interpreter for you to be able to participate). If you would like to have a copy of my questions in advance to help you decide about taking part in this study, I can send or email these to you.

Interviews can be carried out either face-to-face at the Grenfell Health and Wellbeing Service or at the Curve Community Centre, over the phone or online using the Zoom platform. If English is not your first language, an interpreter will be made available with your permission.

Interviews will be recorded using an encrypted audio recording device. Recordings will be kept by the researcher until the recordings have been transcribed, after which time they will be destroyed (no more than two weeks from the interview date). Audio recordings will be transcribed by either myself or by a professional transcription company that I will hire for this purpose.

What are the possible benefits of taking part?
We hope that the findings from this study mean that following a disaster like the Grenfell Tower fire, support for parents and their children can be improved and become more sensitive to different cultures.

Are there any risks in taking part?
It is quite possible that talking about Grenfell, and your child(ren)'s reactions to it, may be upsetting. Should this happen, you have the option of taking a break, changing the interview for another time, or to stop taking part in the study altogether. I can also help with telling you about services that support people affected by the Grenfell tower fire, or speak with professionals involved in your care (such as your GP) if this would help you in finding support.

In order to manage the risk of infection from COVID, study interviews can be carried out either virtually (using Zoom) or face-to-face. If you would like to meet face-to-face, the risk of infection from COVID-19 will be managed by:

- Our adherence to national guidance at the time the interview takes place;
- Our adherence to infection control policies provided by Central & North West London NHS Foundation Trust;
- I will also be taking a lateral flow test the day of the interview, and will only attend if my test is negative for presence of COVID-19.

Will my involvement in this project be kept confidential?
Yes. Your involvement in this project would be completely confidential and anonymous. This means that anything you share in the interview will not contain any information that could identify you or your child(ren) in anything the research team will write based on this research. You and your child(ren)'s information will also not be disclosed to anyone outside of the research team or of professional interview transcribers, who are bound by their own rules of confidentiality.

I would only break confidentiality if you say anything that means that there may be a risk of harm to yourself or your child. I would then contact an external agency such as your GP to get help to manage the risk.

What will happen to the findings of the study?
The anonymised findings of the project will be shared with:
- Canterbury Christ Church University, as this project is part of my professional training.
- Management of the NHS Grenfell Health and Wellbeing Service.
Anonymised findings of this project may also be published in academic journals or presented in conferences.

What happens to my information?
We will need to use information from your interview for this research project.

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

The information you share in the survey will be stored securely on an encrypted device by both the researcher and Canterbury Christ Church University for a period of ten years, after which it will be destroyed.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. Your personal data (name, contact details) will be removed from our digital file at the end of the project.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- at www.hra.nhs.uk/patientdataandresearch
- by sending an email to j.quinn19@canterbury.ac.uk, or
- by ringing us on [phone number].

Will I be paid?

All participants will be provided with a "thank you" voucher of £10 for taking part. You will also receive reimbursement for your travel costs if you have to travel to get to the interview.

What if there is a problem or you have a complaint?

Should you have any concerns or complaints in relation to this study, you are encouraged to contact me in the first place, or if you are not happy with my answer you can contact Dr Fergal Jones, who is the Research Director for Salomons Centre of Applied Psychology (the study sponsor) by email (fergal.jones@canterbury.ac.uk) or mail (Salomons Institute for Applied Psychology, Runcie Court Broomhill Road, Tunbridge Wells, TN3 0TF, UK).

How can I take part?

If you would like to discuss taking part in this study, please let the person who gave you this leaflet know and ask for me to contact you.

Alternatively, you can:
- email me directly on **J.quinn19@canterbury.ac.uk** ;
- or call the following telephone number **01227 927070** and request that I contact you, making sure to provide my name (Jordan Quinn).

Appendix 7. Example of SMS sent to eligible parents

Hello. The Grenfell Health and Wellbeing Service is interested in speaking to parents of children who had therapy with the service, as your child did with [name of clinician]. You are invited to take part in a one-hour research interview to hear your views about the cultural fit of the therapy they were offered. The interviews are entirely voluntary and a choice not to participate does not affect the quality of care you and your child receive from the service. Participants are compensated for their time with a £10 gift voucher.

If you would like to participate or receive more information, please email researcher Jordan Quinn (Trainee Clinical Psychologist) on Jordan.quinn3@nhs.net or text on 07889233307.

Appendix 8. Consent form.

Consent Form

Participant Number: | P | | |

Title of project: An exploration of the cultural dimensions of parents' understanding of their children's psychological assessment and trauma-focused cognitive behavioural therapy following the Grenfell tower fire.

Name of Researchers: Jordan Quinn (Canterbury Christ Church University), Dr Trish Joscelyne (Canterbury Christ Church University), & Dr Sara Northey (NHS Grenfell Health and Wellbeing Service).

Please read the following and initial the box to the right of each statement if you agree. There is space for you to sign and date below.

1. I confirm that I have read and understand the information sheet for the above research study.
   I have had the chance to discuss the information, ask questions and have had these answered by Jordan. ☐

2. I understand that taking part in this research interview is completely my choice and that I am free to leave the research at any time. I don't need to give a reason for leaving, and if I leave this will not affect my care or my child(ren)'s care in any way. ☐

3. I agree that findings and anonymous quotes from my interview may be used in published reports of the research. I understand that me and my child(ren)'s privacy will be protected at all times and that nothing that is written will allow people to identify me or my child(ren). . ☐

4. I understand that the only people who will have access to the recording of the interview are the research team, and the professional interview transcribers. ☐

5. I agree to take part in the above project. ☐

.
_____

Name of participant _____

Date _____

Signature _____

Name of person taking consent _____

Date _____

Signature _____

Name of Interpreter &
Employing Organisation _____

Date _____

Signature _____

Appendix 9. Interview schedule.

<div align="center">

Interview Schedule

</div>

1 Opening

    A. My name is Jordan Quinn. I am a trainee clinical psychologist from Salomons Institute of Applied Psychology.

    B. As part of my training, I am doing research to better understand parents' experiences of having their children seen by the Grenfell Health and Wellbeing Service. I am particularly interested in how you experienced the clinician's understanding of your child's reactions to Grenfell. I would also like to ask how you experienced their recommendation that your child(ren) should have trauma-focused therapy.

    C. I hope to use this information to help improve the way that clinicians understand and support young people and their families after a disaster.

    D. The interview should last about 60 minutes. I would also like to remind you that you are encouraged to share only as much as is comfortable for you. How does that sound to you?

2 Topic – Sociodemographic information and exposure to Grenfell

    A. I would like to begin by asking some questions about your background. Could you please tell me how it came to be that you lived in this area?

    B. Could you tell me how many children you have? How old are they?

    C. Where were you and your children at the time of the fire?
    Prompts- Were you evacuated from the area?

    D. Thank you for sharing that with me. Let's now talk in more detail about your children.

3 Topic – Parent understanding of child(ren)'s reactions to Grenfell?

    A. When did you decide that your child(ren) needed to see a health professional?
    Prompts- What kind of problems did you notice your children having?

    B. What lead to that decision?
    Prompts- What did you think was happening to them? How did you develop this understanding? This understanding- where does it come from?

    C. When you met with the Grenfell Health and Wellbeing service for your child's assessment, what did you think about the clinician's understanding of your child and their reactions to the Grenfell tower fire?
    Prompts: What was your understanding of what the clinician thought about your child's reactions? How did that fit with your own experience and understanding of your child's reactions?

4   Topic – Parent understanding of recommendation for trauma-focused cognitive behavioural therapy

    A.   Thank you for sharing that with me, it is very helpful to know. What were you then offered by the clinician?

    Prompts:

    B.   What did you think of what the clinician was offering?

    Prompts: What was your understanding of what was being offered? How did this fit with what you were expecting to be offered? How did that fit with your own understanding of what was needed? How did this understanding develop?

5   Topic – Parent support for engaging child in therapy

    A.   What did you then decide to do?
    Prompts: how did you reach this decision?

    B.   Considering everything we have discussed so far, what do you think influenced how you supported your child during the time they were receiving therapy?

6   Closing

A. Those are all the questions I have for today. Thank you for taking the time to   speak to me. Is there anything I have not asked which you think is important I should know?

B. How have you found our conversation today?

C. Thank you again for taking part in this study. Would you like me to contact you to let you know about the findings of the study?

D. I would also invite you to contact the following services should you feel upset after our interview. I can also refer you to the NHS Grenfell Health and Wellbeing Service if you would find that helpful.

Appendix 10. Debrief form.

Canterbury Christ Church University

NHS
Grenfell Health and Wellbeing Service

Debriefing Information Sheet

<u>Study Title:</u>

Exploring the cultural dimensions of parents' understanding of their children's psychological assessment and trauma-focused cognitive therapy following the Grenfell tower fire.

<u>Aims of the study</u>

Thank you for taking part in this study. The aim of the study is to explore parents' views about the cultural sensitivity of the therapy their child(ren) have had (or are having) for psychological difficulties related to the Grenfell Tower fire. It is hoped that the findings of this study will help further develop the cultural sensitivity of therapies offered to young people after trauma.

<u>Ongoing support</u>

If you have been upset by participation in this study, you may find the following organisations helpful to you.

If you wish to refer yourself to the Grenfell Health and Wellbeing Service, you can do this in three ways:

- You can complete the self-referral form here:
  https://grenfellwellbeing.com/self-referral-form/

- You can contact the service directly by telephone on:

  020 8637 6279 (Monday to Thursday, 8am to 8pm and Friday 8am to 5pm).
  020 8962 4393 (Fridays 5pm to 8pm, and weekends, 8am to 8pm).
  0800 0234 650 (Overnight from 8pm).

- You can email the service: grenfell.wellbeingservice@nhs.net .

If you would like to anonymously talk to someone for emotional support, you can contact Samaritans by telephone on 116 123.

<u>Feedback of study findings</u>

If you wish to receive a copy of the research findings, this will be shared with you in your preferred format (email or by post).

Parents' views of their child's therapy after Grenfell – Debriefing information sheet Version 1.0

Canterbury Christ Church University

NHS
Grenfell Health and Wellbeing Service

<u>Complaints</u>

Should you have any concerns or complaints in relation to this study, you are encouraged to contact Dr Fergal Jones, who is the Research Director for Salomons Centre of Applied Psychology (the study sponsor) by email (fergal.jones@canterbury.ac.uk) or mail (Salomons Institute for Applied Psychology, Runcie Court Broomhill Road, Tunbridge Wells, TN3 0TF, UK).

Appendix 11. Coded transcript extract

A1: Correct, yes. I must say [clinician] was absolutely outstanding in the work she did.

Q: I'm glad to hear it.

A1: I'm getting emotional, I don't know why.

Q: That's okay, that's all right, it's …

A1: With [YP] because I think the problem – the thing was that she went into, um, the sessions with [clinician] mistrusting her. But not just her the system if you like.

Q: And how could you not?

A1: But she was so broken, you know, that I had to find some way of helping both of them but specifically because her and her [relative] were so close that it was just devastating for her. And on top of that I felt so bad because …

[Interviewee fetching water].

Q: Just appalling time, appalling time.

A1: And I made the mistake of saying to her, "Don't worry, [relative] will be okay," and of course that was not the case. So it took her a long time to forgive me as well I think without wanting to hurt me. So she was in a lot of turmoil, you know, and [clinician] did such a good job on her, such a good job. 'Cos there was a time when [YP] couldn't even call her uncle's name without getting really over emotional – overwhelmed. And [clinician] brought her to a point where she, um, was able to rationalise some of it, I wouldn't say all of it but a great majority of it. Some of the irrational guilt that she was feeling, [clinician] was able to – I wasn't present in – in [YP] sessions but [clinician] was able to give her the tools to deal with – albeit temporary tools because I can tell you now [YP] was back to – I wouldn't say square one, but she's back to not a good place.

Q: And I think it'd be really helpful I think to explore a bit more about what you're noticing actually in terms of – it sounds like there's something about tools at the time, but also equally that actually those weren't – I think the key word there is temporary, isn't it?

A1: Yeah.

Q: And I think it would be really important to discuss that in a bit more detail as well, and some follow-up questions. So just to check in terms of all the family members who accessed the service. So [YP] accessed support with [clinician], and that was trauma focused CBT as far as you're aware?

A1: I – I've got to admit I went in with mistrusting as well, you know, because I walked in, saw two white ladies for want of a better words, and I thought now you tell me what do you understand about my struggle or our struggle? This is what I want to know, and straight away I'm thinking you're probably from Devon or Kent or a very Caucasian environment, have grown up in this Caucasian environment, have got your – your pre-existing biases. And how are you going to, you know, look at this? Are you going to look at it purely from a text book point of view? Or is there going to be some leeway in that?

Q: And what would, in your mind, what would the leeway have looked like? What would leeway mean?

A1: It would be really them taking themselves – okay for me it would be a case of them closing their eyes, so they've got a blank space. And then emerging themselves into that space, in the community in which they were now claiming they were there to help, and seeing exactly what was happening. Not just seeing a block on fire, I'm talking about all the deprivation, all the hostility, all the, you know, the calls when you've called the council and they didn't care. All of that you could only see if you closed your eyes, and you put yourself in that person's place. 'Cos with your eyes open there's too much of a distraction no matter how focused you are.

Author — parent appreciation of support
Reply

Author — Child mistrusting of clinician
Reply

Author — Distress requires intervention
Reply

Author — Noticing distress - unspecified
Reply

Author — Clinician helped YP make sense of their difficulties.
Reply

Author — Therapy gains not sustained
Reply

Author — Parent mistrusting of clinician
Reply

Author — Worry about lack of personalised care
Reply

Author — Parent view of good empathising
Reply

A1: Yeah, so let's change the six to X, you know, you're going to have – we can do X amount of sessions with you and then you're off on your own, we're going to give you some tools if you like, and then you're on your own. But that's not what happened with [YP].

Q: And so – I'm wondering, did they describe – before they made the offer of the trauma focused CBT, did they describe the kind – I wondered was their understanding of what [YP] was experiencing, how did that fit with what you thought was going on? Did it feel like a – yeah, I'm just curious about did it feel like a good enough fit – let me re-phrase that.

A1: I felt [clinician] was an exceptionally good fit because like I said, I don't know what her technique was, I didn't see it, so I can't say what it was. But I know quite a lot of it she allowed [YP] to write her feelings. Um, and then they would discuss what [YP] had written, they'd try and break it down. And, um, I think that's why it worked with [YP]. 'Cos she wasn't expected to sort of just – say well I'm feeling X, Y, and Z verbally. She was allowed to put that – express whatever that was on paper, and then they'd discuss it, and break it down.

Q: That makes sense. In my mind just two questions I want to ask you, I'm going to do one and then the other but that's all right …

A1: That's okay, that's okay, you carry on.

Author
Worry about availability of support

Reply

Author
Uncertainty about therapy strategy that enabled change/ not concerned about what CBT was as long as it helped

Reply

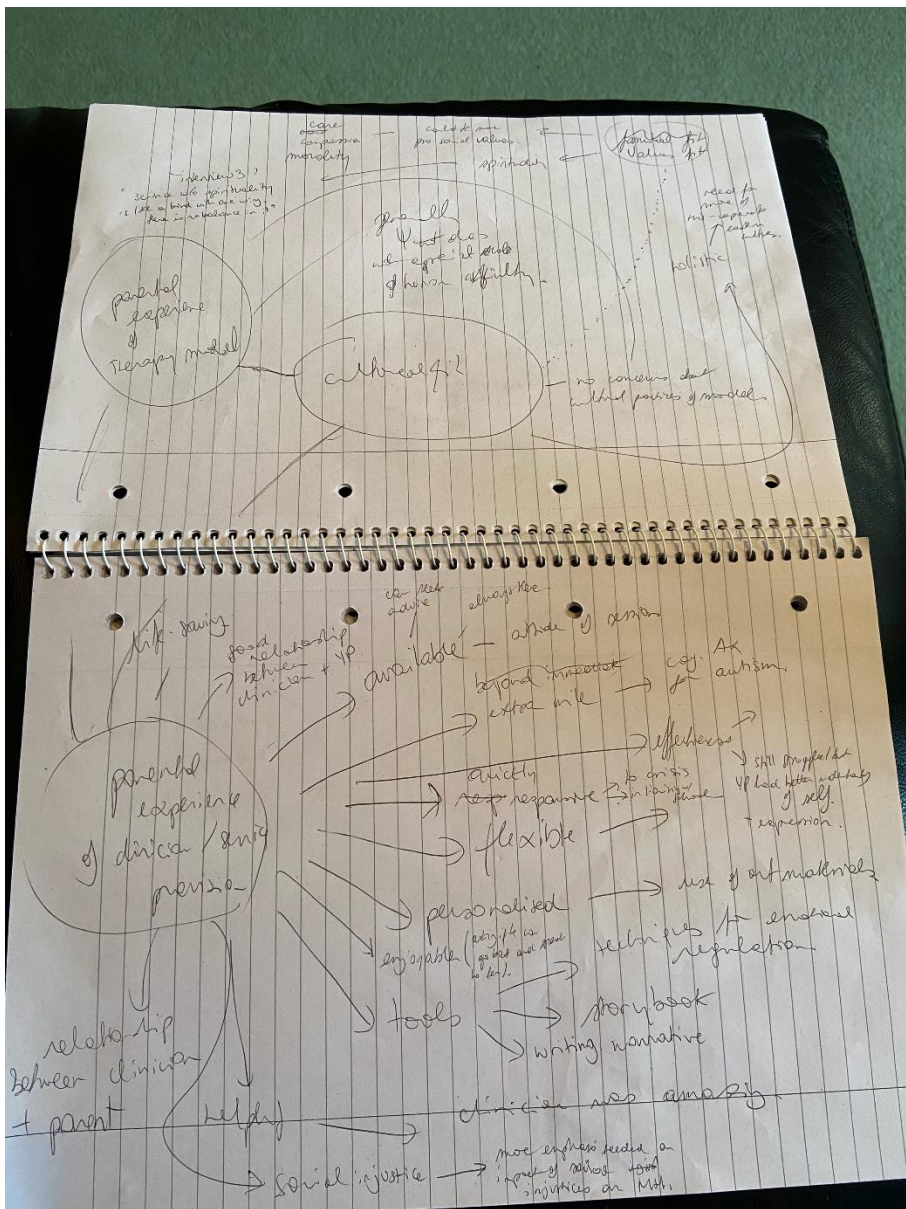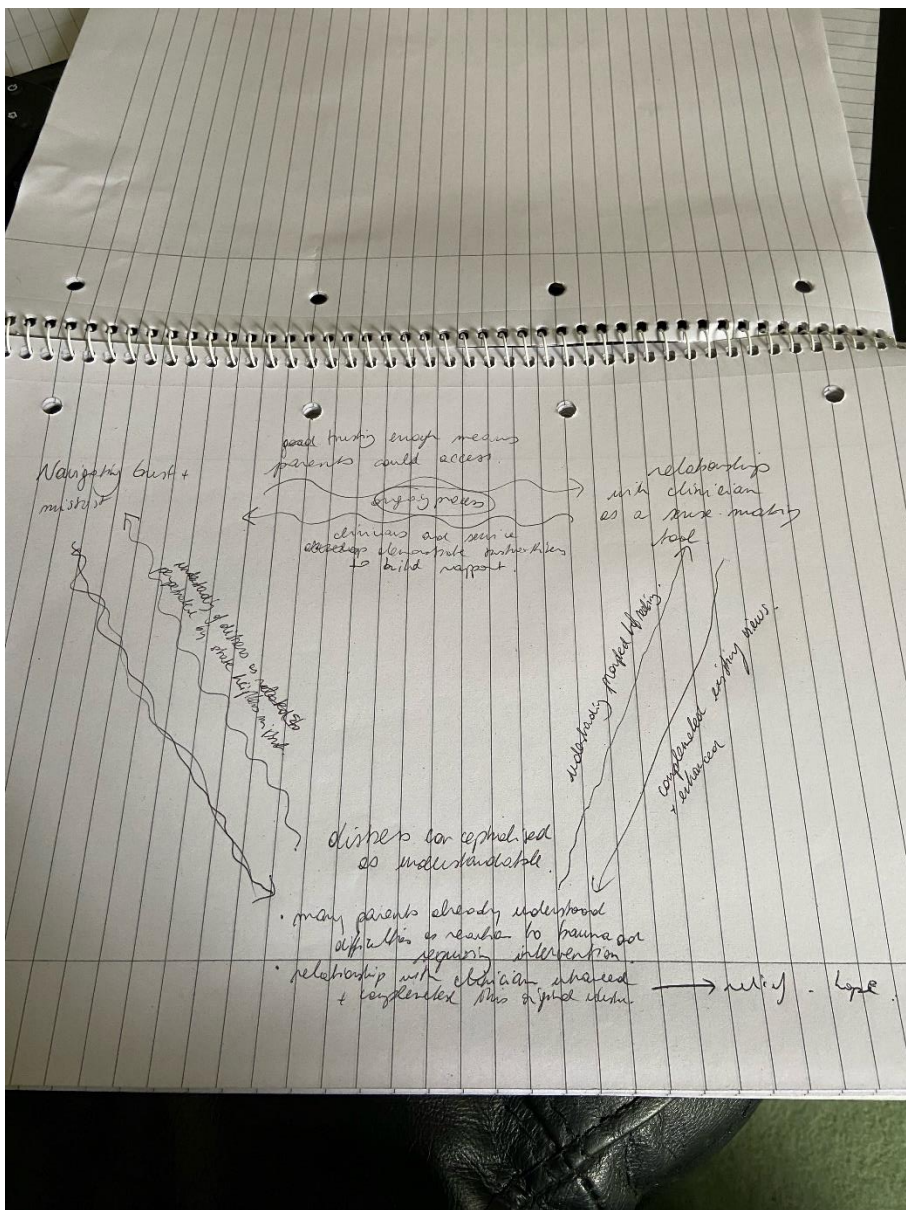**Author**
writing about feelings and thoughts

Reply

Appendix 12. Examples of theme development

Navigating trust +
mistrust

good trust enough means
parents could access

ongoing process

clinicians and service
developers demonstrate partnerships
to build rapport.

relationship
with clinician
as a sense-making
tool

understanding difference in relationship
dynamics in each relationship

understanding purpose of relation.

complexities of conflicting views.
+ enhances

dismiss as rationalised
as understandable.

• many parents already understood
difficulties as reaction to trauma or
requiring intervention

• relationship with clinician enhanced
+ complexities this significant meaning → relief - hope.

Trusting in the process	Trusting in the clinician as enabling change	Clinician ability to navigate difference sensitively	"I think [clinician] had almost done the closing of the eyes where colour wasn't – I'm not going to say she didn't see colour 'cos that's ridiculous, we all see colour." - P4 "Like he has been able to feel stable and he's very comfortable with [clinicians]. And this is two different cultures and diversities but he's very comfortable with [clinician]." – P6
		YP liked clinician	"adores her because he's got that relationship now with her" – P1.
		YP able to express themselves with clinician	"he really has built a relationship with [clinician]. You know, like he expresses himself quite well to her, which we were really happy about" – P1 "then I found that talking was better for him because they were doing it through play" – P6
		YP enjoyed sessions with clinician	" [clinician] always made it fun for her. So that she didn't feel like that she was, you know, sitting on a chair. She always wanted a bit of fun; it was like pencils out and drawing so that they could play. [clinician] would talk to her about the games that she likes. So that's, you know, how they sort of worked together. And then she'd always do like games on the whiteboard because [YP] would choose doing that with [clinician]. So yeah,

Appendix 13. Letter of ethics approval

> **Please note:** This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

13 October 2021

Mr Jordan Quinn
Trainee Clinical Psychologist
Surrey and Borders Partnership NHS Foundation Trust
18 Mole Business Park
Leatherhead
Surrey
KT22 7AD

Dear Mr Quinn

Study title:	**An exploration of the cultural dimensions of parents' understanding of their children's psychological assessment and trauma-focused cognitive behavioural therapy following the Grenfell tower fire.**
REC reference:	**21/LO/0505**
Protocol number:	**Not Applicable**
IRAS project ID:	**291025**

Thank you for your letter responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral:
https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

If you have not already included registration details in your IRAS application form, you should notify the REC of the registration details as soon as possible.

Further guidance on registration is available at:
https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

<u>Publication of Your Research Summary</u>

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit:
https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:
https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: <u>Reporting requirements</u>

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at
https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of insurance]		02 August 2021
Interview schedules or topic guides for participants [Interview Schedule]	1.0	06 May 2021
IRAS Application Form [IRAS_Form_11062021]		11 June 2021
Other [Thank you letter]	Version 1.0	18 August 2021
Other [Letter to REC & HRA with amendments made]		24 September 2021
Participant consent form [Consent Form]	Version 2.0	18 August 2021
Participant information sheet (PIS) [Participant Information Sheet]	Version 2.0	18 August 2021
Referee's report or other scientific critique report [Salomons research panel approval letter]		01 June 2021
Research protocol or project proposal [IRAS 291025 Study Protocol]	Version 2.0	22 September 2021
Summary CV for Chief Investigator (CI) [Jordan Quinn CV Version 1]	1.0	02 June 2021
Summary CV for supervisor (student research) [Dr Trish Joscelyne CV Version 1.0]	1.0	02 June 2021
Summary CV for supervisor (student research) [Dr Sara Northey CV Version 1.0]	1.0	02 June 2021

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high-quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 291025	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Laura Howe
Approvals Specialist

On behalf of

Ms Sunder Chita
Chair

Email:stanmore.rec@hra.nhs.uk

Copy to: Dr Fergal Jones

Appendix 14. Feedback report for Ethics Committee and Participants

Feedback report

Background: The NHS Grenfell Health and Wellbeing Service (GHWS) was tasked to screen and treat for trauma-related difficulties in the communities living near the tower following the fire of Grenfell Tower. Whilst the offering of trauma-focused cognitive behavioural therapy (TF-CBT) is in line with National Institute of Clinical Excellence recommendations for children exposed to traumatic events (NICE, 2018), the delivery of this particular type of therapeutic support presented a dilemma in the application of theory to practice: can a theory that is centralized on white European and global north philosophy, and tested for efficacy on a majority eurocentric sample (Stamm & Friedman, 2000), be a culturally sound trauma intervention for the multiple ethnic minoritised communities affected by the fire?

Aims: The study asked parents for their views about their children's TF-CBT assessment and intervention with the GHWS. The research questions posed by this study were:

1. How do parents understand the clinician's explanation of their child(ren)'s reaction(s) to the Grenfell Tower Fire; how did this fit (or not) with their own family and cultural understandings?
2. How do parents understand and experience the clinician's recommendation that their child(ren) should access trauma-focused cognitive behavioural therapy; how did this fit (or not) with their own family and cultural understandings of how to help children?
3. How do parents report how any similarities and/or differences in understanding affected how they supported their child(ren) during the time they received therapy?

Methodology: Reflexive thematic analysis was used to analyse interview data. Six participants were recruited to the study. Participation involved semi-structured interviews carried out either face to face or by videocall. Participants were provided with a participant information form and consent form prior to interviews and were debriefed afterwards.

Findings: A total of three themes were developed from the data, which were: starting from a place of mistrust; the therapeutic benefits of a working parent-clinician alliance; and trusting in the process of change. Parents described initially mistrusting services due to previous experiences of neglect and harm. Parents who sought help from the GHWS developed trusting relationships with their child's clinician. This relationship meant that parents' understandings of their child's difficulties were validated and expanded. Parents experienced trust in their clinician as a process that was enabling of change, meaning that the relationship was a channel for trust in the wider intervention. This meant that cultural fit was experienced as a relational process underpinned by trust. Overall, participants generally reported that they experienced the assessment and intervention as being of good cultural fit. Participants also shared aspects of the intervention that were particularly valued (relationship with clinician) and that would benefit from further development (incorporation of pro-social values; temporary nature of some strategies).

Conclusions: Findings from this study suggests that clinicians should actively discuss issues relating to culture and trust with the families they support in the delivery of TF-CBT, as well as consider how best to develop a trusting relationship with parents. This study also

emphasizes that parent experience of cultural fit is at least partially a relational process. Future research should consider how to increase research participation for members of communities who may not typically engage in research and who are affected by exposure to traumatic events.

Appendix 15. Journal information for publishing

Author instructions

Aims and Scope

The Cognitive Behaviour Therapist is published for the British Association for Behavioural and Cognitive Psychotherapies and is the sister Journal to *Behavioural and Cognitive Psychotherapy*

The Cognitive Behaviour Therapist is an interdisciplinary peer reviewed journal aimed at CBT practitioners. Published online, the journal will publish a range of types of papers (see below for a full description of each) that support CBT therapists in improving their delivery of CBT, supervision and training and/or develop our knowledge and understanding of CBT across all areas.

A particular feature of the journal is that its electronic nature is designed to ensure timeliness of publication and professional debate whilst also ensuring rigorous standards in the dissemination of high-quality materials with relevance to the practice of the cognitive and behaviour therapies.

Editorial Governance

The Cognitive Behaviour Therapist encompasses most areas of human behaviour and experience, and represents many different research methods, from quantitative to qualitative research, how to flexibly implement specific clinical interventions right through to detailed case studies. Under the guidance of its editorial board *the Cognitive Behaviour Therapist* aims to reflect and influence the continuing changes in the concepts, methodology, and techniques within the cognitive and behaviour therapies.

Editorial Statement – scope of journal content

The Editors welcome authoritative contributions from people involved, in the practice, research, education, training and supervision in the cognitive and behaviour therapies. Articles must be original and focused upon cognitive and/or behaviour therapy. There is no formal word limit but concision is recommended.

In terms of subject areas, our scope includes

- the delivery of CBT
- supervision of CBT
- training in CBT
- service model and forms of delivery of CBT.

Papers on these subject areas may fit within any of the types of papers detailed below.

Papers should be submitted online at https://mc.manuscriptcentral.com/cbt

Manuscripts should be submitted with any identifiers removed for blind review. If authors fail to omit identifiers, anonymised review cannot be guaranteed.

The Editor-in-Chief and Editorial Team will make an initial decision on of whether submitted papers fall within the remit of the journal and/or are of sufficient interest and importance to warrant full review.

Types of Paper

Original Research*

Research evidence is at the heart of the practice of cognitive and behavioural psychotherapists. Original research will be published that directly relevant to the practice of CBT, such as the therapeutic relationship, therapeutic process and the evaluation of therapeutic strategies and techniques. It is expected that such reports meet both the necessary standards of scientific rigour and the journal's requirement of clear implications for the practice of CBT. Consequently, the description of the research and the presentation of results should be sufficiently brief to enable sufficient discussion of the practice implications. Consideration will be given to quantitative, qualitative and mixed approaches given appropriate fit between the question, methodology and research methods chosen.

For examples see:

Hutton, J., Ellett, L., & Berry, K. (2017). Adult attachment and paranoia: An experimental investigation. *The Cognitive Behaviour Therapist, 10*, E4. doi:10.1017/S1754470X17000058

Kobori, O., Salkovskis, P., Pagdin, R., Read, J., & Halldorsson, B. (2017). Carer's perception of and reaction to reassurance seeking in obsessive compulsive disorder. *The Cognitive Behaviour Therapist, 10*, E7. doi:10.1017/S1754470X17000095

McManus, F., Leung, C., Muse, K., & Williams, J. (2014). Understanding 'cyberchondria': An interpretive phenomenological analysis of the purpose, methods and impact of seeking health information online for those with health anxiety. *The Cognitive Behaviour Therapist, 7*, E21. doi:10.1017/S1754470X14000270

This category of paper type could also include single-case experimental design research or a case series.

For example see:

Thomson, C., Wilson, R., Collerton, D., Freeston, M., & Dudley, R. (2017). Cognitive behavioural therapy for visual hallucinations: An investigation using a single-case experimental design. *The Cognitive Behaviour Therapist, 10*, E10. doi:10.1017/S1754470X17000174

Empirically Grounded Clinical Guidance Papers*

Some of the most widely-read and discussed papers in tCBT have been those that are the <u>synthesis</u> of clinical experience, informed reasoning and either limited direct evidence in the field with evidence from related fields.

tCBT is very keen to consider submission of such papers in relevant fields that are of interest to CBT therapists, supervisors and trainers. These tend to be written by experts in the field and are designed to solve specific practical problems or clarify gaps in our knowledge. Ideally they lead to practical implications and recommendations whilst generating hypotheses for future research.

For examples see:

Barton, S., Armstrong, P., Wicks, L., Freeman, E., & Meyer, T. (2017). Treating complex depression with cognitive behavioural therapy. *the Cognitive Behaviour Therapist, 10*, E17.

Duffy, M., & Wild, J. (2017). A cognitive approach to persistent complex bereavement disorder (PCBD). *the Cognitive Behaviour Therapist, 10*, E16.

Freeston, M., Tiplady, A., Mawn, L., Bottesi, G., & Thwaites, S. (2020). Towards a model of uncertainty distress in the context of Coronavirus (COVID-19). *The Cognitive Behaviour Therapist, 13*, E31. doi:10.1017/S1754470X2000029X

Freeston, M., Thwaites, R., & Bennett-Levy, J. (2019). 'Courses for Horses': Designing, adapting and implementing self-practice/self-reflection programmes. *The Cognitive Behaviour Therapist, 12*, E28.

Menzies, R., & Menzies, R. (2020). Death anxiety in the time of COVID-19: Theoretical explanations and clinical implications. *The Cognitive Behaviour Therapist, 13*, E19. doi:10.1017/S1754470X20000215

Murray, H., Merritt, C., & Grey, N. (2015). Returning to the scene of the trauma in PTSD treatment - why, how and when? *the Cognitive Behaviour Therapist, 8*, 1–12.

Murray, H., Pethania, Y., & Medin, E. (2021). Survivor guilt: A cognitive approach. *The Cognitive Behaviour Therapist, 14*, E28. doi:10.1017/S1754470X21000246

Warnock-Parkes, E., Wild, J., Thew, G., Kerr, A., Grey, N., Stott, R., . . . Clark, D. (2020). Treating social anxiety disorder remotely with cognitive therapy. *The Cognitive Behaviour Therapist, 13*, E30. doi:10.1017/S1754470X2000032X

Young, K., Chessell, Z., Chisholm, A., Brady, F., Akbar, S., Vann, M., . . . Dixon, L. (2021). A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. *The Cognitive Behaviour Therapist, 14*, E26. doi:10.1017/S1754470X21000192

Case Studies*

Dissemination of effective practice will be promoted through the publication of case studies that involve CBT with individuals, couples, groups and families. A suggested template is provided which is designed to ensure sufficient information is provided to allow other therapists to replicate successful therapy. All articles must include 3-5 learning objectives that will be achieved through reading the article. At the end of each paper a summary of the main practice points should be included with suggestions for follow-up reading. This stipulation is in keeping with the practitioner and professional development aims of the journal.

The case study should contribute to the development of theory or clinical practice, and feed into CBT practice as a whole rather than just relating to the specific case. Case studies should generally follow this structure:

- Abstract
- Key Learning Points
- Introduction: including an outline of theoretical research and clinical literature relevant to the case
- Presenting problem: including information on the presenting problem and associated goals of treatment, diagnosis, relevant history and development of problems, scores on standard and idiographic measures, relevant history
- Formulation: including a relevant theory-based CBT model used as a framework.
- Course of therapy: including methods used linked to theory and assessment of progress; difficulties encountered and any innovations in therapy
- Outcome: including clinical change, progress towards goals, change to measures, plans for follow-up
- Discussion: including relating to theory and evidence-base as well as reflections on own practice; implications for therapy and recommendations for other clinicians
- Key Practice Points
- Further Reading

For examples see:

Bernstein, R., Angell, K., & Dehle, C. (2013). A brief course of cognitive behavioural therapy for the treatment of misophonia: A case example. *The Cognitive Behaviour Therapist, 6*, E10. doi:10.1017/S1754470X13000172

Jenkins, P. (2017). Can temporary cessation of CBT really be therapeutic? A case study. *The Cognitive Behaviour Therapist, 10*, E8. doi:10.1017/S1754470X17000101

In addition to clinical case studies, there may be case studies related to training or supervision which would require a slightly amended structure to the one outline above.

Invited Papers*

At times tCBT will invite papers on specific issues where there is a gap in the clinical literature. This may involve commissioning papers directly from experts in a particular area or this may be a call to the wider CBT community.

Reviews*

Reviews of historical, contemporary, or innovative approaches to practice are also sought providing that they demonstrate relevance to the practice of the current cognitive and behavioural psychotherapies. Prospective authors for review papers should initially discuss their proposals with the Editor-in-Chief.

Reviews of Assessment Tools and Methods*

Reviews of clinical scales and other assessment methods will also be considered.

These reviews should provide the practitioner with a review of a scale's or other tool's purpose and properties, sufficient information to know how and when to use it, and how to interpret the results and make use of them. All articles must include a set of 3-5 learning objectives that will be achieved through reading the paper. At the end of each paper a summary of the main points from the paper must be included with suggestions for follow-up reading. This stipulation is in keeping with the practitioner and professional development aims of the journal.

For examples see:

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2013). The factor structure and composite reliability of the Profile of Emotional Distress. *The Cognitive Behaviour Therapist, 6*, E15. doi:10.1017/S1754470X13000214

Reiser, R., Cliffe, T., & Milne, D. (2018). An improved competence rating scale for CBT Supervision: Short-SAGE. *The Cognitive Behaviour Therapist, 11*, E7. doi:10.1017/S1754470X18000065

Service Models, Forms of Delivery and Cultural Adaptations of CBT*

The service model is the clinical and operational framework that exists to support the therapist with the delivery of cognitive behavioural therapies. Description and evaluation of innovative clinical service models (both in the UK and internationally) and delivery formats that can be generalised to other services will be considered for publication. Audits will only be considered if they are of wider interest and value in informing the work of other services.

tCBT is keen to publish research that either expands the evidence base for previously under-represented groups or work that describes and evaluates cultural adaptations that are required for different populations.

For examples see:

Jankowska, M. (2019). Cultural modifications of cognitive behavioural treatment of social anxiety among culturally diverse clients: A systematic literature review. The Cognitive Behaviour Therapist, 12, E7. doi:10.1017/S1754470X18000211

King, D., & Said, G. (2019). Working with unaccompanied asylum-seeking young people: Cultural considerations and acceptability of a cognitive behavioural group approach. The Cognitive Behaviour Therapist, 12, E11. doi:10.1017/S1754470X18000260

Thew, G. (2020). IAPT and the internet: The current and future role of therapist-guided internet interventions within routine care settings. The Cognitive Behaviour Therapist, 13, E4. doi:10.1017/S1754470X20000033

Thew, G., MacCallam, J., Salkovskis, P., & Suntharalingam, J. (2017). Developing and evaluating psychological provision in the acute hospital setting for patients with chronic respiratory disease. The Cognitive Behaviour Therapist, 10, E5. doi:10.1017/S1754470X17000071

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