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A Contextual Adaptation of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Victims of the Armed Conflict in Colombia

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Several decades of armed conflict in Colombia have left a large number of victims who present with multiple emotional disorders and reactions that interfere with their capacity to face daily stressors and improve their life conditions. Evidence-based interventions might help to ameliorate their situation, as long as they are properly adapted to the context and culture of victims of armed conflict. The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Barlow, Farchione et al., 2013; Barlow et al., 2018) represents an empirically grounded alternative especially suited to address basic processes common to multiple emotional reactions and improve the level of functioning and quality of life in this population. This article presents a thorough account of the methodology used to adapt the Unified Protocol to the particular contextual and cultural characteristics of victims of armed conflict in Colombia, as well as a detailed description of the end result of the contextual adaptation (CXA-UP). Implications for adapting evidence-based interventions to contexts of extreme violence are discussed and possible directions for future studies are outlined.

Cognitive-behavior therapy (CBT) encompasses various interventions aimed at psychological processes that maintain a variety of clinical problems (Battagliese et al., 2015; Butler, Chapman, Forman, & Beck, 2006). Protocols employing procedures such as exposure, cognitive restructuring, emotion regulation, and mindfulness training have proven efficacious for reducing symptoms in panic disorder (PD), posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and major depressive disorder (MDD; Hofmann & Smits, 2008), and in improving quality of life (Hofmann, Wu, & Boettcher, 2014). Efficacy has also been demonstrated for individuals living in low- and middle-income countries (LMICs; Barry, Clarke, Jenkins, & Patel, 2013) and conflict-afflicted regions (Palic & Elklit, 2011).

There are numerous individuals, especially in conflict zones, who have been exposed to contexts of extreme violence, live under hardship conditions and continuous stress, and present multiple emotional and behavioral problems. In addition to exposure to repeated extreme violence, many are forced to flee, becoming refugees or internally displaced people (IDPs) inside their country. This can cause further stress due to poverty, adverse living conditions, and unsafe neighborhoods. These emotional reactions interfere with individuals' functioning and ability to face daily stressors and increase the impact of previous or current traumatic events (Miller & Rasmussen, 2010). Studies with refugees in conflict zones consistently show that they have a higher risk of developing mental health problems as a result of repeated exposure to traumatic events (Ellis, MacDonald, Lincoln, & Cabral, 2008; Neuner et al., 2004; Steel et al., 2009).

Replicating results of evidence-based interventions (EBIs) in different cultural and educational backgrounds, contexts of violence, and in resource-limited low- and middle-income countries represents a stringent test for their applicability worldwide and for the generalizability of the principles and mechanisms on which they are grounded (Cardemil, 2015; Jalal, Kruger, & Hinton, 2017; Jalal, Samir, & Hinton, 2017).

This paper presents a detailed description of the process of the adaptation and an outline of the changes made to the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders for the particular context of continuous violence and adverse living conditions faced by victims[1]

Keywords: Unified Protocol; CBT; Global Mental Health; Armed conflicts; Low and middle income countries (LMIC)

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[1] Even though the term "victim" is subject to controversy for its subjectiveness and connotations of helplessness, it will be utilized throughout this paper, as the term is widely used and clearly defined in the local context due to legal implications of the Law of Victims (Congreso de la Republica de Colombia, Ley 1448, 2011).

of armed conflict in Colombia (CXA-UP). In a companion paper in this issue (Castro-Camacho, Moreno & Naismith, 2018), we present a detailed illustration of one complex case who completed the treatment, as part of an ongoing randomized clinical trial aiming to evaluate the effects of the CXA-UP on emotional difficulties, specific disorders and quality of life in a group of victims of armed conflict in Colombia.

Context of Armed Conflict in Colombia

Armed conflict in Colombia among government forces and illegal armed groups, such as guerrillas and paramilitaries, has lasted nearly 60 years, leaving over 8 million victims and 7 million IDPs. Many have been exposed to extreme violence, including witnessing massacres, undergoing torture, surviving combat attacks, losing family and friends by death or forced disappearance, experiencing multiple sexual assaults and violence, and being under continuous threat for their lives, among other extreme situations (Unidad de Víctimas, 2018). Moreover, many have been forced to flee their homes, leaving behind property and possessions, social groups and family ties, and cultural and spiritual practices (Shultz et al., 2014). They frequently relocate to hostile urban environments, where they struggle to acquire employment and fulfil basic needs such as food and shelter (Bozzoli, Bruck, & Wald, 2013; Ibáñez & Moya, 2010) and access to medical services (Mogollón-Pérez & Vázquez, 2008). Many face continued threats as they share neighborhoods with former perpetrators of violent acts, some of whom have been victims themselves (Arias, Ibáñez, & Querubin, 2014).

These extreme contexts have effects at multiple levels—individual, family, community, and social—which severely affect mental health and quality of life (Daniels, 2018). Studies in Colombia have consistently shown a higher incidence of anxiety disorders, depression, and substance abuse in active conflict zones (Bell, Méndez, Martínez, Palma, & Bosch, 2012; Campo-Arias, Oviedo, & Herazo, 2014; Gómez-Restrepo et al., 2016). Richards and colleagues (2011) found high rates of PTSD (88%), anxiety (59%) and depression (41%) among IDPs, while Lagos-Gallego, Gutierrez-Segura, Lagos-Grisales & Rodriguez-Morales (2017) found PTSD to be 5.1 times more prevalent in Colombian IDPs than in the general population. Multiple victimizations are associated with greater emotional distress (Campo-Arias, Sanabria, Ospino, Guerra, & Caamaño, 2017). Without adequate treatment, these conditions tend to become chronic and lead to other dysfunctions, like MDD, substance abuse, and violence (Keller et al., 2006; Siriwardhana et al., 2013; WHO, 2003). Economically, Moya (2018) found an association between exposure to violence and risk aversion in victims of armed conflict, which often worsened poverty by decreasing engagement in education, health care, and income-generating activities.

In summary, in reaction to contexts of violence and adversity, victims of armed conflict in Colombia, as in many other conflict zones, show high levels of distress and multiple emotional and behavioral disorders that interfere with their ability to face daily stressors, such as seeking and keeping jobs, maintaining healthy family and social relationships, and taking effective actions to solve problems and improve their living conditions (Miller & Rasmussen, 2010). Therefore, interventions with this population should be geared not only towards reducing symptoms of specific disorders but, more important, to targeting the main factors of interference and improving the level of functioning and quality of life. Unfortunately, in Colombia, evidence-based mental health programs to address this situation are lacking and, like in many other LMIC countries, there is a shortage of mental health professionals with adequate training to provide effective psychological interventions (Patel, 2009).

Intervention Adaptations

Although a logical approach to treat these multiple severe emotional effects of armed conflict would be to implement EBIs that have demonstrated effectiveness for emotional problems similar to the ones found in this population (Spilka & Dobson, 2015), several caveats should be considered beforehand (Hays, 2009).

First, evidence-based practice in psychology advocates integrating the best available research with factors such as personal characteristics, culture, ethnicity, educational and social background, developmental factors, belief systems, context and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). Accordingly, although all interventions must be adapted to the particular conditions of individuals, when there are groups sharing similar characteristics in different cultures and contexts, cultural adaptations are warranted. Although there are similarities, the present population has distinct cultural and educational characteristics from the population for which evidence-based protocols were originally developed. Culture has been defined as "the intergenerational transmitted system of meanings shared by a group or groups of people" (Bernal & Rodríguez, 2012, p. 4), including objects, social norms, values, and behavior. As Ametaj and colleagues (2018) point out, it is a complex and dynamic process that cannot be reduced to ethnicity, race, or nationality. Context, on the other hand, refers to both current and historic environments that influence behavior through consequences (Morris, 1992) or by providing information about possible upcoming events (Bouton & Nelson, 1998). Although structural aspects of context may be difficult to change in the short term, individuals can modify the way they relate to context. For the purposes of this paper, context refers to living conditions and violent environments faced by victims of

armed conflict. Thus, context and culture interactions may give rise to different outcomes. Adaptations of evidence-based interventions in victims of armed conflict should encompass both cultural and contextual characteristics.

Second, most evidence-based interventions have been geared to specific diagnostic categories, such as PD, GAD, MDD, or substance abuse (Batagliese et al., 2015; Hofmann et al., 2012). However, victims of violence, besides meeting criteria for multiple comorbid diagnoses, show other reactions like sleep difficulties, pain and somatic symptoms and emotional outbursts, which interfere with their daily activities and are not always included in diagnostic categories (Bell, Méndez, Martínez, Palma & Bosch, 2012; Gómez-Restrepo et al., 2016).

Cultural Adaptations

The influence of culture on the outcomes of psychological interventions has been widely documented (Bernal, Bonilla, & Bellido, 1995; Bernal & Rodríguez, 2012; Castro, Barrera & Holleran Steiker, 2010; Chu & Leino, 2017; Hays, 2009; Hofmann, 2006). The expression of specific disorders shows cultural variation, such as prevalence of somatic symptoms (Hinton & Otto, 2006; Jobson, Moradi, Rahimi-Movaghar, Conway, & Dalgleish, 2014). Besides, cultural adaptations of EBIs can be more effective than regular interventions (Hall, Ibaraki, Huang, Marti, & Stice, 2016).

The feasibility of culturally adapting EBIs has been widely demonstrated with specific disorders under two different conditions that illustrate culture-context interactions. The first includes adapted interventions with individuals or communities who, although *living in the same context where the intervention was developed and evaluated*, have different culture, ethnicity, traditions, belief systems, and educational background to the majority of the population. As such, they constitute minorities within a culturally different dominant population. One example is the adaptation of psychotherapy for Aboriginal Australians, including modifying language and session structure to social and cultural needs (e.g., ethnicity, literacy, and age) and training Aboriginals to deliver the therapy (Bennett-Levy et al., 2014). Another is the adaptation of manualized treatments for anxiety disorders for native Americans, which have considered contextual elements such as difficulties in transportation, lack of telephones, and poor weather and road conditions, as well as cultural characteristics like collective worldviews, spirituality and educational and language barriers (De Coteau, Anderson, & Hope, 2006). Similar studies support the feasibility of cultural adaptations for substance abuse, social anxiety, and GAD with Latinos (Burrow-Sanchez & Wrona, 2012; Graham-LoPresti, Gautier, Sorenson, & Hayes-Skelton, 2017; Mercado & Hinojosa, 2017), panic disorder and agoraphobia in ethnic minorities (Friedman, Braunstein, & Halpern, 2006); immigrants (Hwang, 2016), as well as PTSD and somatic symptoms in refugees (Hinton & Otto, 2006; Hinton, Safren, Pollack, & Tran, 2006; Schulz, Huber, & Resick, 2006).

The second adaptation involves individuals belonging to the mainstream culture, who are *living in contexts/cultures different from the original context in which the intervention was developed and evaluated* (e.g., different countries, with different languages, religions, value and belief systems, educational backgrounds, and different settings such as rural vs. urban) and economic contexts (low and middle income). Examples include the cultural adaptation of DBT in Nepal (Ramaiya, Fiorillo, Regmi, Robins, & Kohrt, 2017). A three-stage approach, including qualitative interviews with relevant stakeholders, training of local counselors, and conducting a pilot study, produced an intervention adapted to language and terminology, religion, educational background, economic status and literacy level, metaphors and imagery and ethnopsychology, which was effective in reducing suicidal behavior. Additionally, Multiplex CBT in South Africa illustrates the effects of a transdiagnostic protocol emphasizing somatic processing and emotion regulation culturally adapted to the specific needs of a traumatized South African indigenous group with low levels of education. To avoid stigmatization, this program normalized the intervention and used local metaphors to explain basic concepts (Jalal, Kruger, & Hinton, 2017). Similarly, Jalal, Samir, and Hinton (2017) describe a culturally adapted program with traumatized Egyptians where they use culturally meaningful practices to illustrate CBT principles. Common elements of all these adaptations include training providers of the same cultural background as the clients, adaptation to language and terminology, and using culturally relevant examples and practices reflecting the clients' worldview. The results of the above-mentioned studies support the efficacy of cultural adaptations of CBT for the most prevalent disorders (e.g., PTSD, panic attacks, depression and somatic symptoms) among this population. When adapting EBIs to victims of armed conflict, the second type of adaptation should be more relevant. Therefore, cultural elements including family and collective values, graphic rather than text-based materials, accessible language and colloquial terminology, and use of examples of victims' own experiences to explain concepts should be integrated into the intervention.

Contextual Adaptations

When adapting EBIs for victims of armed conflict, adaptation to context is at least as important as adaptation to culture. This refers to conditions such as exposure to

intense, unpredictable violence, human rights violations, and displacement leading to feelings of lack of control, personal and social losses, and helplessness, which naturally generate intense emotional reactions, behaviors, and beliefs in individuals, families, and communities. Of course, these properties can hardly be considered cultural, and may produce similar reactions in individuals from different cultural backgrounds. Consequently, in our particular case we prefer the concept of contextual (CXA), rather than cultural adaptation. In our view, contextual adaptations encompass cultural elements but also include other factors such as continuous exposure to violence and adverse living conditions generating intense distress.

As discussed in the literature, diagnosis-driven interventions may not be appropriate for this population (Miller, Kulkarni & Kushner, 2006; Summerfield, 1999). Victims of armed conflict understandably are reluctant to be labeled and treated according to psychiatric diagnoses, as this can invalidate extremely traumatic experiences. Furthermore, they show multiple comorbid emotional disorders that would require a diversity of EBIs, constituting a barrier for dissemination due to high costs of providing different treatments and training mental health providers in different therapeutic interventions for each disorder.

Transdiagnostic interventions aimed at common psychological processes seem more suitable for this particular population and allow individuals to increase their level of functioning to face daily stressors and improve quality of life (Farchione & Bullis, 2014; Mansell, Harvey, Watkins, & Shafran, 2009; Murray et al., 2014; Norton & Paulus, 2017). Indeed, several transdiagnostic CBT interventions, such as modular approaches based on Common Element Treatment Approach (CETA; Bolton et al., 2014; Murray et al., 2014) or Culturally Adapted CBT programs (CA-CBT; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012), and Culturally Adapted Multiplex CBT for trauma (Jalal, Kruger et al., 2017; Jalal, Samir et al., 2017), have shown to be effective with refugees and victims of armed conflict.

The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Allen, McHugh, & Barlow, 2008; Barlow, Farchione et al., 2011; Barlow et al., 2018) has been widely investigated and seems particularly appropriate for the specific characteristics of victims of armed conflict for several reasons. First, it distills the essential features of CBT interventions for emotional disorders that have demonstrated applicability for a diversity of emotional and behavioral difficulties like those found in the victim population (Barlow, Allen & Choate, 2004). In fact, studies have found evidence of effectiveness in anxiety, depression, and a variety of emotional difficulties (Barlow et al., 2017; Ellard et al., 2010; Farchione et al., 2012) and personality disorders (Lopez et al., 2014; Sauer-Zavala, Bentley & Wilner, 2016), with different age groups (Ehrenreich, Kennedy, Sherman, Bilek, & Barlow, 2018; Kennedy, Bilek & Ehrenreich-May, 2018) and with outcomes maintained over time (Bullis, Fortune, Farchione & Barlow, 2014). Some preliminary data also suggest changes in temperament (Carl, Gallagher, Sauer-Zavala, Bentley, & Barlow, 2014). Furthermore, it has been adapted (Ametaj et al., 2018) and shown evidence of effectiveness in different cultural settings, including Japan (Ito et al., 2016), Spain (Castellano, Osma, Crespo, & Fermoselle, 2015), and Brazil (de Ornelas Maia, Nardi & Cardoso, 2015).

Second, since the UP targets transdiagnostic processes common to different emotional problems, the same protocol may be used with different diagnoses, rather than requiring different interventions for each disorder. The UP has comparable effects and less relapse rate than specific evidence-based disorder targeted protocols (Barlow et al., 2017; Steele et al., 2018). This emphasis on transdiagnostic processes also means that emotional problems that do not fit diagnostic categories can be addressed too (Ellard et al., 2010). Gallagher et al. (2013) showed that the UP significantly increases quality of life, which may be more relevant than symptom reduction for this population.

Third, the UP is a short-term treatment (12–16 sessions) feasible for a highly mobile population (Barlow, Farchione et al., 2011). Finally, being structured around specific modules, it allows some flexibility, can be delivered in group and other formats (Bullis et al., 2015; Castellano et al., 2015; de Ornelas Maia et al., 2015), which simplifies training of therapists, making it amenable to stepped-care dissemination (Cassiello-Robins, Murray-Latin, & Sauer-Zavala, 2018).

Contextual Adaptation of the UP (CXA-UP)

Contextual adaptation involves both matching cultural characteristics and contextual elements. Although different methods for developing cultural adaptations of EBIs have been outlined in the literature (Bernal & Rodríguez, 2012; Castro et al., 2010; Hinton & Jalal, 2014; Marsiglia & Booth, 2015; Spilka & Dobson, 2015), there is less emphasis in contextual adaptations. There are two dimensions that have been the focus of debate in cultural adaptations of EBIs: fidelity to the original protocol and fit to the needs and conditions of the target population (Castro et al., 2010). Resnicow et al. (2000) distinguished surface structure adaptations (matching interventions to superficial characteristics of the target population such as language, intervention setting and reference to familiar concepts) from deep structure adaptations (including deeper social, cultural and historical elements of the culture, such as involving family in collectivist cultures, or

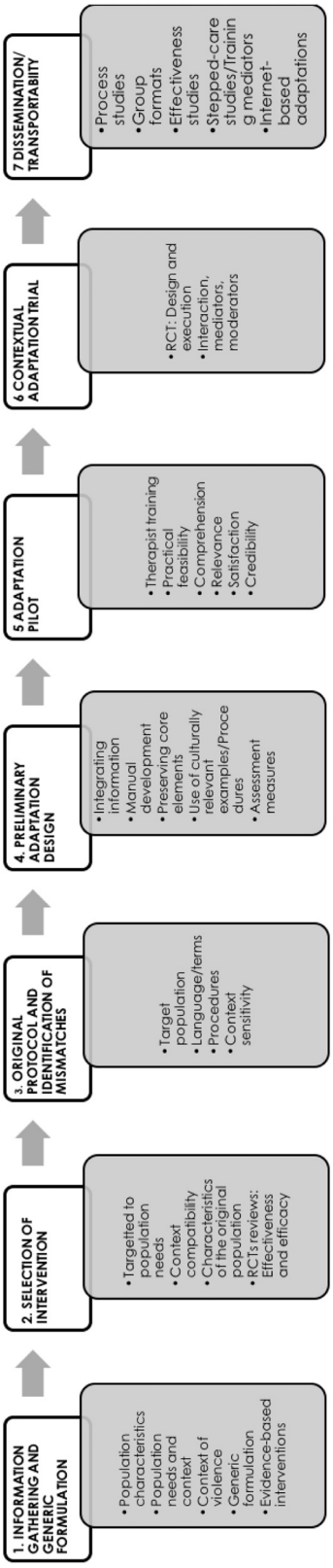

Figure 1. Stages of the contextual adaptation process

incorporating cultural understandings of illness onset and alleviation, like illness being a punishment from God). The need for deep adaptations is an open empirical question, related to differences between the two cultural settings. Certainly, Latin America shares considerable cultural similarities with the U.S. (where the UP was developed), including Christian values and some European customs from Spanish colonialism. Differences in education level and literacy, while important, can be responded to with surface adaptations. Therefore, as a first step in the process of the contextual adaptation we decided to evaluate the efficacy of the UP by preserving its fundamental properties. Along those lines, we used a methodology that balanced the essential characteristics of the protocol, core concepts, order of modules, specific procedures, methodology of delivery, and targeted problems with the particular characteristics of the population, including educational background, cultural values, beliefs, and customs to react to a context of violence and living conditions. For that purpose, we expanded on the methodology for cultural adaptations outlined by Barrera et al. (2013) as follows (see Figure 1).

Information Gathering and Generic Formulation

First, we gathered information about relevant characteristics of the population and context, as well as on evidence-based interventions with similar problems and in similar contexts.

Population Characteristics

Although there are some predominant characteristics like Spanish language, Catholic religion, and family values, given its topographical characteristics that hinder transportation and communication among different regions, Colombia is a multicultural country with diverse ethnicities, customs, climate, and both rural and urban population. Over 98% of victims of armed conflict are literate but highest education level attained varies widely (18% primary education, 49% high-school). More than half of victims are unemployed, 41.2% with an informal employment and only 2.8% with a formal employment, resulting in 93.9% in conditions of poverty in contrast with 30.6% of the general population. In terms of traumatic events, 78% of victims are IDPs, 10.8% have experienced homicides of close relatives and friends, and 4.2% have been threatened (Unidad de Víctimas, 2018). To inform the adaptation, taped testimonies of victims describing their own experiences with traumatic events and violent context were analyzed, with emphasis on language, terms, and detailed examples of their experiences.

Population Needs and Context

Specific mental health and emotional problems were identified through (a) a systematic literature review of epidemiological and descriptive studies about the effects of armed conflict in mental health problems in Colombia and in conflict zones around the world; (b) a review of government reports, archives of the Colombian Center of Historical Memory, and unpublished studies and reports assessing mental health characteristics of victims of armed conflict in Colombia; (c) analysis of taped testimonies; (d) interviews with psychosocial professionals working with victims of armed conflict; and (e) interviews with victims of armed conflict, aimed at identifying specific mental health and emotional needs. The diagnostic categories most frequently identified were: PTSD, GAD, panic disorder, MDD, somatic symptoms, complicated grief, and substance use disorders, as well as a wide array of emotions (e.g., fear and anxiety, sadness, helplessness, guilt, shame, and anger), and emotional behaviors (e.g., avoidance, intrafamily violence, passivity and substance abuse).

Generic Formulation

On the basis of such information, a generic formulation was developed pointing to the role of context providing inaccurate information about potential dangers resulting from previous experience with violent events, eliciting intense emotional reactions that hindered useful reactions to current stressors.

Information About Evidence-Based Interventions

Based on the specific needs identified and the generic clinical conceptualization, an extensive literature review was undertaken of (a) evidence-based interventions addressing specific problems identified in the population (e.g., PTSD, depression, substance abuse, and somatic symptoms); and (b) EBIs for populations with similar contexts to those previously identified (e.g., refugees, IDPs, or in conflict zones).

Selection of Intervention

Based on the outcome of Stage 1 and the generic conceptualization, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders was selected as the most suitable approach to fit the needs of the target population, for the reasons described previously.

Original Protocol and Identification of Mismatches

Core elements described in the original protocol were identified from the therapist manual (Barlow, Farchione et al., 2011) and the workbook (Barlow, Ellard et al., 2011), in terms of basic concepts in each session, content, structure (i.e., modules and order), examples, homework exercises, delivery, and methodology. Potential mismatches between the original protocol and the

characteristics of the population were identified as an initial step for adaptation to cultural disparities. First, the original protocol's emphasis on the definition of specific emotional disorders according to diagnostic categories, reflecting familiarity with psychiatric labels in the cultural context where the UP was developed, clearly does not match the culture and context of our target population. Second, considering the target population's lower level of formal education and familiarity with reading material, most of the text in the adapted workbook was not appropriate and needed to be reduced and replaced with more graphic explanations. Third, the need to use more inductive methodologies to explain basic concepts was identified, starting from specific examples of victims' experiences to illustrate concepts rather than starting from formal explanations and ending with examples from their own experience. Likewise, the use of colloquial terms and examples relevant to the current context were identified as targets for adaptation.

Preliminary Adaptation Design

Based on the guidelines above, the therapist manual and workbook were translated and adapted into Spanish by the principal investigator and members of the research team, who were all experienced clinical psychologists and bilingual. Specific examples relevant to the experiences and characteristics of the population were rewritten to illustrate basic concepts (e.g., examples related to traumatic events, displacement and current experiences in new settlements). Likewise, graphic material was added to explain concepts, and specific homework assignments were modified on the basis of their educational level (see Figure 3). For the reasons stated above, the first three chapters of the original workbook on definition and examples of emotional disorders, evaluating appropriateness of the program and recording emotions were replaced by a single chapter on emotional difficulties affecting areas of functioning. Vignettes and self-assessment quizzes in the original workbook were removed and replaced by a summary of skills expected to be learned at the end of each session, since lower-educated individuals could feel threatened or simply were not used to completing quizzes. The therapist manual was also adapted and special sections on the therapeutic relationship, particularly the importance of respect and validation and inductive method for explaining concepts based on victims' own experience, were added. Like in other EBI adaptations, an additional unstructured session, "Session 0," was added before the first structured protocol session, for reasons described later.

Input from relevant stakeholders was obtained to evaluate fidelity to original intervention and appropriateness for the target population. First, both the adapted therapist manual and participant workbooks were evaluated by a member of the group of the original program developers who was fluent in Spanish. Second, the adapted versions of both workbook and therapist manuals were evaluated by an expert panel comprised of three psychosocial therapists with more than 1,000 hours of direct contact with victims, three community leaders, and two victims of armed conflict. They were asked to rate the following elements: language/terms, core concepts, examples, in-session exercises, homework exercises, forms and graphic illustrations; on three 1–5 Likert scales representing three dimensions: (a) ease of understanding, (b) familiarity and cultural relevance (i.e., had meaning within the cultural context of individuals), and (c) usefulness (i.e., responded to specific needs of the potential participants), for the workbook as a whole and for each of the sessions. On the basis of both inputs, adjustments were made to the final protocol.

Adaptation Pilot

To ensure protocol quality and fidelity when piloting the program, therapists were advanced postgraduate students of clinical psychology, with knowledge of the theoretical foundation of the program and a minimum of 2 years previous supervised clinical experience in CBT for emotional disorders. Therapists first participated in a training workshop conducted by one of the developers of the original protocol (K. Ellard) and had to pass an evaluation testing knowledge of protocol content, theoretical foundations, and methodology. Then, they participated in a second training workshop on the final contextually adapted sessions, including recorded clips of the director of the study (LCC) modeling skills with a real participant.

A pilot application with three participants allowed final adjustments to timings and agenda of sessions, content, and homework materials. Session length was adjusted to 90 minutes from the original 60 minutes to enable thorough explanations of all concepts, given that in this context it was expected that some participants would not complete the pre-session workbook readings, or not understand them. Furthermore, it provided time to complete the session measures verbally when necessary. Some examples were made more relevant to victims' experience. The revised version of the protocol was further evaluated both by therapists and by participants regarding clarity of concepts (degree to which participant understood main concepts in each session); timing and organization of the session; clarity of written materials and workbook; in-session practical exercises; homework assignments; and general satisfaction with the program. On the basis of collected information, adjustments were made to both therapist manual and participant's workbook, resulting in the final version to be used in the RCT

of the CXA-UP. The final program consisted of an initial pre-protocol session and 12 to 14 ninety-minute sessions, as described in the following section.

Contextual Adaptation Trial

A randomized controlled trial (RCT) of the CXA-UP is being currently undertaken to compare the effects of the CXA-UP in a group of 100 victims of armed conflict with emotional problems, randomly assigned to a treatment condition (N = 50) or a waiting-list, delayed treatment condition (N = 50).

Participants continue to be recruited from various referral sources: government agencies providing psychosocial assistance, victims' organizations, NGOs, and snowball sampling. Inclusion criteria include: (a) having experienced the violence of the armed conflict, being an IDP or having been exposed to other traumatic events within the context of armed conflict; (b) presenting strong emotional reactions as shown by screening instruments, and (c) having food and shelter, since unmet basic needs can interfere with progress in the program. Participants with psychotic symptoms, antisocial personality, substance dependency or current suicide ideation are excluded from the study and referred to mental health services.

The intervention is being conducted in Spanish via individual sessions in university therapy rooms. Therapists (10) are native Colombians and are completing or have completed postgraduate studies in clinical psychology, again with a minimum of 2 years supervised clinical experience. All therapists attend weekly supervision sessions with senior therapists, the director of the study (LCC) and a member of the original program development group (AA). The program is currently being delivered weekly or twice-weekly according to participants' availability.

CXA-UP Description

Since the UP modules and case illustration have been clearly described elsewhere (Barlow, Farchione et al., 2011; Barlow et al., 2018; Boisseau et al., 2010; Ellard et al., 2010), here we outline the contextually adapted sessions, emphasizing the essential elements of the original protocol that were preserved and the changes that were introduced to fit the contextual and cultural characteristics of participants. Like in the original protocol, sessions are structured according to the manual but there is some degree of flexibility in terms of the number of sessions per module, to fit specific needs of participants.

Every session is fully described in the therapist manual, which includes the following sections: (1) module description and an overview of main concepts; (2) materials: assessment forms, workbook, in-session exercises and forms, homework assignments; (3) core concepts to be presented through exercises and examples; (4) participant objectives; (5) specific goals for the therapist; (6) agenda; and (7) homework assignments. Emphasis is made throughout all sessions on a working relationship based on empathy, validation, and respect for participants' expressions. This is achieved through using first name to address each other to promote closeness, active listening, acknowledging and validating feelings and reactions, frequent summary statements, and asking for feedback at the end of each session. A bottom-up, inductive method was used to illustrate concepts through past and current experiences of participants, rather than lecturing or providing and theoretical explanation of concepts. The participant's workbook describes the session objectives, a graphic depiction of the main concepts, in-session exercises, and recording forms with instructions for homework.

Session Structure

Session 0

The first change introduced in the CXA-UP is the introduction of this preliminary session. Due to participants' lack of previous exposure to psychological interventions, this unstructured session is first aimed at providing relevant information about the skills-oriented nature of the program. Second, the session establishes a trusting and respectful relationship (described earlier). Third, this session provides the opportunity for participants to talk freely about their experiences, feelings, and thoughts, in a safe and validating context, fostering a collaborative therapeutic relationship. This is important since victims of conflict are often eager to share and narrate their experiences so that the therapist understands their context (Acosta, Yamamoto, Evans, & Skilbeck, 1983; Hwang, 2016). Conversely, some participants had previous negative experiences with help-seeking (since healthcare expertise varies widely in LMICs) and being interviewed about their experiences (e.g., having to give testimonies about their traumatic experiences in legal and/or police contexts). Fourth, since there are idiosyncratic cultural characteristics unique to individuals (Muñoz & Mendelson, 2005), it allows the therapist to gather preliminary information about individual cultural and contextual features, educational background, current functioning and areas of interference, history of trauma, and initial level of motivation to predict engagement. This information may assist in intervention planning.

Module 1. Motivation Enhancement and Definition of Distress (2 Sessions)

Session 1

At the beginning of this and every session, three instruments for tracking progress during the program

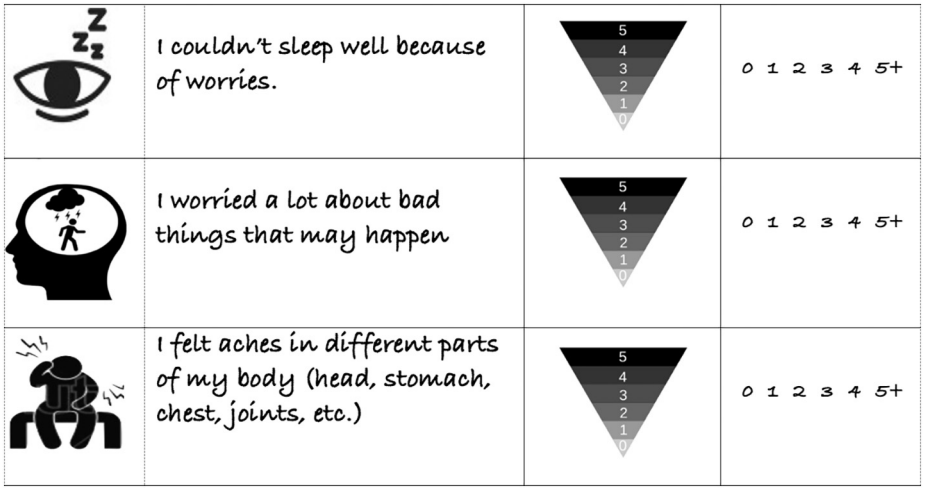

Figure 2. Example of 3 pictorial items in CURE

were completed by the participant, with the therapist reading aloud when necessary. These were two short instruments assessing frequency, intensity, avoidance, and interference of anxiety and sadness with activities and social life: The Overall Anxiety Severity and Impairment Scale (OASIS; Norman, Cissell, Means-Christensen & Stein, 2006) and the Overall Depression Severity and Impairment Scale (ODSIS; Bentley, Gallagher, Carl, & Barlow, 2014). The third instrument was the CURE (Uniandes Illustrated Questionnaire for Emotional Reactions), a graphic 12-item self-report scale, designed for this study, where participants rated on a 1–5 scale frequency and intensity of specific emotional reactions: avoiding intense emotions, feeling nervous, difficulties sleeping, nightmares, anger, emotional outbursts, pain, worries, sadness, and physical symptoms (sample items are depicted in Figure 2).

Session 1 represents the most significant modification to the original protocol. While the first session of the original UP focuses on defining emotional disorders, the corresponding section in the CXA-UP describes the relationship between emotional reactions and functioning in different areas of life (marriage, family, work, study, social relationships, recreation and health), and defines emotional difficulties in specific behavioral terms. Additionally, this session aims to help participants identify how intense emotional states and current coping mechanisms may interfere with functioning and facing daily stressors. Third, participants learn to relate those emotions to

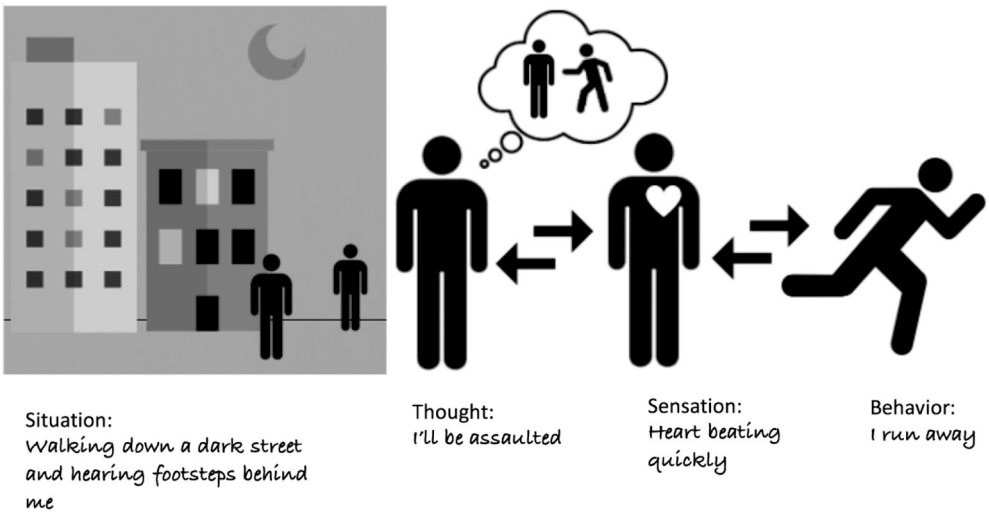

Figure 3. Graphic illustration of the three components of emotions in the Workbook.

previous experience with violent events and displacement and to current stressors, so they can view those reactions as "normal" responses to "abnormal" events, instead of attributing them to personal faults or pathologies. These steps provide a simple way for participants to describe and understand their difficulties. Finally, therapists explain the nature, methodology, and purposes of the program: to provide participants with practical tools to react more effectively to emotions and daily demands, to reduce distress, and increase their quality of life.

Session 2. Motivation and Treatment Engagement

The previous session helped participants to understand the effects of emotional experiences on different areas of their lives in order to highlight possibility for change, which is the basis for motivational interviewing exercises in this module. Since their previous experiences and lack of control often lead to motivational deficits, this session helps participants to recognize that even though there are some aspects of their situation that are beyond their control, there are many others that they can change. Mirroring the original protocol but adapted to include graphic material, a decision balance between advantages and disadvantages of changing or remaining the same, and goal-setting exercises to practice deconstructing goals into specific steps, are carried out both in session and as homework. In order to increase compliance, a final exercise on anticipation of obstacles to complete the program and possible solutions was added.

Module 2. Psychoeducation and Tracking Emotional Experiences (1–2 Sessions)

The original topic and main concepts of the original UP were preserved, but emphasis is made on using examples of individuals' previous traumas to show how emotions are adaptive in situations of real danger and provide useful information about context. Yet, in their current situation they remain intense, provide inaccurate information and inhibit their present functioning. The three components of emotions (physical sensations, thoughts, and behaviors) and how they interact, as well as triggers and short and long-term consequences of emotional reactions, are explained through exercises using graphic illustrations (see Figure 3) and examples from participants' own experience. The objective is for individuals to attain a more objective view instead of feeling trapped in their emotions. Participants are asked to keep practicing the same exercise in the workbook. Considering the cultural importance of family and social values, they are encouraged to share information and practices with family and friends after all sessions.

Module 3. Emotional Awareness Training (1 Session)

The core concept of the original session of the UP (learning to observe one's emotional experience in the present moment without judging) was preserved but framed in the context of victims' previous experience with violence. The focus for the adapted version is to increase awareness of how emotions may be linked to past traumatic experiences, not allowing victims to perceive the present context objectively. The mindfulness and "anchoring in the present" exercises from the original workbook were integrated into one. Simple graphs illustrating the natural course of emotions, not included in the original workbook, were added to help them observe how emotions tend to self-regulate without active attempts of control. Depending on individual preferences, affective induction exercises with audios of music or natural sounds were practiced both in session and assigned as homework.

Module 4. Cognitive Appraisal and Reappraisal (1 Session)

In the original UP, the cognitive component of emotions is introduced with a theoretical explanation that a person can attend to many different stimuli in any situation; that our minds select certain ones and interpret them according to past experiences; that the stimuli we select affect our emotions; and that this is often unconscious, followed by an exercise of interpreting an ambiguous image (Barlow, Farchione et al., 2011). The adapted manual moved straight to the ambiguous image exercise to illustrate inductively how prior experiences shape our thinking, and inflexible thinking in turn may contribute to maintaining intense emotional reactions. A new worksheet for participants to record examples of daily experience and possible different interpretations was also added. Following the original UP, in-session exercises and homework on identification of thinking traps are used to help participants develop more flexible appraisals. The original exercise of the downward arrow technique was eliminated, as it was shown to be difficult to understand in the pilot studies while not enhancing flexible thinking.

Module 5. Avoidance and Emotion-Driven Behaviors

This session focuses on the second component of emotions, behavior and automatic action tendencies, such as patterns of avoidance and emotional behaviors. The original exercises on identification of avoidance patterns, subtle avoidance, safety signals and thought avoidance were presented in a graphic form to complete in-session and practice afterwards. Following the original UP, participants were also asked to identify emotional behaviors they were using and possible opposite actions. The role of avoidance behavior in maintaining distress

long-term was explained using participants' own experiences. The only modification to the original UP was that the two chapters in the workbook on emotional avoidance and emotional behaviors in the original workbook are subsumed into one chapter.

Module 6. Awareness and Tolerance of Physical Sensations

This module focuses on the third component of emotions: physical sensations. Mirroring the original UP, participants learn to become aware of their physical sensations and to observe them in perspective, through several exercises triggering uncomfortable physical sensations, like hyperventilation, breathing through a straw, static running, and spinning. Participants are instructed to repeat these exercises for homework and learn to tolerate those sensations without attempts to avoid or decrease their intensity. The homework form was adapted to include pictures indicating how to perform each exposure.

Module 7. Emotional Exposure (4 Sessions)

Based on information gathered during treatment, the content and number of exposure sessions are targeted to specific needs and characteristics of each participant, providing them with the opportunity to integrate skills learned during the program and practice exposure to emotional experiences and internal sensations in different situations. Previous sessions have provided the basic skills for emotional exposure sessions. Participants gradually face internal experiences, such as physical sensations, images, or memories, as well as external situations that elicit intense emotions and avoidance tendencies. A hierarchy based on emotional intensity and situational avoidance collaboratively built with the participant guides the design of specific exposure situations. In-session exposures are conducted during these four sessions according to the previously built hierarchy and jointly agreed with the participant, targeting intermediate levels of difficulty to ensure a high likelihood of initial success. In-vivo exposures are planned in-session and instructions for practice and for recording results in the workbook are provided. The need for continuous practice in learning new skills of daily living?such as cooking or handicrafts?is emphasized.

Module 8. Maintenance and Relapse Prevention

Session 12

The last session of the protocol is aimed at reviewing the skills learned and encouraging participants to continue practicing in different situations. A bulleted list is included in the workbook listing four tools: (1) present moment attention, (2) awareness of automatic interpretations, (3) identifying action tendencies and conducting opposite action, and (4) observing and tolerating physical sensations. This is a simplified version of the list in the original UP, with large number icons to emphasize the four steps. The therapist assists the participant in developing an idiosyncratic practice plan and setting specific goals. Importance of anticipating difficulties and acknowledging normal fluctuations in terms of results is emphasized to enhance motivation for progress.

A detailed description of the CXA-UP with a complex case, who has lived in a context of continuous extreme violence and has little formal education, is presented in a companion paper (Castro-Camacho et al., 2018).

Conclusion

This article describes in detail the procedures through which individuals' characteristics, values, and contexts can be integrated with the best research evidence. The process of adapting the UP (an intervention grounded in extensive research) to the particular social, cultural, and contextual characteristics of victims of armed conflict in Colombia represents a further step in making effective interventions available to individuals with severe emotional difficulties in a particularly unfavorable context.

This population constitutes a challenge for evaluating the generalizability of interventions. First, high levels of exposure to violence and adverse living conditions compared to the general population likely result in higher levels of emotional distress. Second, Colombia represents a broad spectrum of cultural backgrounds, educational levels, ethnicities, and value systems. Consequently, while adapting the original UP to the cultural characteristics of particular individuals, the CXA-UP focuses contextual characteristics, i.e., exposure to violence and living conditions that are common to individuals with diverse cultural backgrounds.

The CXA-UP matches the needs of victims of armed-conflict in several ways. The process-driven transdiagnostic nature of the UP enables therapy to focus on useful targets of intervention, particularly emotional behaviors that interfere with daily functioning. Furthermore, the UP's core concepts are integrated into the personal experience and cultural/contextual characteristics of participants. A redesigned workbook with graphic presentations, examples relating to participants' context, and homework assignments adjusted for lower educational levels constitute a pivotal step for the implementation of the intervention. In addition, emphasis in a collaborative and validating therapeutic relationship as well as explanation of main concepts from their own experience contributes to the appropriation of the program in their daily lives.

Although the gold-standard test of the effectiveness of an intervention is an RCT, it represents only the first step in the process of making the CXA-UP feasible for dissemination to wider segments of the population. Indeed, while the preliminary outcomes of the ongoing RCT look promising,

the problem of cost-effectiveness remains. The last stage of the adaptation process we propose is therefore dissemination and transportability (see Figure 1).

Once a contextual adaptation of an intervention has shown evidence of efficacy under optimal conditions (i.e., individual formats, highly trained therapists and measured fidelity to the protocol), several issues must be empirically resolved to increase cost-effectiveness and enable dissemination to new contexts. First, process studies aimed at evaluating the effects of particular modules and order of presentation in relation to characteristics and psychological markers of individuals would enable development of a more targeted and efficient intervention. Second, since group interventions with the UP in clinical populations have shown to be effective (Bullis et al., 2015; Castellano et al., 2015; de Ornelas Maia et al., 2015), research in group delivery for this population informed by process study outcomes would give rise to modular targeted interventions for homogeneous groups sharing similar characteristics (Chorpita, Daleiden & Weisz, 2005; Murray et al., 2014). Third, effectiveness studies of the CXA-UP administered by local mental health providers within the public health system would permit its implementation on a larger scale (Chambless & Hollon, 1998). Fourth, cost-effectiveness and program availability could further be increased by developing and evaluating secondary prevention and stepped-care programs offering differential delivery of intensity of the protocol according to different levels of complexity and/or severity, offered by providers with different levels of competencies, e.g., community leaders, health professionals and specialized mental health professionals (Kazdin, 2017; Patel, Chowdhary, Rahman & Verdeli, 2011). However, training and supervision costs for ensuring fidelity and high quality of the intervention would still represent a barrier for implementation of interventions. Consequently, the use of web-based technologies and mobile applications to increase the reach of CXA-UP to individuals with mild-to-moderate symptoms represent another promising step toward increasing availability of services (Andersson, 2016).

In summary, the availability of well-disseminated contextual adaptations of evidence-based interventions would not only improve mental health in vulnerable individuals but also develop individuals' potential and have important social and economic conditions in war-affected regions globally (Layard & Clark, 2014).

References

Acosta, F. X., Yamamoto, J., Evans, L. A., & Skilbeck, W. M. (1983). Preparing low-income hispanic, black, and white patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology*, *39*(6), 872–877. https://doi.org/10.1002/1097-4679(198311)39:6<872::AID-JCLP2270390610>3.0.CO;2-X PMID:6662938.

Allen, L. B., McHugh, R. K., & Barlow, D. H. (2008). Emotional disorders: A unified protocol. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 216–249). New York: Guilford Press.

Ametaj, A. A., Wong Sarver, N., Analwenze, O., Ito, M., Rattner-Castro, M., & Potlury, S. (2018). Cross-cultural applications of the Unified Protocol: Examples from Japan and Colombia. In D. H. Barlow & T. J. Farchione (Eds.), *Applications of the Unified Protocol for Transdiagnostic Treatments of Emotional Disorders* (pp. 268–290). New York: Oxford University Press. https://doi.org/10.1093/med-psych/9780190255541.003.0016

Andersson, G. (2016). Internet-delivered psychological treatments. *Annual Review of Clinical Psychology*, *12*(1), 157–179. https://doi.org/10.1146/annurev-clinpsy-021815-093006 PMID:26652054

APA Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Arias, M. A., Ibáñez, A. M., & Querubin, P. (2014). The desire to return during civil war: Evidence for internally displaced populations in Colombia. *Peace Economics, Peace Science & Public Policy*, *20*(1), 209–233. https://doi.org/10.1515/peps-2013-0054

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, *35*(2), 205–230. https://doi.org/10.1016/S0005-7894(04)80036-4 PMID:27993336

Barlow, D. H., Ellard, K. K., Fairholme, C. P., Farchione, T. J., Boisseau, C. L., Allen, L. B., & Ehrenreich-May, J. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders: Workbook*. New York: Oxford University Press. https://doi.org/10.1093/med:psych/0780199772674.001.0001

Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., . . . Cassiello-Robbins, C. (2017). The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders. *JAMA Psychiatry*, *74*(9), 875–884. https://doi.org/10.1001/jamapsychiatry.2017.2164PMID:28768327

Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., & Ehrenreich-May, J. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist Guide*. New York: Oxford University Press. https://doi.org/10.1037/e556572013-126

Barlow, D. H., Farchione, T. J., Sauer-Zavala, S., Murray-Latin, H., Ellard, K. K., Bullis, J. R., & Cassiello-Robins, C. (2018). *Unified protocol for the transdiagnostic treatment of emotional disorders* (2nd ed.). New York: Oxford University Press. https://doi.org/10.1093/med-psych/9780190685973.001.0001

Barrera, M., Jr., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology*, *81*(2), 196–205. https://doi.org/10.1037/a0027085 PMID:22289132

Barry, M. M., Clarke, A. M., Jenkins, R., & Patel, V. (2013). A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC Public Health*, *13*(1), 835–854. https://doi.org/10.1186/1471-2458-13-835 PMID:24025155

Battagliese, G., Caccetta, M., Luppino, O. I., Baglioni, C., Cardi, V., Mancini, F., & Buonanno, C. (2015). Cognitive-behavioral therapy for externalizing disorders: A meta-analysis of treatment effectiveness. *Behaviour Research and Therapy*, *75*, 60–71. https://doi.org/10.1016/j.brat.2015.10.008 PMID:26575979

Bell, V., Méndez, F., Martínez, C., Palma, P. P., & Bosch, M. (2012). Characteristics of the Colombian armed conflict and the mental health of civilians living in active conflict zones. *Conflict and Health*, *6*(1), 10–19. https://doi.org/10.1186/1752-1505-6-10 PMID:23171497

Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., . . . Beale, D. (2014). Can CBT be effective for aboriginal Australians? Perspectives of aboriginal practitioners trained in CBT. *Australian Psychologist*, *49*(1), 1–7. https://doi.org/10.1111/ap.12025

Bentley, K. H., Gallagher, M. W., Carl, J. R., & Barlow, D. H. (2014). Development and validation of the Overall Depression Severity and Impairment Scale. *Psychological Assessment*, *26*(3), 815–830. https://doi.org/10.1037/a0036216

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation

and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, *23*(1), 67–82. https://doi.org/10.1007/BF01447045 PMID:7759675

Bernal, G., & Rodríguez, M. M. D. (2012). *Cultural Adaptations.* Washington, DC: American Psychological Association.

Boisseau, C. L., Farchione, T. J., Fairholme, C. P., Ellard, K. K., & Barlow, D. H. (2010). The development of the unified protocol for the transdiagnostic treatment of emotional disorders: A case study.*Cognitive and Behavioral Practice*, *17*(1), 102–113. https://doi.org/10.1016/j.cbpra.2009.09.003 PMID:23997572

Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., . . . Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: Development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Medicine*, *11*(11), e1001757. https://doi.org/10.1371/journal.pmed.1001757 PMID:25386945

Bouton, M. E., & Nelson, J. B. (1998). The role of context in classical conditioning: Some implications for cognitive behavior therapy. In W. O'Donohue (Ed.), *Learning and behavior therapy*. New York: Allyn & Bacon.

Bozzoli, C., Bruck, T., & Wald, N. (2013). Self-employment and conflict in Colombia. *The Journal of Conflict Resolution*, *57*(1), 117–142. https://doi.org/10.1177/0022002712464849

Bullis, J. R., Fortune, M. R., Farchione, T. J., & Barlow, D. H. (2014). A preliminary investigation of the long-term outcome of the unified protocol for transdiagnostic treatment of emotional disorders. *Comprehensive Psychiatry*, *55*(8), 1920–1927. https://doi.org/10.1016/j.comppsych.2014.07.016 PMID:25113056

Bullis, J. R., Sauer-Zavala, S., Bentley, K. H., Thompson-Hollands, J., Carl, J. R., & Barlow, D. H. (2015). The unified protocol for transdiagnostic treatment of emotional disorders: Preliminary exploration of effectiveness for group delivery. *Behavior Modification*, *39*(2), 295–321. https://doi.org/10.1177/0145445514553094 PMID:25316034

Burrow-Sanchez, J. J., & Wrona, M. (2012). Comparing culturally accommodated versus standard group CBT for Latino adolescents with substance use disorders: A pilot study. *Cultural Diversity & Ethnic Minority Psychology*, *18*(4), 373–383. https://doi.org/10.1037/a0029439 PMID:22866693

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17–31. https://doi.org/10.1016/j.cpr.2005.07.003 PMID:16199119

Campo-Arias, A., Oviedo, H. C., & Herazo, E. (2014). Prevalence of mental symptoms, possible cases and disorders in victims displaced by the internal armed conflict in Colombia: A systematic review.*Revista Colombiana de Psiquiatría*, *43*(4), 177–185. https://doi.org/10.1016/j.rcp.2014.07.003 PMID:26574074

Campo-Arias, A., Sanabria, A. R., Ospino, A., Guerra, V. M., & Caamaño, B. H. (2017). Multiple-victimisation due to armed conflict and emotional distress in the State of Magdalena, Colombia.*Revista Colombiana de Psiquiatría*, *46*(3), 147–153. https://doi.org/10.1016/j.rcp.2016.06.005 PMID:28728798

Cardemil, E. V. (2015). Evidence-based practice in a global context. *Clinical Psychology: Science and Practice*, *22*(1), 76–81. https://doi.org/10.1111/cpsp.12089

Carl, J. R., Gallagher, M. W., Sauer-Zavala, S. E., Bentley, K. H., & Barlow, D. H. (2014). A preliminary investigation of the effects of the unified protocol on temperament.*Comprehensive Psychiatry*, *55*(6), 1426–1434. https://doi.org/10.1016/j.comppsych.2014.04.015 PMID:24933653

Cassiello-Robins, C., Murray-Latin, H., & Sauer-Zavala, S. (2018). The Unified Protocol: Future directions. In D. H. Barlow, & T. J. Farchione (Eds.), *Applications of the Unified Protocol for Transdiagnostic Treatments of Emotional Disorders* (pp. 291–301). New York: Oxford University Press. https://doi.org/10.1093/med-psych/9780190255541.003.0016

Castellano Badenas, C., Osma López, J. J., Crespo Delgado, E., & Fermoselle Esclapez, E. (2015). Adaptación grupal del protocolo unificado para el tratamiento de los trastornos emocionales (Group adaptation of the unified protocol for the treatment for emotional disorders). *Àgora De Salut*, *2*, 151–162. https://doi.org/10.6035/AgoraSalut.2015.2.15

Castro, F. G., Barrera, M., Jr., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, *6*(1), 213–239. https://doi.org/10.1146/annurev-clinpsy-033109-132032 PMID:20192800

Castro-Camacho, L., Moreno, J. D., & Naismith, I. (2018). Contextual adaptation of the unified protocol for the transdiagnostic treatment of emotional disorders in victims of the armed conflict in Colombia: A case study. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2018.09.002.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*(1), 7–18. https://doi.org/10.1037/0022-006X.66.1.7 PMID:9489259

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology*, *11*(3), 141–156. https://doi.org/10.1016/j.appsy.2005.05.002.

Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology*, *85*(1), 45–57. https://doi.org/10.1037/ccp0000145 PMID:28045287

Congreso de la República de Colombia (2011). Ley 1448 de Víctimas y Restitución de Tierras (Law 1448 of Victims and Land Restitution). Bogotá: Diario Oficial 48096. Retrieved from: https://www.ictj.org/sites/default/files/subsites/colombia-linea-tiempo/docs/Ley1448/ley1448.pdf.

Daniels, J. P. (2018). Mental health in post-conflict Colombia. *The Lancet Psychiatry*, *5*(3), 199. https://doi.org/10.1016/S2215-0366(18)30068-3.

De Coteau, T., Anderson, J., & Hope, D. (2006). Adapting manualized treatments: Treating anxiety disorders among native Americans. *Cognitive and Behavioral Practice*, *13*(4), 304–309. https://doi.org/10.1016/j.cbpra.2006.04.012

de Ornelas Maia, A. C., Nardi, A. E., & Cardoso, A. (2015). The utilization of unified protocols in behavioral cognitive therapy in transdiagnostic group subjects: A clinical trial. *Journal of Affective Disorders*, *172*(C), 179–183. https://doi.org/10.1016/j.jad.2014.09.023PMID:25451415

Ehrenreich, J. T., Kennedy, S. M., Sherman, J. A., Bilek, E. L., & Barlow, D. H. (2018). *Unified protocol for transdiagnostic treatment of emotional disorders in children*. New York: Oxford University Press. https://doi.org/10.1093/med-psych/9780190642952.001.0001

Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice*, *17*(1), 88–101. https://doi.org/10.1016/j.cbpra.2009.06.002

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology*, *76*(2), 184–193. https://doi.org/10.1037/0022-006X.76.2.184 PMID:18377116

Farchione, T. J., & Bullis, J. R. (2014). Addressing the global burden of mental illness: Why transdiagnostic and common elements approaches to evidence-based practice might be our best bet. *Cognitive and Behavioral Practice*, *21*(2), 124–126. https://doi.org/10.1016/j.cbpra.2013.12.003

Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., . . . Barlow, D. H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy*, *43*(3), 666–678. https://doi.org/10.1016/j.beth.2012.01.001 PMID:22697453

Friedman, S., Braunstein, J. W., & Halpern, B. (2006). Cognitive behavioral treatment of panic disorder and agoraphobia in a multiethnic urban outpatient clinic: Initial presentation and treatment outcome. *Cognitive and Behavioral Practice*, *13*(4), 282–292. https://doi.org/10.1016/j.cbpra.2006.04.009

Gallagher, M. W., Sauer-Zavala, S. E., Boswell, J. F., Carl, J. R., Bullis, J., Farchione, T. J., & Barlow, D. H. (2013). The impact of the unified

protocol for emotional disorders on quality of life. *International Journal of Cognitive Therapy*, *6*(1), 57–72. https://doi.org/10.1521/ijct.2013.6.1.57 PMID:24358405

Gómez-Restrepo, C., Tamayo-Martínez, N., Buitrago, G., Guarnizo-Herreño, C. C., Garzón-Orjuela, N., Eslava-Schmalbach, J., . . . Rincón, C. J. (2016). Violence due to armed conflict and prevalence of mood disorders, anxiety and mental disorders in the Colombian adult population. *Revista Colombiana de Psiquiatría*, *45*(Suppl. 1), 147–153. https://doi.org/10.1016/j.rcp.2016.11.001 PMID:27993250

Graham-LoPresti, J. R., Gautier, S. W., Sorenson, S., & Hayes-Skelton, S. A. (2017). Culturally sensitive adaptations to evidence-based cognitive behavioral treatment for social anxiety disorder: A case paper. *Cognitive and Behavioral Practice*, *24*(4), 459–471. https://doi.org/10.1016/j.cbpra.2016.12.003

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005 PMID:27993346

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice*, *40*(4), 354–360. https://doi.org/10.1037/a0016250

Hinton, D. E., & Jalal, B. (2014). Parameters for creating culturally sensitive CBT: Implementing CBT in global settings. *Cognitive and Behavioral Practice*, *21*, 139–144. https://doi.org/10.1016/j.cbpra.2014.01.009.

Hinton, D. E., & Otto, M. W. (2006). Symptom presentation and symptom meaning among traumatized Cambodian refugees: Relevance to a somatically focused cognitive-behavior therapy. *Cognitive and Behavioral Practice*, *13*(4), 249–260. https://doi.org/10.1016/j.cbpra.2006.04.006 PMID:19823603

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry*, *49*(2), 340–365. https://doi.org/10.1177/1363461512441595 PMID:22508639

Hinton, D. E., Safren, S. A., Pollack, M. H., & Tran, M. (2006). Cognitive-behavior therapy for Vietnamese refugees with PTSD and comorbid panic attacks. *Cognitive and Behavioral Practice*, *13*(4), 271–281. https://doi.org/10.1016/j.cbpra.2006.04.008

Hofmann, S. G. (2006). The importance of culture in cognitive and behavioral practice. *Cognitive and Behavioral Practice*, *13*(4), 243–245. https://doi.org/10.1016/j.cbpra.2006.07.001

Hofmann, S. G., & Smits, J. A. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *The Journal of Clinical Psychiatry*, *69*(4), 621–632. https://doi.org/10.4088/JCP.v69n0415 PMID:18363421

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1 PMID:23459093

Hofmann, S. G., Wu, J. Q., & Boettcher, H. (2014). Effect of cognitive-behavioral therapy for anxiety disorders on quality of life: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *82*(3), 375–391. https://doi.org/10.1037/a0035491 PMID:24447006

Hwang, W. C. (2016). Culturally adapting evidence-based practices for ethnic minority and immigrant families. In N. Zane, G. Bernal, & F. T. Leong (Eds.), *Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical strategies* (pp. 289–308). Washington, DC: American Psychological Association. https://doi.org/10.1037/14940-014

Ibáñez, A. M., & Moya, A. (2010). Vulnerability of victims of civil conflicts: Empirical evidence for the displaced population in Colombia. *World Development*, *38*(4), 647–663. https://doi.org/10.1016/j.worlddev.2009.11.015

Ito, M., Horikoshi, M., Kato, N., Oe, Y., Fujisato, H., Nakajima, S., . . . Ono, Y. (2016). Transdiagnostic and transcultural: Pilot study of unified protocol for depressive and anxiety disorders in Japan. *Behavior Therapy*, *47*(3), 416–430. https://doi.org/10.1016/j.beth.2016.02.005 PMID:27157034

Jalal, B., Kruger, Q., & Hinton, D. E. (2017). Adaptation of CBT for traumatized South African indigenous groups: Examples from Multiplex CBT for PTSD. *Cognitive and Behavioral Practice*, 25. https://doi.org/10.1016/j.cbpra.2017.07.003

Jalal, B., Samir, S. W., & Hinton, D. E. (2017). Adaptation of CBT for traumatized Egyptians: Examples from culturally adapted CBT (CA-CBT). *Cognitive and Behavioral Practice*, *24*(1), 58–71. https://doi.org/10.1016/j.cbpra.2016.03.001

Jobson, L., Moradi, A. R., Rahimi-Movaghar, V., Conway, M. A., & Dalgleish, T. (2014). Culture and the remembering of trauma. *Clinical Psychological Science*, *2*(6), 696–713. https://doi.org/10.1177/2167702614529763

Kazdin, A. E. (2017). Addressing the treatment gap: A key challenge for extending evidence-based psychosocial interventions. *Behaviour Research and Therapy*, *88*, 7–18. https://doi.org/10.1016/j.brat.2016.06.004 PMID:28110678

Keller, A., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., . . . Porterfield, K. (2006). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *The Journal of Nervous and Mental Disease*, *194*(3), 188–194. https://doi.org/10.1097/01.nmd.0000202494.75723.83 PMID:16534436

Kennedy, S. M., Bilek, E. L., & Ehrenreich-May, J. (2018). A randomized controlled pilot trial of the unified protocol for transdiagnostic treatment of emotional disorders in children. *Behavior Modification*, *47*, 014544551775394–31. https://doi.org/10.1177/0145445517753940

Lagos-Gallego, M., Gutierrez-Segura, J. C., Lagos-Grisales, G. J., & Rodriguez-Morales, A. J. (2017). Post-traumatic stress disorder in internally displaced people of Colombia: An ecological study. *Travel Medicine and Infectious Disease*, *16*, 41–45. https://doi.org/10.1016/j.tmaid.2017.02.008 PMID:28242350.

Layard, R., & Clark, D. M. (2014). *Thrive. The power of evidence-based psychological therapies*. London: Penguin.

Lopez, M. E., Stoddard, J. A., Noorollah, A., Zerbi, G., Payne, L. A., Hitchcock, C. A., . . . Ray, D. B. (2014). Examining the efficacy of the unified protocol for transdiagnostic treatment of emotional disorders in the treatment of individuals with borderline personality disorder. *Cognitive and Behavioral Practice*, *22*(4), 522–533. https://doi.org/10.1016/j.cbpra.2014.06.006

Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2009). Conceptual foundations of the transdiagnostic approach to CBT. *Journal of Cognitive Psychotherapy*, *23*(1), 6–19. https://doi.org/10.1891/0889-8391.23.1.6

Marsiglia, F. F., & Booth, J. M. (2015). Cultural adaptation of interventions in real practice settings. *Research on Social Work Practice*, *25*(4), 423–432. https://doi.org/10.1177/1049731514535989 PMID:26213454

Mercado, A., & Hinojosa, Y. (2017). Culturally adapted dialectical behavior therapy in an underserved community mental health setting: A Latina adult case study. *Practice Innovations*, *2*(2), 80–93. https://doi.org/10.1037/pri0000045

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029 PMID:19854552

Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *The American Journal of Orthopsychiatry*, *76*(4), 409–422. https://doi.org/10.1037/0002-9432.76.4.409 PMID:17209709

Mogollón-Pérez, A. S., & Vázquez, M. L. (2008). Factors affecting access to health care institutions by the internally displaced population in Colombia. *Cadernos de Saúde Pública*, *24*(4), 745–754. https://doi.org/10.1590/S0102-311X2008000400004 PMID:18392351

Morris, E. K. (1992). The aim, progress and evolution of behavior analysis. *The Behavior Analyst*, *15*(1), 3–29. https://doi.org/10.1007/bf03392582.

Moya, A. (2018). Violence, psychological trauma, and risk attitudes: Evidence from victims of violence in Colombia. *Journal of Development Economics*, *131*, 15–27. https://doi.org/10.1016/j.jdeveco.2017.11.001

Muñoz, R. E., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology, 73*, 790–799. https://doi.org/10.1037/0022-006X.73.5.790

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., . . . Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice, 21*(2), 111–123. https://doi.org/10.1016/j.cbpra.2013.06.005 PMID:25620867

Neuner, F., Schauer, M., Karunakara, U., Klaschik, C., Robert, C., & Elbert, T. (2004). Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. *BMC Psychiatry, 4*(1), 34. https://doi.org/10.1186/1471-244X-4-34 PMID:15504233

Norman, S. B., Hami Cissell, S., Means-Christensen, A. J., & Stein, M. B. (2006). Development and validation of an Overall Anxiety Severity And Impairment Scale (OASIS). *Depression and Anxiety, 23*(4), 245–249. https://doi.org/10.1002/da.20182

Norton, P. J., & Paulus, D. J. (2017). Transdiagnostic models of anxiety disorder: Theoretical and empirical underpinnings. *Clinical Psychology Review, 56*, 122–137. https://doi.org/10.1016/j.cpr.2017.03.004 PMID:28450042

Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and a critique. *Journal of Affective Disorders, 131*(1-3), 8–23. https://doi.org/10.1016/j.jad.2010.07.005.

Patel, V. (2009). The future of psychiatry in low- and middle-income countries. *Psychological Medicine, 39*(11), 1759–1762. https://doi.org/10.1017/S0033291709005224

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy, 49*(9), 523–528. https://doi.org/10.1016/j.brat.2011.06.012.

Ramaiya, M. K., Fiorillo, D., Regmi, U., Robins, C. J., & Kohrt, B. A. (2017). A cultural adaptation of dialectical behavior therapy in Nepal. *Cognitive and Behavioral Practice, 24*(4), 428–444. https://doi.org/10.1016/j.cbpra.2016.12.005 PMID:29056846

Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance abuse prevention. *Journal of Community Psychology, 28*(3), 271–290. https://doi.org/10.1002/(SICI)1520-6629(200005)28:3<271::AID-JCOP4>3.0.CO;2-I

Richards, A., Ospina-Duque, J., Barrera-Valencia, M., Escobar-Rincón, J., Ardila-Gutiérrez, M., Metzler, T., & Marmar, C. (2011). Posttraumatic stress disorder, anxiety and depression symptoms, and psychosocial treatment needs in Colombians internally displaced by armed conflict: A mixed-method evaluation. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 384–393. https://doi.org/10.1037/a0022257

Sauer-Zavala, S., Bentley, K. H., & Wilner, J. G. (2016). Transdiagnostic treatment of borderline personality disorder and comorbid disorders: A clinical replication series. *Journal of Personality Disorders, 30*(1), 35–51. https://doi.org/10.1521/pedi_2015_29_179 PMID:25710737

Schulz, P. M., Huber, L. C., & Resick, P. A. (2006). Practical adaptations of cognitive processing therapy with Bosnian refugees: Implications for adapting practice to a multicultural clientele. *Cognitive and Behavioral Practice, 13*(4), 343–344. https://doi.org/10.1016/j.cbpra.2006.07.003

Shultz, J. M., Garfin, D. R., Espinel, Z., Araya, R., Oquendo, M. A., Wainberg, M. L., . . . Neria, Y. (2014). Internally displaced "victims of armed conflict" in Colombia: The trajectory and trauma signature of forced migration. *Current Psychiatry Reports, 16*(10), 475. https://doi.org/10.1007/s11920-014-0475-7 PMID:25135775

Siriwardhana, C., Adikari, A., Pannala, G., Siribaddana, S., Abas, M., Sumathipala, A., & Stewart, R. (2013). Prolonged internal displacement and common mental disorders in Sri Lanka: The COMRAID study. *PLoS One, 8*(5), e64742. https://doi.org/10.1371/journal.pone.0064742 PMID:23717656

Spilka, M. J., & Dobson, K. S. (2015). Promoting the internationalization of evidence-based practice: Benchmarking as a strategy to evaluate culturally transported psychological treatments. *Clinical Psychology: Science and Practice, 22*(1), 58–75. https://doi.org/10.1111/cpsp.12092

Steele, S. J., Farchione, T. J., Cassiello-Robbins, C., Ametaj, A., Sbi, S., Sauer-Zavala, S., & Barlow, D. H. (2018). Efficacy of the Unified Protocol for transdiagnostic treatment of comorbid psychopathology accompanying emotional disorders compared to treatments targeting single disorders. *Journal of Psychiatric Research, 104*, 211–216. https://doi.org/10.1016/j.jpsychires.2018.08.005

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *Journal of the American Medical Association, 302*(5), 537–549. https://doi.org/10.1001/jama.2009.1132 PMID:19654388

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48*(10), 1449–1462. https://doi.org/10.1016/S0277-9536(98)00450-X PMID:10369444

Unidad de víctimas (Unit of Victims) (2018). National Register of Victims. Retrieved from https://rni.unidadvictimas.gov.co/RUV 05/01/2018.

World Health Organization. (2003). *Mental health in emergencies: Psychological and social aspects of health of populations exposed to extreme stressors*. Geneva: Author.

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