Exploring the Feasibility and Acceptability of BRiTA's Individual and Online delivery

Nazanin Ahangari[1] Nigar G. Khawaja[1] & Dragos Ileana[2]

Building Resilience in Transcultural Australians (BRiTA) is a strength-based preventative program that facilitates the acculturation and resilience of migrants. This study explored the feasibility and acceptability of delivering the BRiTA program to culturally and linguistically diverse adults in an individual setting via an online platform, Zoom. Four adults participated in four weekly sessions of BRiTA in either English or Persian. Participants completed pre-and post-questionnaires assessing acculturation, resilience, and psychological well-being. They also provided feedback after every session and at the end of the program. Thematic analysis was used to interpret the qualitative data. A reliable change index was used to investigate pre-to-post change quantitatively. Findings supported the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom and highlighted the strength and utility of the program. Participants demonstrated varying levels of change in acculturation, resilience, and psychological well-being. BRiTA's individual delivery via Zoom, implications and future research directions are discussed.

Keywords: *Acculturation, BRiTA Futures, Culture, Diversity, Prevention, Resilience.*

The cultural diversity in Australia has increased exponentially. Seven and a half million immigrants constituting 30% of the overall population, call Australia home (Australian Bureau of Statistics, 2019). These individuals are from almost 200 different ethnically and linguistically diverse groups (Department of Immigration and Border Protection, 2015). The Cultural and Linguistically Diverse (CALD) population in Australia refers to individuals, who themselves or their parents were born overseas, identify with a culture different from the mainstream, and speak a language that is different from English (Khawaja et al., 2013). The CALD population is composed of immigrants who enter Australia as immigrant or refugees and mostly settle well and contribute to Australian society.

Nonetheless, some CALD immigrants (term used in this paper to represent immigrants and refugees) experience acculturative stress, impacting their mental health and well-being (Driscoll & Torres, 2013). These mental health concerns get exacerbated if the CALD immigrants do not possess adaptive and non-avoidant coping strategies and personal resilience (Lumley et al., 2018). Therefore, there is a consensus to use preventative programs to enhance CALD adults' and children's acculturative experience and promote their well-being in the early stages of their journey (Frounfelker et al., 2020).

Acculturation and Acculturative Stress

All those who migrate to another country undergo an acculturation process unique to each person (Lee et al., 2020). It involves the newly arrived individuals going through psychological (behavioural, emotional, and cognitive) and cultural changes when exposed to the host and other cultural groups (Berry, 2005). Although most of the CALD immigrants adapt and acculturate well, around 15% of this population in Australia experience acculturative stress. Studies indicate that if acculturative stress exceeds their psychosocial resources to cope, their mental health becomes compromised (Minas et al., 2013; Silva et al., 2017) and can lead to the development of mental health difficulties such as Post-traumatic Stress Disorder (PTSD), anxiety and depression (Kartal & Kiropoulos, 2016; Spallek et al., 2015).

Corresponding Authors: Professor Nigar Gohar Khawaja[1], Nazanin Ahangari[1], Dragos Ileana[2].
School of Psychology & Counselling[1], Faculty of Health
Queensland University of Technology
O Block B wing, Rm 525
Ring Rd, Kelvin Grove, Qld 4059
Phone: 61 7 3138 4540
Fax: 61 7 3138 0486
Queensland Transcultural Mental Health Centre[2]
Running Head: BRiTA

Australian Counselling Research Journal ISSN1832-1135

Risk and Protective Factors

A set of risk factors exacerbate immigrants' acculturative stress due to language barrier (71%), separation from friends and family (43%), worries associated with families in their country of origin (57%), and being extraordinarily young or older (Alizadeh-Khoei et al., 2011; Ngwena, 2014). Other risk factors are structural and cultural barriers (Agrawal & Venkatesh, 2016). Structural barriers can be limited access to healthcare, psychosocial challenges, and financial limitations. In contrast, cultural barriers are composed of a lack of culturally sensitive services and interpreters, perceived discrimination, absence of materials in one's native language, and lack of knowledge about the hosting country (Disney & McPherson, 2020).

Nonetheless, some studies indicate that CALD immigrants are mentally and physically healthier than the host population and possess higher levels of resilience in response to their life stressors, which is a protective factor in their acculturation journey (Kennedy et al., 2015). Resilience is a dynamic multidimensional phenomenon resulting from interactions between social, neurological, and personality traits (Reich et al., 2010). Resilience can help CALD immigrants bounce back and overcome their challenging experiences and respond effectively and adaptively to stress (Hosseini et al. 2017). Considering that acculturative stress can result in some immigrants developing mental health difficulties, it is crucial to assist them through preventative interventions. To conceptualise such programs for CALD immigrants, their risk and protective factors must be acknowledged (Mitchelson et al., 2010).

Preventative Programs

Preventative programs are formulated to foster individuals' protective factors, thus delaying and reducing the potential for individuals to experience mental health difficulties (Amodeo et al., 2004). These programs enhance the protective factors, minimise risk factors, and reduce the future costs of providing secondary care interventions for difficulties that may become severe (Close et al., 2016). The same principles can be extended to the challenges that CALD immigrants experience through the process of settlement. Preventative programs focus on promoting CALD immigrants' and refugees' experiences of acculturation and resilience and lead to prolonged benefits for the individual and the society (Ehsan et al., 2020; Wu et al., 2018).

One of the evidence-based preventative group programs for CALD immigrants in Australia is Building Resilience in Transcultural Australians (BRiTA) (Mitchelson et al., 2010; Queensland Transcultural Mental Health Centre [QTMHC], 2010). BRiTA is an eight-module program developed in Australia by the Queensland Transcultural Mental Health Centre (QTMHC) to foster protective factors and minimise the effects of the risk factors in adults, adolescents, and children from CALD immigrant backgrounds (Lemerle & Prasad-Ildes, 2004). Further, this program uses a strength-focused approach and Cognitive Behavioural Theory principles to foster well-being, identify risk and protective factors, and increase self-reflection on cultural identity and the process of acculturation (Mitchelson et al., 2010; QTMHC, 2010). BRiTA attempts to reduce experiences of acculturative stress by fostering their resilience. Research indicates that CALD adults and adolescents who attend BRiTA experience enhancing their psychological well-being, resilience, and acculturation experiences (Khawaja & Ramirez, 2019). The eight modules (see Table one) can be delivered over eight weeks or in other flexible formats, such as four weeks or in a 2-day intensive workshop, to increase immigrants' accessibility to the program (Khawaja & Ramirez, in press).

Online Delivery

Most of the preventative programs offered to CALD individuals have been face-to-face. Nonetheless, online platforms are associated with easier accessibility of mental health services required and higher levels of self-disclosure, engagement, and activity within sessions (Feijt et al., 2020). In online sessions, clinicians found the experience of rapport building and progress to be homogenous to face-to-face delivery (Acierno et al., 2017). It is important to note that a qualitative study reported Zoom to be more beneficial for participants than the traditional method using face-to-face, telephone, or other platforms due to its ease of use, encryption, and cost-effectiveness (Archibald et al., 2019; O'Mahony et al., 2012). In particular, CALD immigrants and refugees reported online delivery as a beneficial method of accessing the support they require through a confidential platform (O'Mahony et al., 2012). Moreover, Choi et al. (2012) reported that delivering an internet-based intervention for CALD individuals can reduce the acuteness of their depressive symptoms when juxtaposed to the group receiving no intervention.

Group and Individual Delivery

Preventative programs are primarily delivered in face-to-face group-based settings, associated with experiencing "healing" through normalisation from hearing other individuals' narration of their difficulties within groups (Stige & Binder, 2017). According to the randomised controlled trial by Holgersen et al. (2020), group delivery is cost-effective, enhances an individual's psychosocial functioning, and reduces PTSD symptoms. Nonetheless, Strauss et al. (2015) found that nearly 75% of the participants experienced individual delivery as more beneficial than group delivery. Chouliara et al. (2020) reported that the perceived fear and experienced threat of receiving judgement from group members tend to prevent individuals from disclosing details of their experiences, making individual delivery more preferred. Moreover, allocating individuals to homogenous groups where they feel culturally and linguistically comfortable can be associated with long periods of being on a waitlist (Leiderman, 2020). Furthermore, problem-solving language barriers and involving interpreters can be facilitated more easily in individual settings (Jaeger et al., 2019).

Feasibility and Acceptability

As Australia faces an increase in the CALD population through humanitarian and non-humanitarian migration and becomes more culturally and linguistically diverse, a need for providing suitable and culturally competent services becomes of high importance for CALD populations (Geerlings et al., 2018; Kayrouz et al., 2017). Despite the documented benefits of the BRiTA program being successfully delivered in a face-to-face group setting, there is scarce evidence on other methods of providing this preventative program. Feasibility and acceptability

studies play a role in determining whether an intervention or program is fit for further testing and whether it would be acceptable to the target population and sustainable (Bowen et al., 2009). It is critical to examine the demand for the intervention and whether it can be delivered without any constraints as planned (Bowen et al., 2009). Thus, feasibility and acceptability studies tend to be the first step in evaluating a new intervention and set the scene for further pilot and effectiveness studies (Orsmond & Cohn, 2015).

Aims of the Study

The study aimed to assess the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom. It examined whether the individual delivery via Zoom produced a Reliable Change (RC) in acculturation, resilience, and psychological well-being across participants, pre-to-post delivery. It was hypothesised that BRiTA's individual and online delivery would be acceptable and feasible and would predict changes across participants' acculturation, resilience, and psychological well-being over time. Qualitative data explored the participants' experiences and how the program could be further refined.

Methods

Design

Qualitative and quantitative methods were used (Creswell & Clark, 2017). The qualitative component explored the participant's experiences, which was deemed an essential element in studying the feasibility and acceptability of delivering the BRiTA program in a novel method (Yardley et al., 2015). Quantitative methods examined changes as a result of the program.

Participants

Four adults (one male and three females) residents of South-East Queensland participated in the study. Their age ranged from 22 to 55 (M = 36.25, SD = 14.86). Their stay in Australia ranged from 1.5 to 4.5 years (M = 2.75, SD = 1.32). One participant was married, while the others were single. Two participants had children. One participant was from Africa, while others were from the Middle East. One participant was a student, and one was a business operator. Two were professionals. Three were university graduates, and one had completed high school. All participants demonstrated adequate proficiency in English.

Measures

Demographic Form

A form collected data on participants' demographics such as gender, age, language spoken at home, religious and educational background, the reason for leaving their home country, number of years residing in Australia, occupation, marital status, visa, and financial situation.

Adult Acculturation and Resilience Scale (AARS)

AARS (Khawaja et al., 2014) measured the acculturation processes of CALD immigrants to Australia and was developed with the Australian CALD population. It consisted of three subscales: resilience (14 items), acculturation (11 items), and spirituality (five items). Participants scored on a Likert Scale of one (do not agree) to four (always agree) to items such as "I can find many ways to solve a problem". Total overall scores range from 30 to 120, where high scores reflect elevated levels of resilience concerning settling in a new country, acculturation and adaptation in Australia, and spirituality. AARS is effective with CALD individuals, has a good Cronbach Alpha value of .90, good test-retest reliability (.86), and divergent validity (Khawaja et al., 2014).

The Connor Davidson Resilience Scale (CD-RISC)

CD-RISC (Campbell-Sills & Stein, 2007) was utilised to investigate general resilience. It is an abbreviated version of the CD-RISC-25 which focuses on dimensions of resilience. It is composed of 10-items such as, "I tend to bounce back after illness or hardship", which the participants responded to on a Likert scale of zero (not true at all) to four (true nearly all of the time), with total scores ranging from zero to 40, with higher scores indicating higher levels of resilience (Connor & Davidson, 2003). CD-RISC is a unidimensional measure of resilience that has been validated across different countries, has a Cronbach's Alpha of .91, demonstrates good test-retest reliability, convergent and construct validity, and is successfully used cross-culturally (Coates et al., 2013; Notario-Pacheco et al., 2011).

Patient Health Questionnaire-2 (PHQ-2)

PHQ-2 (Kroenke et al., 2003) was administered to screen the participants' psychological well-being. This questionnaire is the shorter version of PHQ-9 and is composed of 2 items, such as "Feeling down, depressed, or hopeless", which participants scored on a zero (not at all) to three (nearly every day) Likert scale. Overall scores are the sum of both items and ranged from zero to six. The lower score indicates an absence of depression and a presence of well-being. This scale is used as a screener for depression and participants' psychological well-being. PHQ-2 has a robust internal consistency, as demonstrated by .7. Cronbach's Alpha value and good construct validity cross-culturally (Dadfar et al., 2019; Scoppetta et al., 2020).

Qualitative Prompts

The authors developed a semi-structured 6-item checklist that explored the participants' experiences of attending the program, what they found beneficial from the program and what they think could be improved (e.g. "What did you find helpful about today's session?")

Procedure

Ethical clearance and health and safety were obtained from the Health Department and the respective university. The QTHMC staff disseminated the information about the study among their consumers. Those who expressed an interest were recruited and informed about the study. Feasibility and acceptability studies do not require large sample sizes as they are not aimed at carrying out null hypothesis testing (Tickle-Degnen, 2013). Therefore, four participants were recruited. To determine participants' suitability for the study, the first and third author interviewed the participants via Zoom. Those CALD immigrants who met the inclusion criteria and not the exclusion criteria (serious mental health issues, such as Substance abuse, psychoses and suicidality) were recruited. Written informed

consents were obtained, and these suitable participants were informed of confidentiality and their ability to withdraw consent at any time. Participants completed the pre-delivery questionnaires and subsequently attended the eight modules of BRiTA (Table one) over four weeks in an individualised format on Zoom. The duration of each session was 120 minutes and was delivered in English or Persian by the first author. At the end of each session, participants completed the battery (excluding the demographic form) and responded to the first author's queries about the content and delivery of the sessions. Within a week after completing the program, participants attended another semi-structured telephone interview with the second author to provide feedback on their experience of attending the program, intending to reduce the interpretation bias. The first author kept a reflexive journal record of every session and met with the other authors every week to discuss potential process issues. Participants were debriefed upon the end of the program. The qualitative data were transcribed and prepared for the analysis.

Table 1

BRiTA Future's session details.		
Week	**Eight Modules**	**Rationale**
One	• Healthier and BRiTA Futures	Establishing foundations for the program and introducing the concept of risk factors, protective factors, and well-being.
	• A different and common journey: The migratory process	Increasing participant's awareness of the different stages of migration and associated emotions.
Two	• Building a new society: The meeting of cultures	Expand the understanding of culture and cultural identity as part of the acculturation process.
	• Challenges and strengths to bounce back: Resiliency	Increasing knowledge on resilience and coping strategies to manage adverse situations related to immigration and AS.
Three	• Weaving links: Social connectedness	Increase knowledge of social connectedness and its importance.
	• Communication: Steps to a better dialogue	To review ways of communicating and practicing cross-cultural communication.
Four	• Family: Evolving roles	Impact of immigration on the roles of men, women, and parents.
	• Intergeneration: Challenges for all	Increase awareness of participant's interpersonal challenges and acculturation across generations.

Data Analysis

Qualitative

The qualitative data obtained after every session and at the end of the program were analysed utilising Braun and Clarke's (2006) six steps of conducting a thematic analysis. The first author familiarised herself with the data, ensuring a continuous and prolonged engagement with the data while recording personal reflections, generating codes, organising and conceptualising themes, reviewing themes, defining themes, and producing the analysis (Braun & Clarke, 2006). The trustworthiness criteria by Lincoln and Guba (1985) and Nowell et al. (2017) were followed. To achieve credibility, the study ensured triangulation in qualitative data collection (e.g. internal and external interviews, reflexive journal, observations), had prolonged engagement with the participants for five to eight weeks, consistent recording of observations, reflections, and sharing the interpretations with participants, as well as regular consultations with the second author (Lincoln & Guba, 1985; Nowell et al., 2017). Transferability was achieved by providing a "thick description". Dependability was ensured by utilising the code-re-code strategy and triangulation (analyst and data collection). Confirmability was attained by having an audit trail of keeping the original data, preparing transcripts, keeping a reflexive journal (containing author's external dialogues, objective observations, internal affective experiences as a researcher, and their values), and referencing participants so their quotes could be traced back to the interviews. Following all of the steps outlined by Braun and Clark (2006), the first and second author identified a number of primary and secondary themes.

Reflexivity

All authors were from CALD backgrounds. The authors actively reflected on their own experiences of acculturation and how being a bilingual (fluent in English and other languages) international student or migrants from the Middle East, South Asia, and Eastern European background could influence the interpretation of the data. Thus, the first author kept a reflexive journal about their experiences and interpretation of the data. Moreover, prolonged proximity to the data was maintained, the code-re-code strategy and analyst triangulation were utilised, to minimise the potential bias in interpreting the qualitative data by the author.

Quantitative

The participants' pre- and post-responses to the acculturation, resilience, and psychological well-being measures were used to examine reliable change (Guhn et al., 2014). Reliable Change Index (RCI) was calculated using Jacobson and Truax's (1991) four steps of calculating the RCI, as seen in Table 2. The total pre- and post-scores were then compared to existing normative data.

Table 2

Outlining the RCI approach to calculating clinical change pre-to-post delivery		
Step	**Step**	**Formula**
One	Calculating Standard Error of Measurement	SEM = s$\sqrt{1-rxx}$
Two	Calculating Standard difference between pre-and-post scores	SDIFF = $\sqrt{2}$(SEM 2)

Three	Calculating the difference scores between pre-to-post measurements	Diff = xt1 -xt2
Four	Calculating the clinical change using the RCI index formula	RC= xt1 -xt2 /SDIFF

Note: RCI = Reliable Change Index.

Results

Qualitative Findings

Table 3

Identified primary and secondary themes through thematic analysis.		
Theme	**Primary**	**Secondary**
One	Acceptability of BRiTA's individual delivery	• Confidentiality and provision of a safe space in an individualised setting. • The importance of keeping a balance between individual and group delivery. • The organisation of the program and potential modifications.
Two	Feasibility of BRiTA's delivery	• Attendance in the comfort of my home via Zoom, individually.
Three	BRiTA fostering reflection, normalisation, and processing	

Acceptability of BRiTA's Individual Delivery through Zoom

Confidentiality and Provision of a Safe Space in an Individualised Setting

Participants supported the individualised and online delivery of the sessions via Zoom. This delivery method was found to be acceptable as it enabled participants to understand the program's content through flexible means and in a safe space. Being in a safe space enabled them to reflect on and share their personal experiences, which allowed a higher level of engagement with the program's content and strengthened their understanding of acculturation and adaptation to the Australian cultures. For instance, participant one stated, "some cultures are concerned about their image which makes them not share the things they feel. In individual setting, there is less judgement". Further, this mode of one-on-one delivery eliminated the fear of judgement by other community members. It reduced the perceived possibility of breaching confidentiality, which is often a concern in group settings. For example, participant four shared "individual (setting) may be good. Trust may be built easier." This may have indicated that the non-judgemental safe space and established trust allowed participants to explore and process their experiences of acculturation at a deeper and more personal level. Thus, it was evident that individualised and online delivery of BRiTA was an acceptable delivery method across all participants.

The Importance of Keeping a Balance Between Individual and Group Delivery

Despite strongly supporting the individualised delivery of BRiTA, all participants recognised the value of delivering this program in a group setting. They saw the value in amalgamating individual and group delivery by emphasising that certain activities and contents could be better understood within a group setting. It would foster social connectedness and facilitate normalisation and externalisation of acculturation stress. There was a consensus that modules focused on the evolving roles of families and acculturation are best suited for a group setting. Participant three shared, "people could get support and encouragement and understand that it's normal to feel like this", and participant two corroborated this comment by stating, "the program could work in a small group version of four people, to be able to learn from each other, therapeutically". Likewise, participant four emphasised the importance of fostering hope in group settings "group allows getting opinions from different people, having different experiences, and get to know more people and hear different stories which may give hope". A combination of group and individual format was recognised as valuable.

The Organisation of the Program and Potential Modifications

All participants reported that the BRiTA program's sessions covered the content gradually in a meaningful manner. According to participant one, "the sessions have good orders, it goes slowly and doesn't jump over topics which is good". Thus, emphasising the importance of gradual exposure to the content covered in the program. Participants suggested that BRiTA's content can be adapted in future to suit the needs of an individual's specific cultural background and status of voluntary or involuntary immigration. For instance, participant one reported, "the content can be modified to match the person's current lifelike, I have a job, I have been here for a number of years, single, no kids". Similarly, participant two reported that "different versions of the program would be good, for example, specifically for refugees". Therefore, it was suggested that content could be modified or components could be selected consistent with the participant's stage in their journey of acculturation and background.

Feasibility of BRiTA's Delivery

Attendance and Accessibility in the Comfort of My Home via Zoom

Participants attended all sessions. Zoom increased the accessibility to the program by enhancing the participants' ability to participate in the program after work hours or between domestic and work commitments. It also saved financial resources by limiting travel costs and time. For instance, participant one highlighted these merits by stating, "my work and life are busy, so attending the session online reduces the movement time between appointments". Similarly, participant four emphasised the importance of having online delivery when having multiple commitments "Zoom is better for very busy people. To be honest, I don't think I could come for five weeks if it was in person". Also, all participants reported that online delivery through Zoom did not impact the author's level of connection and rapport building.

Participant three stated, "I feel comfortable with Zoom and the two-way communication", indicating that individual and online delivery via Zoom did not impact the quality of the relationship that the facilitators often establish in a one-to-one setting.

BRiTA Fostering Reflection, Normalisation, and Processing

All participants found the experience of attending the program positive, beneficial, and therapeutic. The content of the program helped them understand their journey of acculturation. The information provided enabled them to incorporate new learnings and skills into life outside of sessions, which was deemed therapeutic for their well-being. Participant two reported, "the program was a good journey of reflecting over the past, and I could relate to the stages discussed in the program like the honeymoon period and acculturation". Moreover, participant four acknowledged that the experiences explored in the BRiTA program were a common experience for immigrants - "the experience is something that I have gone through, and it was good to learn about it". Participants also reported reflecting on their cultural identity and values outside of sessions. For instance, participant two reported, "I was thinking of what you said in the session last week. It made me feel better because I tried to accept my feelings and turn it into a positive experience". According to participant one, "it was good to reflect on my culture and what is good/bad about my culture", thus highlighting the therapeutic values of the BRiTA program.

Acculturation

As shown in Table 4, AARS pre-delivery scores for all participants were above the normative mean score (M = 88.57) for CALD individuals within Australia (Khawaja et al., 2014). Participant two demonstrated a significant RC post-delivery (RCI = -2.42 > 1.96). Participant three (RCI = 1.77 < 1.96) and four (RCI = 1.13 < 1.96) experienced a decline in their acculturation score, which did not meet the threshold for an RC (Table 5). As seen in Table 4 and 5, participant one exhibited a minimal change in their acculturation scores which was not an RC over time (RCI = -.32 < 1.96).

Resilience

As illustrated in Table four, all participants' levels of resilience were above the normative mean (M = 32.0) range (Chamberlain et al., 2016). As seen in Table five, participant one (RCI = .15 < 1.96) and two (RCI = -.61 < 1.96) experienced an incline in their scores of resilience. However, they did not meet the threshold for RC. Participants three (RCI = .45 < 1.96) and four (RCI = .61 <1.96) both experienced a decline in their resilience score, which did not meet the threshold for an RC.

Psychological Well-being

According to Table 4, all participant's pre-and post-scores were below the level of community mean for the psychological well-being scale (M = 2.1), indicating higher levels of well-being (Boyle et al., 2011). As seen in Table 5, an RC in participant one's psychological well-being was found (RCI = 3.12 > 1.96). Participant two experienced a decline in their score post-delivery. However, this change did not meet the threshold for an RC (RCI = 1.56 < 1.96). According to Table 5, participant three (RCI = .0 < 1.96) and four (RCI = .0 < 1.96) did not demonstrate a RC pre and post-delivery of the program.

Table 4

Acculturation, Resilience and Well-being (pre and post-delivery scores.)			
Participants	**Acculturation**	**Resilience**	**Well-being**
1	100(102)	37(38)	2(0)
2	89(104)	34(38)	1(0)
3	114(103)	36(33)	0(0)
4	112(105)	40(36)	0(0)

Note: Post-delivery scores are in the paratheses.

Table 5

Reliable Change in AARS, CD-RISC, and PHQ-2 for participants through RCI.				
Participants	**AARS**	**CD-RISC**	**PHQ-2**	**RCI**
A	-.32	.15	3.12*	PHQ-2 Improved
B	2.42*	.61	1.56	AARS Improved
C	1.77	.45	.0	No change
D	1.13	.61	.0	No change

Note: * RCI>1.96 indicating a Reliable Change.

Discussion

A combination of qualitative and quantitative methods examined the acceptability and feasibility of the BRiTA program when used in an individual setting via an encrypted and confidential platform, Zoom. Qualitative findings supported the feasibility of this delivery method as the program was delivered as planned previously without any constraints. Qualitative findings supported the acceptability of this delivery method through having a consistent level of attendance, no dropouts, and high levels of engagement. However, not all participants experienced a reliable change in their experiences of acculturation, levels of resilience, nor psychological well-being, pre-to-post delivery. Overall, the study supported the implementation of a preventative program to enhance the acculturation and resilience of CALD immigrants.

Individual Delivery Via Zoom

Feasibility

The findings indicated that the BRiTA program could be delivered in an individualised and online setting without significant challenges. The format of delivery helped maintain attendance and prevented dropouts. Consistent with previous research (Archibald et al., 2019; O'Mahony et al., 2012), online delivery was associated with better ease of access and cost-effectiveness in CALD adults and ran without significant complications. Congruent with previous research conducted by Acierno et al. (2017), rapport building and the quality of the therapeutic relationship on an online platform was as effective as that observed in face-to-face delivery format. Participants did not identify barriers towards the delivery of the program via Zoom for

either rapport building and therapeutic alliance.

Acceptability

The qualitative data obtained indicated that participants found the experience of attending the BRiTA program individually and online beneficial and therapeutic. Protected space within their home environments, where they could attend the program via Zoom, was valued. Consistent with the previous research (Chouliara et al., 2020), delivery in an individualised setting provided participants with a safe space to express their thoughts, and explore and process their cultural strength, without the fear of receiving judgement for expressing potential weaknesses in the presence of individuals from their community. Interestingly, consistent with Türk et al.'s (2019) findings, participants recognised the benefits of group format and recommended mixing individual and group delivery formats. Further, participants emphasised the need for the BRiTA program's content to be refined to suit the needs of a CALD consumer's background. This may indicate that the program's acceptability could be further enhanced if there is an amalgam of individual and group delivery, with a greater focus on the individual's particular background.

Acculturation, Resilience, and Psychological Well-Being

The quantitative data revealed mixed results. Scores of two participants improved, while those of the other two decreased. Nonetheless, all participants possessed higher levels of acculturation, resilience, and psychological well-being when compared to the community sample at both the baseline and post-delivery of the program.

The increases in the scores reflected better acculturation and adaptation to the Australian culture, which supports the content in BRiTA's modules and its impacts on enhancing individuals' protective factors. These findings were congruent to previous research indicating that the delivery of BRiTA enhances participants' experience of acculturation and resilience (Khawaja & Ramirez, 2019; Mitchelson et al., 2010). Moreover, the demonstrated improvement in half of the participants may also indicate that they had been engaging in more positive and adaptive coping strategies introduced by the BRiTA program's modules. Further, they were also utilising their cultural and personal strengths and building positive relationships with other individuals (Khawaja & Ramirez, 2019). These improvements were potential indicators of adapting further to the Australian culture after attending the BRiTA program.

It is suggested that the lack of demonstrated improvement in the other half of the participants' scores may not have been correlated to the delivery of the program. For instance, some participants had been in Australia for more than two years, experienced financial stability, had an adequate level of education and security in their life, and were potentially acculturated with good personal resources. Thus, the participants may have learnt and adopted some of the concepts introduced in the program through their journey of acculturation. As a result, the lack of improvement was due to them already possessing high levels of acculturation and resilience, regardless of their attendance of the program. Further, participants' age may also be a predicting factor. The youngest and the oldest participant demonstrated a lack of improvement in their scores, indicating that they may have been exposed to more psychosocial stressors congruent with past research (Alizadeh-Khoei et al., 2011).

Implications

This study had theoretical and practical implications for the literature. Firstly, the study highlights the significance of the preventative intervention. The data indicated that BRITA could be utilised with newly arrived immigrants to enhance their psychological well-being. Further, the combination of qualitative and quantitative data provided different sources of information on CALD adults' experiences of attending the individual and online delivery of BRiTA. Moreover, this study provided preliminary evidence for the feasibility and acceptability of delivering BRiTA to CALD immigrants in an individual and online setting as a new delivery method that could improve the accessibility and attendance of CALD immigrants to the preventative help that they need within the community. The program was also offered to one participant in her native language, Persian, which suggests that individual delivery, online, in a language other than English is also feasible and acceptable. Moreover, suggestions provided by participants indicate that individual delivery can be combined with group delivery if required by facilitators in the future. The program also helped consolidate and normalise CALD immigrants' challenges and experiences of acculturation, which positively impacted their well-being.

Limitations and Future Directions

This study exhibited a few limitations. The study's participants were already highly acculturated and high functioning individuals and may represent a subsection of CALD immigrants. Moreover, the sample size was not equally balanced across genders. Therefore results should be taken with caution. Future studies should recruit a diversity of gender group of CALD immigrants from different communities. The sample was recruited only in Queensland. Future studies should expand to other states at a national level. This study only measured RC pre-to-post treatment without any follow-ups. Studies in the future can employ a longitudinal design to continue with follow-ups six months and 12 months after the provision of the program to assess whether the changes persist, as acculturation is a dynamic construct. The study lacked a comparison group of delivering in an individual setting via Zoom and face-to-face. Therefore, future studies may deliver the program in an individual setting face-to-face to further the literature. The participants all had an adequate level of English proficiency.

Nonetheless, their levels of fluency were different, impacting their interpretation and understanding of the questions. Future studies would benefit future studies to use translations of the questionnaires to prevent any potential language barriers. Lastly, as this was a preliminary feasibility and acceptability study, future research should focus on recruiting a larger sample size to replicate this study, followed by conducting more rigorous studies to evaluate the effectiveness of this method of delivery for a preventive program such as BRiTA.

Conclusion

The preliminary findings support the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom.

It opens further options of accessing preventative programs in a range of settings. BRITA has emerged as a promising program to promote CALD immigrants' psychological well-being and integration into Australian society.

Conflict of Interest

There are no conflicts of interest.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Acknowledgements

The authors would like to thank Queensland Transcultural Mental Health Centre staff for their support with the execution of the program and the participant for their participation.

References

Acierno, R., Knapp, R., Tuerk, P., Gilmore, A. K., Lejuez, C., Ruggiero, K., Muzzy, W., Egede, L., Hernandez-Tejada, M., A., Foa, E. B. (2017). A non-inferiority trial of Prolonged Exposure for post-traumatic stress disorder: In person versus home-based telehealth. *Behaviour Research and Therapy, 89*(1), 57–65. https://doi.org/10.1016/j. brat.2016.11.009

Agrawal, P., & Venkatesh, A. K. (2016). Refugee resettlement patterns and state-level health care insurance access in the United States. *American Journal of Public Health, 106*(4), 662–663. https://doi.org/10.2105/AJPH.2015.303017

Alizadeh-Khoei, M., Mathews, R. M., & Hossain, S. Z. (2011). The role of acculturation in health status and utilisation of health services among the Iranian elderly in metropolitan Sydney. *Journal of Cross-Cultural Gerontology, 26*(4), 397-405. https://doi.org/ 10.1007/s10823-011-9152-z

Amodeo, M., Peou, S., Grigg-Saito, D., Berke, H., Pin-Riebe, S., & Jones, L. K. (2004). Providing culturally specific substance abuse services in refugee and immigrant communities: Lessons from a Cambodian treatment and demonstration project. J*ournal of Social Work Practice in the Addictions, 4*(3), 23-46. https://doi.org/10.1300/J160v04n03_03

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18(1),* 1-8. https://doi.org/10.1177/1609406919874596

Australian Bureau of Statistics [ABS]. (2019). *Migration, Australia, 2018–19.* Australian Bureau of Statistics. Retrieved from https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3412.0Main+Features12018-19?OpenDocument

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C. P.,Squires, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine, 36*(5), 452-457. https://doi.org/10.1016/j.amepre.2009.02.002

Boyle, L. L., Richardson, T. M., He, H., Xia, Y., Tu, X., Boustani, M., & Conwell, Y. (2011). How do the phq-2, the phq-9 perform in aging services clients with cognitive impairment?. *International Journal of Geriatric Psychiatry, 26*(9), 952-960. https://doi.org/10.1002/gps.2632

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

Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress, 20,* 1019 –1028. https://doi.org/10.1002/jts.20271

Chamberlain, D., Williams, A., Stanley, D., Mellor, P., Cross, W., & Siegloff, L. (2016). Dispositional mindfulness and employment status as predictors of resilience in third year nursing students: A quantitative study. *Nursing Open, 3*(4), 212-221. https://doi.org/10.1002/nop2.56

Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., Andrews, G., & Hunt, C. (2012). Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders, 136*(3), 459-468. https://doi.org/10.1016/j.jad.2011.11.003

Chouliara, Z., Karatzias, T., Gullone, A., Ferguson, S., Cosgrove, K., & Burke Draucker, C. (2020). Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice. *Journal of Interpersonal Violence, 35*(15-16), 2897-2916. https://doi.org/10.1177/0886260517696860

Close, C., Kouvonen, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and well-being of first-generation migrants: A systematic-narrative review of reviews. *Globalisation and Health, 12*(1), 1-13. https://doi.org/10.1186/s12992-016-0187-3

Coates, E. E., Phares, V., & Dedrick, R. F. (2013). Psychometric properties of the Connor-Davidson Resilience Scale 10 among low-income, African American men. *Psychological Assessment, 25*(4), 1349-1354. https://doi.org/10.1037/a0033434

Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*(1), 76 – 82. https://doi.org./10.1002/da.10113

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research.* Sage publications.

Dadfar, M., Salabifard, S., Dadfar, T., Roudbari, M., & Moneni Safarabad, N. (2019). Validation of the Patient Health Questionnaire-2 with Iranian students. *Mental Health, Religion & Culture, 22*(10), 1048-1056. https://doi.org/10.1080/13674676.2019.1699042

Department of Immigration and Border Protection (2015). *Migration programme statistics.* Australian Government. Retrieved from http://www.immi.gov.au/ media/statistics/pdf/report-migration-programme-2013–14.pdf

Disney, L., & McPherson, J. (2020). Understanding Refugee Mental Health and Employment Issues: Implications for Social Work Practice. *Journal of Social Work in the Global Community, 5*(1), 19-30. https://doi.org/10.5590/JSWGC.2020.05.1.02

Driscoll, M. W., & Torres, L. (2013). Acculturative stress and Latino depression: The mediating role of behavioral and cognitive resources. *Cultural Diversity and Ethnic Minority Psychology, 19*(4), 373-382. https://doi.org/10.1037/a0032821

Ehsan, A., Bolano, D., Guillaume-Boeckle, S., & Spini, D. (2020). Reducing loneliness in older adults: looking at locals and migrants in a Swiss case study. *European Journal of Ageing,* 1-12. https://doi.org/10.1007/s10433-020-00577-4

Feijt, M., de Kort, Y., Bongers, I., Bierbooms, J., Westerink, J., & IJsselsteijn, W. (2020). Mental Health Care Goes Online: Practitioners' Experiences of Providing Mental Health Care During the COVID-19 Pandemic. *Cyberpsychology, Behavior, and Social Networking, 00,* 1-8. https://doi.org/10.1089/cyber.2020.0370

Frounfelker, R. L., Miconi, D., Farrar, J., Brooks, M. A., Rousseau, C., & Betancourt, T. S. (2020). Mental Health of Refugee Children and Youth: Epidemiology, Interventions, and Future Directions. *Annual Review of Public Health, 41*(1), 159-176. https://doi.org/10.1146/annurev-publhealth-040119-094230

Geerlings, L. R., Thompson, C. L., Bouma, R., & Hawkins, R. (2018). Cultural competence in clinical psychology training: A qualitative investigation of student and academic experiences. *Australian Psychologist, 53*(2), 161-170. https://doi.org/10.1111/ap.12291

Guhn M., Forer B., & Zumbo B.D. (2014) Reliable Change Index. In: Michalos A.C. (Eds.) *Encyclopedia of Quality of Life and Well-Being Research.* Springer.

Holgersen, K. H., Brønstad, I., Jensen, M., Brattland, H., Reitan, S. K., Hassel, A. M., Arentz, M., Lara-Cabrera, M., & Skjervold, A. E. (2020). A combined individual and group-based stabilisation and skill training intervention versus treatment as usual for patients with long lasting posttraumatic reactions receiving outpatient treatment in specialised mental health care–a study protocol for a randomised controlled trial. *Trials, 21*(1), 432-445. https://doi.org/10.1186/s13063-020-04297-z

Hosseini, A., Kakuma, R., Ghazinour, M., Davern, M., Evans, W. P., & Minas, H. (2017). Migration experience, resilience and depression: A study of Iranian immigrants living in Australia. *International Journal of Culture and Mental Health, 10*(1), 108-120. https://doi.org/10.1080/17542863.2016.1270977

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

Jaeger, F. N., Pellaud, N., Laville, B., & Klauser, P. (2019). The migration-related language barrier and professional interpreter use in primary health care in Switzerland. *BMC Health Services Research, 19*(1), 429-439. https://doi.org/10.1186/s12913-019-4164-4

Kartal, D., & Kiropoulos, L. (2016). Effects of acculturative stress on PTSD, depressive, and anxiety symptoms among refugees resettled in Australia and Austria. *European Journal of Psychotraumatology, 7*(1), 28711-28723. https://doi.org/10.3402/ejpt.v7.28711

Kayrouz, R., Senediak, C. I., & Laube, R. (2017). Building a bridge: A case report on communicating mental-health diagnoses to patients of a culturally and linguistically diverse background. *Australasian Psychiatry, 25*(5), 478–480. https://doi.org/10.1177/1039856217726685

Kennedy, S., Kidd, M. P., McDonald, J. T., & Biddle, N. (2015). The healthy immigrant effect: patterns and evidence from four countries. *Journal of International Migration and Integration, 16*(2), 317-332. https://doi.org/10.1007/s12134-014-0340-x

Khawaja, N. G., & Ramirez, E. (2019). Building resilience in transcultural adolescents: An evaluation of a group program. *Journal of Child and Family Studies, 28*(11), 2977-2987. https://doi.org/10.1007/s10826-019-01473-x

Khawaja, N. G., & Ramirez, E. (in press). Building resilience in transcultural adults: An evaluation of a group program. *Australian Psychologists*

Khawaja, N. G., McCarthy, R., Braddock, V., & Dunne, M. (2013). Characteristics of culturally and linguistically diverse mental health clients. *Advances in Mental Health, 11*(2), 172–187. https://doi.org/10. 5172/jamh.2013.11.2.172

Khawaja, N. G., Moisuc, O., & Ramirez, E. (2014). Developing an acculturation and resilience scale for use with culturally and linguistically diverse populations. *Australian Psychologist, 49*(3), 171-180. https://doi.org/10.1111/ap.12052

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care, 41*(11), 1284-1292. https://doi.org/10.1097/01.MLR.0000093487.78664.3C

Lee, R. M., Titzmann, P. F., & Jugert, P. (2020). Towards a more dynamic perspective on acculturation research In P. F. Titzmann & P. Jugert (Eds.). *Youth in multicultural societies: New directions for future research and interventions* (pp. 74-91). Psychology Press. https://doi.org/10.4324/9781351040266-6

Leiderman, L. M. (2020). Psychodynamic group therapy with hispanic migrants: Interpersonal, relational constructs in treating complex trauma, dissociation, and enactments. *International Journal of Group Psychotherapy, 70*(2), 162-182. https://doi.org/10.1080/00207284.2019.1686704

Lemerle, K. & Prasad-Ildes, R. (2004). *Final report on the development and pilot of the 'BRiTA' Program: Building resilience in transcultural adolescents.* Brisbane: Queensland Transcultural Mental Health Centre.

Lincoln, Y., & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lumley, M., Katsikitis, M., & Statham, D. (2018). Depression, anxiety, and acculturative stress among resettled Bhutanese refugees in Australia. *Journal of Cross-Cultural Psychology, 49*(8), 1269-1282. https://doi.org/10.1177/0022022118786458

Minas, H., Kakuma, R., San Too, L., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *International Journal of Mental Health Systems, 7*(1), 23.-48. https://doi.org/10.1186/1752-4458-7-23

Mitchelson, M. R., Erskine, H. E., Ramirez, E., Suleman, F.,

Prasad-Ildes, R., Siskind, D., & Harris, M. (2010). BRiTA Futures: A resilience-building program for children and young people from culturally and linguistically diverse backgrounds–Program description and preliminary findings. *Advances in Mental Health, 9*(3), 243-254. https://doi.org/10.5172/jamh.9.3.243

Ngwena, J. (2014). Black and minority ethnic groups (BME) suicide, admission with suicide or self-harm: An inner-city study. *Journal of Public Health, 22*(2), 155-163. https://doi.org/10.1007/s10389-013-0600-9

Notario-Pacheco, B., Solera-Martínez, M., Serrano-Parra, M. D., Bartolomé-Gutiérrez, R., García-Campayo, J., & Martínez-Vizcaíno, V. (2011). Reliability and validity of the Spanish version of the 10-item Connor-Davidson Resilience Scale (10-item CD-RISC) in young adults. *Health and Quality of Life Outcomes, 9*(1), 63. https://doi.org/10.1186/1477-7525-9-63.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1-13. https://doi.org/10.1177/1609406917733847

O'Mahony J.M., Donnelly T.T., Bouchal S.F. & Este D. (2012) Barriers and facilitators of social supports for immigrants and refugee women coping with postpartum depression. *Advances in Nursing Science, 35*(3), 42–56. https://doi.org/10.1097/ANS.0b013e3182626137

Orsmond, G. I., & Cohn, E. S. (2015). The distinctive features of a feasibility study: Objectives and guiding questions. *OTJR: occupation, participation and health, 35*(3), 169-177. https://doi.org/10.1177/1539449215578649

Queensland Transcultural Mental Health Centre [QTMHC] (2010). *BRiTA Futures Building Resilience in Transcultural Australians Program Report.* Queensland Government: Brisbane. https://metrosouth.health.qld.gov.au/qtmhc/programs-and-services/brita-futures

Reich, J. W., Zautra, A. J., & Hall, J. S. (Eds.). (2010). *Handbook of adult resilience.* Guilford Press.

Scoppetta, O., Cassiani-Miranda, C. A., Arocha-Díaz, K. N., Cabanzo-Arenas, D. F., & Campo-Arias, A. (2020). Validity of the Patient Health Questionnaire-2 (PHQ-2) for the Detection of Depression in Primary Care in Colombia. *Journal of Affective Disorders, 278*(1), 576-582. https://doi.org/10.1016/j.jad.2020.09.096

Silva, N. D., Dillon, F. R., Verdejo, T. R., Sanchez, M., & De La Rosa, M. (2017). Acculturative stress, psychological distress, and religious coping among Latina young adult immigrants. *The Counseling Psychologist, 45*(2), 213-236. https://doi.org/10.1177/0011000017692111

Spallek, J., Reeske, A., Norredam, M., Nielsen, S. S., Lehnhardt, J., & Razum, O. (2015). Suicide among immigrants in Europe - a systematic literature review. *The European Journal of Public Health, 25*(1), 63-71. https://doi.org/10.1093/eurpub/cku121

Stige, S. H., & Binder, P. E. (2017). From painstaking work to a new way of meeting the world—Trauma clients' experiences with skill training in a stabilisation group approach. *Psychotherapy Research, 27*(5), 571-582. https://doi.org/10.1080/10503307.2016.1138335

Strauss, B., Spangenberg, L., Brähler, L., & Bormann, B. (2015). Attitudes towards (psychotherapy) groups: Results of a survey in a representative sample. *International Journal of Group Psychotherapy, 65*(3), 410–430. https://doi.org/10.1521/ijgp_2014_64_001

Tickle-Degnen, L. (2013). Nuts and bolts of conducting feasibility studies. *American Journal of Occupational Therapy, 67*(2), 171-176. https://doi.org/10.5014/ajot.2013.006270

Türk, D. (2019). Combined and parallel individual and group therapy—still a red rag?. *Group Analysis, 52*(3), 313-329. https://doi.org/10.1177/0533316419849503

Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., Mason-Jones, A. J., Reid, S., Theron, L., Ungar, M., & Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: A cross-country comparative study. *Public Health, 162*(1), 63-70. https://doi.org/10.1016/j.puhe.2018.05.006

Yardley, L., Ainsworth, B., Arden-Close, E., & Muller, I. (2015). The person-based approach to enhancing the acceptability and feasibility of interventions. *Pilot and Feasibility Studies, 1*(1), 37-44. https://doi.org/10.1186/s40814-015-0033-z