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Evaluating the feasibility and acceptability of a community-based parenting support intervention for refugee parents from Burma.

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Introduction

Resettlement stressors experienced by refugee families are a potential source of tension that can disrupt relationships between parents and their youth. Protecting and nurturing a child in war influences nearly every decision that a parent makes with regard to their circumstance. Refugee resettlement is a contextual shift. Yet while the stressors differ from war and refugee settings, the complexities of these experiences do not always lessen. As resettled men and women navigate the work of parenting across cultures, resilience and adaptation are inherently connected to the extent to which their youth thrive in a new environment.^{1–3}

Purpose

Our primary objective was to assess the feasibility and acceptability of the Refugee Family Cohesion Program parenting intervention with a sample of Karen refugees from Burma living post resettlement in the United States. The intervention is a six session culturally oriented curriculum that aims to promote Karen refugee family cohesion and communication through parent education, skill building, and social support. A key facet of the program is supporting parents as they address adolescent youth behavior and promote adolescent sense of belonging and positive identity.

Background

Since 2006, the United States (US) has resettled more than 120,000 refugees from Burma; a majority identify as ethnic Karen.^{4,5} Trends documented in state health department refugee arrival reports as well as aggregate migration data indicate that females comprise approximately 45% of the population of refugees from Burma in the US. The community of refugees from Burma in the US is a relatively young population, with 64% of individuals under the age of 40. Approximately 26% of community-members are youth under 18 years of age.⁶ These statistics demonstrate the large number of women of childbearing age and the significance of the youth generation in the make-up of communities of refugees from

Burma. The emergence of the parenting experience as an area of concern post-resettlement is important given these population dynamics.

Though limited, research describing the experiences of parenting post-resettlement is frequently situated within the context of the school-based education experience of refugee youth.^{7–12} These studies report target the parenting experience of younger pre- or school-aged children. Though critical from a growth and development perspective, this focus overlooks the growing segment of adolescent youth in the community. Furthermore, refugee-focused educational programs tend to focus on orienting parents to the US educational system with the primary goal of promoting student academic success. A lack of evaluated community-based parenting interventions highlights that a key point of engagement with refugee families has been underutilized. Community-based parenting programs have the potential to address the integration of positive parenting strategies within the refugee family system and community structures through partnerships designed to promote family and adolescent health.^{13–15}

Facets unique to refugee status contribute social and cultural challenges and add complexity to the resettlement transition. Complicating factors include war and trauma histories, uncertain employment status, social isolation, and the circulating sociopolitical discourses of migration.¹⁶ Refugee families may encounter shifts in the ways power is distributed among family members, and subsequent shifts in role dynamics within the family system.⁹ Resources that support the refugee transition process post-resettlement are generally focused in the early phases of resettlement, are temporary, and emphasize economic self-sufficiency.¹⁴ Successful resettlement of families, however, requires culturally-derived support programs targeted to bridging culture, language, and educational barriers.^{13,14}

Several studies report outcomes from parenting support programs specifically developed and implemented with Karen refugee communities post-resettlement. From an interpretive phenomenologic lens, McLaughlin & Guilfoyle¹⁷ examined the role of an early childhood play-group in developing informal networks of social support among refugees from Burma. Authors identified direct parallels between stressors associated with the experience of acculturation and the experience of mothering. Findings highlight sources of tension involved in parenting across hybrid cultural spaces. Harper¹⁸ explored disparities between collective and individualist cultural frameworks through a critical lens. In response to a recognized need to reconcile Karen ways of knowing within a third country school science curriculum, the study described an exploration of resilience as it is anchored to inherited cultural practices of Karen parents. Koh, Liamputtong, and Walker¹⁹ approached an understanding of dynamic familial roles from the perspective of young Burmese refugee women living in Australia. The authors explored sources of power and the roles of linguistic brokering and technology in the dynamics of intergenerational positionality. Ballard et al.¹⁵ tested a parenting intervention addressing parent management of negative child behaviors in children age 5–13 years. Authors reported descriptive findings that suggested participants perceived the intervention was valuable in supporting positive parenting practices and emotional regulation.

Our objective was to evaluate the feasibility and acceptability of a pilot parenting intervention, designed to support refugee parents of adolescent youth in a community-based setting post-resettlement. The intervention was adapted to meet specific Karen cultural needs and practices. We envision potential for future adaptations of the intervention to meet the needs of other emerging migrant and refugee groups. As families negotiate flipped social structures, separation (e.g. as opportunities to pursue work force couples to separate during the week), and other post-resettlement stressors, the health of the family system is vulnerable. This work will inform community-based programs designed to strengthen family systems.

Theoretical Framework

Family Systems Theory informed aspects of curriculum development, study design, and interpretation of results in the Refugee Family Cohesion Program. The framework considers the family as a cohesive unit within which members are influenced by interactions and emotional connectedness with other family members. These interactions are integral to the family structure and define the health of the entire family system.²⁰ The theory has been applied in a broad array of contexts within which families live and function. Among migrant and refugee groups, the framework has been used to assess familial interconnectedness⁸; coping strategies and resilience²¹; and the essential role of the family unit to the cultural integration of adolescent youth.²² Family Systems Theory has important relevance in the stability of refugee families given shared histories and trajectories in migration between parents and particularly adolescent youth.

Methods

Our primary objective was to assess the feasibility and acceptability of engaging Karen refugee mothers and fathers together in a multi-session community-based parenting curriculum. The Refugee Family Cohesion Program parenting intervention was developed to promote family cohesion and communication through parental education and skill building to address adolescent behavior, and promote adolescent sense of belonging and positive identity. We implemented a community-engaged, explanatory sequential mixed methods pilot study in partnership with the Karen Organization of Minnesota (Figure 1).

Partnership

The Karen Organization of Minnesota is the first Karen-led organization in the US supporting the wellbeing of refugees from Burma. The organization functions as a central and prominent source of support in the Minnesota Karen community and has established pathways through which community leaders and community stakeholders are continually engaged within its programs. The co-executive director served as a principal co-investigator in this project, and members of the community health team served as essential research team members. In planning this project, we consulted with members of the Karen Chemical Dependency Task Force and the Karen Organization of Minnesota Board of Directors. Stakeholders perceived direct benefits of the project to Karen mothers and fathers, as well as a potential secondary benefit of strengthening Karen families and the community.

Participants

The Karen Organization of Minnesota led the recruitment of 50 maternal and paternal caregivers (representing 46 families). Of the 50 research participants, 6 comprised married couples attending the intervention jointly. Results we discuss are based on pre/post data from 40 families, with one parent selected per family (the parent that attended the most sessions or if equal attendance the maternal caregiver results were included).

Sources of participant recruitment included youth and adult Karen Organization of Minnesota programs, referrals from Karen Organization of Minnesota case managers, and word of mouth within the Karen community. Participants identified as ethnic Karen, had refugee status, were residing post-resettlement in the Twin Cities metro area, and had current caregiving responsibilities of adolescents in high school or eligible to begin high school the next academic year.

Study Design

The total sample was divided into three consecutive intervention training waves. For each training wave, the intervention and data collection procedures were delivered in three phases:

Phase I – Participants completed a demographic questionnaire and structured pre-test measures. Additionally participants were asked several open-ended questions concerning needs relevant to the proposed intervention, feasibility of the intervention, factors that facilitate family cohesion post-resettlement and factors that stress the health of the family structure.

Phase II – Participants attended the 6-session intervention.

Phase III – Participants were re-administered structured measures in the post-test period. The study team facilitated a post-intervention focus group for participants. Additionally post-intervention interviews with a small sample adolescents in participant families were conducted. The primary and secondary aims of adolescent interviews were to inform: 1) modifications to the intervention, and 2) strategies to include refugee adolescents in future phases of refugee family systems research. The study team did not conduct a full analysis on adolescent interview content.

The three phases occurred in three consecutive, non-overlapping and largely identical intervention periods. Results of the first and second focus group discussions informed curriculum modifications and data collection procedures in the second and third training waves.

In a final *Phase IV*, we recruited a sub-sample of 18 participants that had completed the intervention and re-administered the Family Adaptability and Cohesion Scales (FACES) subscales (Family Communication and Family Satisfaction) as an exploratory assessment of intervention outcome stability. Participants in *Phase IV* represented all three training wave samples. Based on the timing of *Phase IV*, participants were thus distributed at time points of 3, 6, or 9 months post-intervention. Though an assessment of long-term outcomes was

not within the scope of the project, we display the *Phase IV* exploratory analysis as an examination of intervention stability.

Curriculum

Led by a Karen Organization of Minnesota social worker and the organization's community health educator, the study team adapted the *Family Talk Time* curriculum to address parenting needs expressed by the Karen community in the Twin Cities area.²³ *Family Talk Time* was developed by a multi-ethnic work group including refugee parents in partnership with the Refugee Women's Alliance in Washington state. The intent was to provide tools and information specific to parenting in the US to refugee and immigrant parents in a way that facilitated empowerment and family cohesion. The Refugee Cohesion Program adaptation included the development of six topic areas that prioritized specific parenting needs reported to the Karen Organization of Minnesota by members of the Karen community in Minnesota (Figure 2). The Karen Organization of Minnesota community health educator and social worker co-facilitated the first training wave. The community health educator (Karen speaking) led the delivery of the intervention in the second and third training waves. Study PIs observed the intervention delivery throughout the training waves.

Measures

Instruments were administered to participants at baseline and immediately post-intervention. An additional follow up survey was administered, either at 9 months post intervention (Training Wave 1), 6-months post-intervention (Training Wave 2), or 3-months post-intervention (Training Wave 3), to a purposefully selected small sample of participants. English language instruments were translated to the Karen language through a process of translation, back translation, and consensus.²⁴ Table 1 outlines the structured assessments completed by participants.

Focus group interviews were held at the Karen Organization of Minnesota. Each session lasted approximately one hour and were audiotaped and transcribed. Each focus group interview was co-moderated by the Karen study facilitator and a study PI. Focus group questions were developed by the research team and reviewed by collaborators at the Karen Organization of Minnesota for cultural and program relevance. Focus group discussions were initiated with questions that grounded participants to their experiences of parenting (e.g. *Please share an example of a Karen value or a view, as it relates to raising children?*). The questions went on to explore strengths and opportunities to improve the intervention, how families were integrating information from the intervention into daily parenting routines (e.g. *Are there examples of times that you have taken what you learned here and used it with your children or in your family?*; *How have you shared what you have learned with your partner/children?*), and opportunities participants observed to provide access to the information more broadly and outside of the brief intervention period.

Analysis

We summarized completed measures as a total group, by training wave, and by key participant characteristics (gender, age, time since resettlement, type of parental unit). Summary statistics along with ANOVA and chi-square were used to test for group

differences in demographics and characteristics. As post-intervention results are highly correlated with baseline, Analysis of Covariance (ANCOVA) was used to test factors of interest (time in US, training wave, Mental Health Screening referral), while adjusting by baseline. Spaghetti plots show family communication, family satisfaction and parent self-efficacy from baseline. All statistical results focused on immediate post-intervention assessments, and data visualization plots include the longer-term follow-up data.

We approached the qualitative data through basic content analysis. Qualitative data we report in this manuscript includes responses to focus group questions collected post intervention.

Results

Despite opening the intervention to maternal and paternal caregivers, 62% of the total sample were women (Table 2). Married couples were similar in the assessed intervention outcomes (mean differences .2). Based on findings of the baseline mental health screening tool, we referred 25% of participants (n=10) for mental health services.

We experienced an overall attrition of 14% (n = 7, representing 6 families). Of these individuals, two of the participants began new employment that conflicted with session times. One participant became ill and was hospitalized. Of the total attrition, 5 individuals withdrew from the study in the first training wave.

Structured Assessments

Efficacy.—We assessed the average change in Family Communication, Family Satisfaction, and Parent Self-Efficacy pre and post the parenting intervention. On average, Family Communication scores increased by .89 (.34) on a four-point scale. Family Satisfaction scores increased by .74 (.46). Parent Self-Efficacy scores increased by .70 (.56). All differences were significant ($p<.001$). At baseline, the maximum self-efficacy score became the minimum score in the post-test period. In the review of the post-intervention follow up data point, all sampled respondents had the same or higher mean scores on the Family Communication, Family Statistics, and Parent Self-Efficacy scales.

Subsequent exploratory analyses reflected our interest in the impact of time since resettlement, mental health status of the parent, and structure of the training wave on the experience of the family and impact of the intervention.

Time in Country.—Time in Country is based on an informal but broadly accepted characterization of new (0 – 1 year), early (>1 – 5 years), and late resettlement (>5 years). There were no significant differences across groups characterizing time in country for Family Communication [$F(2,35)=.91$, $p=.41$], Family Satisfaction [$F(2,35)=.80$, $p=.46$], or Parent Self-Efficacy [$F(2,24)=.97$, $p=.97$] (Table 3 and Figure 3).

Mental Health Screening.—Similarly, we assessed average change in pre and post assessments in relation to baseline mental health status. There were no significant differences across groups based on mental health screening data, Family Communication [$F(1,37)=.08$, $p=.78$], Family Satisfaction [$F(1,37)=3.88$, $p=.057$], or Parent Self-Efficacy

[F(1,25)=.89, $p=.36$]. We provided behavioral health provider referrals if the participant scored 4 or higher on the screening tool (Table 3 and Figure 4).

Training Wave.—Assessments were compared by training wave, once again showing no statistical differences, Family Communication [F(2,36)=1.22, $p=.31$], Family Satisfaction [F(2,36)=.12, $p=.89$], or Parent Self-Efficacy [F(1,25)=1.08, $p=.31$].

Qualitative Data

Focus group sessions comprised the unit of analysis and here we present findings from our cross-case comparison. The primary function of focus group data collection was to inform subsequent structure and content of the training waves and final recommendations to the partner organization. Several key themes emerged across the analysis of the focus group data. Prominent in the discussions were references to spaces of cultural difference that participants navigated as parents. Through migration and resettlement, power and authority, and the influences these shifting structures had on the ability to protect a child, were important experiences in the lives of parents.

Discipline.—The shifting norms and legal structures that surround disciplining youth is well documented in the literature describing the resettlement experiences of Karen refugees.^{1,15} Concerns around discipline were similarly expressed through the perspectives of parents participating in the end of session focus groups. *Back in our country or back in Thailand or Burma, when our kids do something wrong, we spank them and we hit them and you know, and we don't let them...and it's very different for here in the United States. Because if you hurt them you know sometimes they call 911 or told their teachers. So yeah we discipline them in different ways...So that is the problem, for the parents.*

Authority.—An experience that was expressed repeatedly in the focus group discussions was the perceived loss of power as a parent post-resettlement. Participants reflected on this transition as a loss of authority. *We can't control our kids... it seems like they have more power than their parents... They can read write and everything... They thought their parent doesn't know anything, like to speak English.* Language ability and differences in the levels of formal education between parents and their children were perceived as barriers to authority for group participants.

Protecting children.—There was consensus among the groups that a deeply valued role in parenting in the Karen community was the protection of children. And in the context of cultural difference, and the ways in which shifting norms and legal structures dictated practices of authority, new challenges emerged in this role. *If the children still going out even though the parent don't give them the permission, they can't protect them you know? I don't want the children to go but then they still go out and then if anything happen we just worry... I will have a hard time sleeping if anything happen.* Post-resettlement, parents concurrently navigated new ways that youth engage with the legal system. *One of my neighbors, she has a daughter, that they go out, and they kind of late at night and they very late. So her parents talk them [tell her] "don't do that", and then she keeps don't listen to her parents. And then she really mad at her parents and then called the police and tell them "my*

parents doesn't love me, they hit me and they spank me". Luckily the police didn't take her parents, take her instead. Subsequently parent engagement with the legal system has also transitioned.

Integration of Intervention Strategies

Participants discussed elements of the intervention that they had integrated into the relationships with their children. Experiences that were shared represented strategies relevant to communication, being present in the lives of youth, and mindfulness.

Communication.—Points along the trajectory of migration necessitate adaptation of communication styles and norms within families. Schedules, economic self-sufficiency, integration into the United States public school system, and other factors in resettlement demand this adjustment. In the context of raising adolescent children, communication factors become even more complex. Parents in the groups reflected on ways in which they were able to modify their approach and style of communication with their children during the intervention, and how that served themselves, the child, and the relationship. One woman reflected on her reminder to her child before leaving the house, *I always remind my kids that if you are going to go out...don't forget to let us know because some of your friend might be bad or might be good.* The focus this participant relates emphasized open bidirectional communication with her child, and less of an emphasis on restricting behaviors.

Participants shared a developing understanding of the importance of mirroring gratitude and respect that they have for their children. *I have never done that before but when I take the class here, I used that method. When I ask my children to do anything, I praise them, I thank them, "you're good at this", "you're good at that"... You have to praise them, you have to thank them so that next time they will do it again.* Participants related communication back to their experiences disciplining children. One participant shared, *but then in two weeks I came here I took the class and I learned how to teach and discipline my children. When my kids don't listen to me I don't have to hit or hurt them. I can take their phone away or computer away or give them time out, and then tell them if you guys ready and listen to me, then I will give you guys the phone or computer for you guys to play.* She describes fostering listening and communication in the relationship with her children, as she regained authority in the relationship.

Participants discussed the importance of bringing the content of the intervention back to their spouses and children for *discussion, to talk to each other, understand.* Participants referenced the value of bringing new strategies they had learned into family rituals, *we pray before they sleep, so before that we discuss what I learned here with the kids. I say, "I came to the Karen Organization of Minnesota, I take the parenting class, this is what I learned."*

Presence in the lives of youth.—Participants discussed new and different ways of interacting with children, in particular in their social lives and technological lives. *In this country kids use a lot of internet or Facebook, things like that. So we learn how to check pin numbers or password.* Substance use is a prevalent concern within resettled Karen communities. Participants reflected on this as they discussed active involvement with their children as they encounter exposures to the use of alcohol and other drugs. *Also drug and*

alcohol, we have to pay attention to them and check on them. We check under their bed or by looking at their face and if their face getting red, and every day activities...if they sleep too much.

Mindfulness.—Participants reflected on the ways in which positive parenting strategies discussed in the intervention impacted how they considered their own responses to their children's behaviors. *After I take the class, now anytime when I talk to the kids I control my emotions, not to punch them, try to talk to them, try to calm them; I changed my behavior not to get mad at them, to control my emotion... Just talk to them and calm myself too.*

Participants reflected on the structure strategies discussed in the intervention added into their family routines, and the receptivity of youth to this structure. *[When my child is home] I tell them to do their homework and sleep on time. I take away the phone when it is the bedtime. They don't get mad I already give them time to play. I also told them "you go to school, come home, eat, and do your homework. You don't have to do anything in the house." They do listen. If we compare back in Burma, they have to do everything like cleaning, cooking.*

Discussion

Refugee families engage risk and protective factors as they adjust to the culture and customs of communities of resettlement. New stressors frequently require families to revise traditional approaches to communication. Compounded by a lack of exposure to and subsequent understanding of adolescent behaviors and parenting practices in the United States, these shifting structures and dynamics can undermine resilience and cohesion in families. The purpose of this study was to pilot a culturally oriented, community-based parenting curriculum delivered to members of the Karen refugee community in Minnesota and evaluate social and behavioral outcomes of the intervention. We hypothesized that the intervention would influence self-reported family cohesion, communication processes, and confidence in the parenting role. We anticipated that through the study period, the network of parenting support among Karen men and women participating in this program would be strengthened.

We focused our application of Family Systems Theory on the Family Projection Process construct, one of eight constructs described in the model. This process describes the ways in which emotional well-being can be communicated across generations. This connection between family members reinforces a need to consider dynamic family processes including the impact of individual experiences on the whole, and the impact of the whole on the individual. This dynamic model is essential to acknowledge given the multi-faceted transition families experience. Considered within this framework, the observed outcomes of the program related to family communication, family satisfaction, and self-efficacy in the parenting role are credible. Through aligning understanding and expectations of parents and their adolescent children, it is reasonable to expect improvement in cohesion and family functioning. Future studies focused on the youth perspective of family function are necessary in developing a full understanding of the needs of refugee family system post-resettlement.

Parent participants reported improvements in family communication, family satisfaction, and parent self-efficacy immediately post intervention and at long term follow up (only family communication and satisfaction assessed). We explored differences in intervention outcomes by time since resettlement, training wave, and mental health screening and found no differences.

Overall we experienced high program adherence and a low rates of attrition given the community engaged structure. Intervention acceptability improved when the curriculum was condensed and delivered over a 3-week period in terms of attendance and the time burden for families. Families were willing to participate in the additional follow up time point.

Subsequent to the pilot, the Karen Organization of Minnesota secured funding to implement the Karen Family Cohesion Program two additional times over the next year. The organization plans to recruit 15 participants per session, and will expand the age range of participants to include refugee parents of children across age groups. Participants will be grouped in sessions according to the ages of children. Curriculum content will be adapted to include appropriate developmental content based on the levels of development of the children. We will continue to assess program success in this naturalistic context and consider opportunities for sustainable integration of parenting support services.

The Karen Family Cohesion Program demonstrated opportunity in three key areas. First, the intervention represents a culturally oriented intervention adapted to uniquely address the experiences of a group of refugee parents. Second, the foundation of the intervention was built on a community-engaged research model and incorporated the needs and priorities of community members themselves. The partnered aspects of the approach were essential in the design and testing of the intervention. Finally, beyond the promising findings from the structured and qualitative assessments was a recognition of the potential of the intervention to build social support networks among parents of adolescent youth in the Karen community, a central element of resilience in refugee migration.

Interpreting aspects of the results proved challenging. The 5-item Likert response scale to Family Satisfaction and Family Cohesion sub-scales created a ceiling effect around which meaningful interpretation or improvement proved difficult. We questioned the extent to which social desirability factored into the high response ratings, though found that the authenticity of the qualitative data helped to mitigate this concern. We anticipated that we would note patterns of difference in groups characterized by time since resettlement, however these patterns did not emerge in our data. This remains a future area of inquiry.

Presently, there is limited literature describing the experience of parenting adolescents in the context of refugee migration. The majority of the studies on parenting post refugee resettlement refer to elementary school aged children or younger. Adolescents of refugee parents often have a greater memory of the trauma and stress than younger pre- or school-aged counterparts.⁷⁻¹² Refugee parents identify priorities such as improved parenting communication as well as skill-building to address new social challenges that youth face.²⁹ Understanding the legal rights of children and adults in the country of resettlement is essential. Parents identified positive parenting strategies as priority topics to support a

healthy family dynamic, build balance, and strengthen their capacity to foster respect in children without a reliance on physical punishment.²⁹ As a result of the divergent migration experiences through the trajectory of migration and resettlement, Karen parents expressed a lack of familiarity with typical adolescent behaviors in the United States. These included health-risk behaviors such as alcohol consumption or gang involvement. Karen refugees have reported interest to programmatic partners, in a program centered on improving family cohesion through a parenting curriculum that addresses such gaps in understanding. A key design decision in our research study, the inclusion of families with youth eligible for high school within the year, was driven by a recognition of this need. We structured the development of the intervention around these concepts.

Study findings informed the refinement of the Karen Family Cohesion Program. The Karen Organization of Minnesota is offering the parenting intervention within its programmatic scope. The organization has received referrals from health providers seeking community resources to address social and familial needs of patients. In light of these conversations, we determined that an essential facet of the ongoing activities of the Refugee Family Cohesion Program would center on a balance of families with high functioning, and those needing more support. This is a result of observations surrounding the impact of positive and productive experiences shared within the group, and the balance these types of insights provided to families bringing challenges. To ensure a productive experience, at this point we recommend balancing group composition, including families with healthy function with those who need targeted support. Establishing a pathway for provider referrals for families with adolescent youth experiencing significant challenges is an important future direction of study as we customize the intervention to the needs of the Karen community. Parents whose youth are in crisis may benefit from an adapted parenting intervention. Healthcare providers have expressed interest in options to support families experiencing more urgent needs.

Based on our findings, we believe strategies parents gained from this intervention will facilitate the negotiation of shifting norms in parenting. For Karen parents, these outcomes could mitigate experiences of depression and anxiety in the long term, though we did not see these patterns emerge in our data. Empowering parents with communication strategies and boundary setting could influence adolescent engagement in risk behaviors. Outcomes support strengthened family structures and thriving and wellbeing of youth post-resettlement.

Limitations

This pilot represented an initial step in exploring facets of the implementation of a newly adapted parenting intervention. Thus our sample size is small and we are not able to generalize our findings beyond the sample of families we included in our study. Reported findings represent the parental perspectives. Adolescent perspectives are not represented in the results and could vary substantially. To support intervention testing we designed the study to maximize participation, and thus provided transportation to and from the sessions for all participants. Adherence to the intervention once integrated into a routine and naturalistic setting is an important element of our continued monitoring. Social desirability bias was a likely factor in the responses of participants in the quantitative assessments. We

designed a mixed methods study and integrated the responses of participants in post-intervention focus groups to address this source of bias. The FACES IV instrument (including the communication and satisfaction subscales) have not previously been validated with the Karen cultural group. Based on pilot findings, we anticipate expanding the use of the FACES IV in the next steps of our research trajectory to include the full 62-item instrument, as well as an analysis of the validity of the instrument.

Conclusion

We developed the project to address a need identified as a priority by community members and community stakeholders. The prominent role of Karen Organization of Minnesota on our research team was essential to the success of the project. As migration has reached a stable endpoint in resettlement, Karen families negotiate shifting social, cultural, political, economic, and legal norms. These shifts impact the structure, balance, and dynamics of power within the family system. The Refugee Family Cohesion Program intervention demonstrated the potential to positively impact the parenting experience. The intervention provided participants with tangible strategies to promote family cohesion and communication through parent education, skill building, and social support.

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Figure 1.

Sequential explanatory mixed methods pilot study design. *Measures collected in sessions 2 and 3.

<p>Topic 1: Immigrant teenagers and parents in the United States</p> <ul style="list-style-type: none"> • Discuss and describe experiences of Karen parent participants with teenage development and what it means to be a parent in the United States. 	<p>Topic 2: Raising a healthy teenager</p> <ul style="list-style-type: none"> • Discuss basics of healthy adolescent and teenage development. 	<p>Topic 3: Communication & problem solving</p> <ul style="list-style-type: none"> • Discuss ways to give attention to teenagers, communication strategies, and ways to effectively address attitudes and behavior. 	<p>Topic 4: Discipline</p> <ul style="list-style-type: none"> • Cultural comparison of discipline (Karen and United States cultures). • Consider various forms of discipline and how these impact behavior. 	<p>Topic 5: Harm reduction: Identifying risk behaviors</p> <ul style="list-style-type: none"> • Discuss behavioral risks teenagers face in the United States. • Consider approaches to teenage drug and alcohol use, sexuality, gang involvement, and social media. 	<p>Topic 6: The education environment</p> <ul style="list-style-type: none"> • Provide overview of the United States education system. • Discuss school involvement resources, and challenges immigrant parents face.
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Figure 2.

Key study outcomes—family communication, family satisfaction, and parent self-efficacy by time in the United States.

Figure 3.

Topic areas delivered over a 6-session Refuge Family Cohesion Program period. In training wave 1, curriculum was delivered over 6 weeks. In training waves 2 and 3, curriculum was delivered over 3 weeks.

Figure 4.
Key study outcomes - Family Communication, Family Satisfaction, and Parent Self-Efficacy by Mental Health Screen.

Table 1.

Quantitative assessment instruments and psychometrics

Instrument	Characteristics	Item sample	Psychometrics	Citation
<i>Family Communication</i>	A 10-item subscale of the Family Adaptability and Cohesion Scales (FACES) IV instrument assessing the degree to which family members feel unconstrained and satisfied with family communication	<i>Family members are able to ask each other for what they want</i>	$\alpha = 0.9$	Olson, 2011 ²³
<i>Family Satisfaction</i>	A 10-item subscale of the FACES IV instrument assessing fulfilment and enjoyment among family members	<i>Your family's ability to cope with stress</i>	$\alpha = 0.92$ (test re-test 0.85)	Olson, 2011 ²³
<i>Parental Self-Efficacy</i>	A 17-item scale assessing self-agency and coping in the parental role	<i>Setting clear rules and expectations for your teen and sticking with them</i>	$\alpha = 0.92-0.93$	Dumka et al., 2010 ²⁶ ; Allen et al., 2013 ²⁷ ; Sieving et al., 2017 ¹³
<i>Mental Health</i>	A five item screener assessing general mental health concerns and identify individuals for referral	<i>In the past month, have you been unable to concentrate, remember things, or make decisions?</i>	$\alpha = 0.83$	Brink et al., 2015 ²⁸

Table 2.

Demographic data by time in US, mental health screen, and training wave.

				< 1 year	Time in US 1 – 5 years	> 5 years
	N	Mean (SD)	Range	Mean (SD)	Mean (SD)	Mean (SD)
Female, n (%)		27 (68%)		5 (71%)	13 (81%)	8 (50%)
Age, years	40	48.2 (8.3)	33–64	46.4 (6.7)	45.8 (8.4)	52.2 (7.4)
Years in a Camp	40	13.3 (5.1)	6–27	16.3 (6.0)	12.5 (4.8)	12.9 (4.9)
Years in the US	39	4.6 (3.1)	0.5–11	1.0 (0.3)	2.9 (0.7)	7.9 (1.5)
Children	40	4.8 (1.8)	2–10	4.9 (1.7)	4.9 (1.5)	4.8 (2.1)
Child in the home	39	3.8 (1.9)	1–10	4.0 (2.2)	3.9 (1.7)	3.9 (2.1)
Modules attended	40	5.5 (1.2)	2–6	4.9 (1.6)	5.8 (0.5)	5.8 (1.0)
Mental Health Screen						
Referral, n (%)		10 (25%)		1 (14%)	5 (31%)	4 (25%)
Training Wave, n (%)						
First		11 (28%)		4 (57%)	6 (38%)	1 (6%)
Second		17 (44%)		1 (14%)	5 (31%)	11 (69%)
Third		8 (28%)		2 (29%)	5 (31%)	4 (25%)

Table 3.

Mean of family communication, family satisfaction, and parent self-efficacy by resettlement time, mental health, and training wave

	Time in the United States						
	0–1 year		>1–5 year		>5 year		p-value
	Mean	Std Error	Mean	Std Error	Mean	Std Error	
Family Communication	4.75	0.12	4.78	0.08	4.91	0.08	0.41
Family Satisfaction	4.78	0.17	4.66	0.11	4.86	0.11	0.46
Parent Self-Efficacy	4.99	0.07	4.97	0.04	4.91	0.03	0.97

	Mental Health Screen				
	Referral		No Referral		p-value
	Mean	Std Error	Mean	Std Error	
Family Communication	4.79	0.11	4.83	0.06	0.78
Family Satisfaction	4.53	0.13	4.84	0.08	0.057
Parent Self-Efficacy	4.97	0.04	4.93	0.03	0.36

	Training Wave						
	First		Second		Third		p-value
	Mean	Std Error	Mean	Std Error	Mean	Std Error	
Family Communication	4.71	0.10	4.82	0.08	4.92	0.10	0.31
Family Satisfaction	4.75	0.13	4.81	0.11	4.71	0.14	0.89
Parent Self-Efficacy	NA	NA	4.92	0.03	4.97	0.03	0.31